STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165440	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow House Care Center	**3456 Indian Creek Road , Marion, Iowa, 52302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ KBS	INITIAL COMMENTS Correction date: 02/17/2026 The following deficiencies resulted from investigation of complaint #2712565-C and facility reported incident #2697013-I conducted on January 27, 2026 to January 28, 2026. Complaint #2712565-C resulted in a deficiency. Facility reported incident #2697013-I resulted in a deficiency. See Code of Federal Regulations (42FR) Part 483, Subpart B-C.	F0000		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical review, staff and resident interviews, and facility policy review, the facility failed to complete wound treatment as ordered for 1 of 5 sampled residents (Resident #1). The facility reported a census of 47 residents. The facility corrected the deficient practice though past-noncompliance through the following actions: *All residents with active treatment orders were assessed and treatments confirmed as completed per physician order *Reeducation of all licensed nursing staff on 1/4/26 and 1/5/26	F0684	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Molly Schulte NHA-ADM/LNHA	Administrator ✓	2/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165440	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

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F0684 SS = D	Continued from page 1 *Post correction audits and weekly audits 1.Review of the Minimum Data Set (MDS) dated 10/23/25 revealed Resident #1 had diagnoses which included heart failure, diabetes, non-Alzheimer's dementia, vascular disease and a stage 3 pressure ulcer, and received pressure ulcer/injury care. The resident required substantial assistance from staff for toileting, bathing, and partial assistance for ambulation. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident had severe cognitive impairment. Review of the Care Plan revised 1/24/26 revealed Resident #1 had an actual pressure ulcer related to impaired mobility, described as a Stage III (full-thickness skin loss) on the left lateral foot. The Care Plan intervention dated 1/24/26 directed the staff to provide adequate calories and protein for skin healing and integrity, and the interventions dated 9/17/25 revealed to assess the condition of the pressure ulcer and surrounding skin weekly and to complete treatments as ordered. Review of a Progress Note dated 12/16/25 revealed Resident #1 went out to a local [wound provider] appointment on December 16, 2025 and returned without new orders. Review of a progress note from a local [wound provider] dated 12/16/26 indicated the resident's wound appears worse as noted by an increase in dimensions. The diabetic left lateral wound described as clean, painful and fragile and has been present for more than a year. The Physician Order dated 11/17/25 directed the staff to cleanse the foot wound and surrounding skin. Paint callous and wound with betadine, cover with a foam dressing and secure with gauze wrap and tape. The wound care should be completed daily on the evening shift. Review of the Physical Therapy Treatment Encounter Note for date of service 12/18/25 signed by Staff L, Physical Therapy Assistant and Rehabilitation Director revealed, Pt (patient) states wound care was not completed last night. Wound cover is still dated 12/16 from wound Dr. (doctor) appointment. Per this note, the Administrator was notified. The Incident Report dated 12/18/25 for Resident #1 revealed, Administrator informed nurse that therapy aide informed her that the dressing to the residents left foot had a past date on it and had not been changed on the evening shift. The Resident Description	F0684		

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F0684 SS = D	Continued from page 2 section revealed, When day nurse went to change dressing, resident stated that no one has changed dressing for a couple days. The Immediate Action Taken section revealed, Nurse changed dressing ASAP (as soon as possible) after being informed it wasn't changed by 2-10 nurse. Review of Resident #1's December 2025 treatment record revealed Staff K, LPN (Licensed Practical Nurse) signed of the wound treatment which indicated he completed it on 12/15, 12/16 and 12/17/25. Staff K placed his initials with a check mark on the record indicating the treatment was completed. Interview with Staff K, LPN on 1/28/26 at 8:55 am revealed Staff K forgot to do the dressing change whatever day in December the resident went to the wound clinic. Staff K was uncertain of the day but stated it was around her appointment date. He admitted he just signed it off because the wound clinic did the dressing change that day. Staff K stated he really cannot remember the date, but stated he just signed it off and reported everyone else did it that way on the days a resident goes to the wound clinic. He stated he did not make any progress notes in regards to the wound in the resident's clinical record. He stated he got terminated for just signing off the dressing change without having completed it. During an interview with Staff G, Director of Nursing (DON) on 1/28/26 at 7:30 am, Staff G stated apparently he was not doing the skin treatments as ordered and was just signing it off as completed. She stated they became aware of the situation on 12/18/25 when Resident #1 had a wound dressing dated 12/16/25. Staff G stated Staff E, Assistant Director of Nursing (ADON) handled the investigation. During an interview with Staff E on 1/27/26 at 11:48, the incident was brought to his attention on 12/18/25 from the Administrator who she received a report from the [wound provider] in regards to Resident #1's dressings not being changed as ordered. Staff E stated the resident went to the [wound provider] on 12/16/25 and stated he really cannot remember if the reported date on the dressing was the day before the weekend or the weekend before. He stated he came into the investigation at the end and was told by the Administrator that on 12/18/25 Resident #1 had a dressing dated 12/16/25. During an interview on 1/28/26 at 1:00 pm with Staff I, Registered Nurse (RN), Staff I stated it was brought to her attention on 12/18/25 that Resident #1's pressure	F0684		

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F0684 SS = D	Continued from page 3 sore dressing currently had a date on 12/16/25 on it. She observed this to be true. She completed the scheduled dressing change on her shift as it was apparently not completed on 12/17 as ordered. According to the Medication Administration Policy last revised on 6/30/2023 directed staff to administer medications as prescribed. The procedure for dispensing medications is as follows: Wash hands with soap and water prior to beginning medication pass. Alcohol waterless sanitizer is acceptable between residents. Open medication cart with key held by licensed nurse/OMT/Director of nurses. Medication labels will be checked against current MAR for individual resident's medication pass. Remove medication with labels facing the nurse/certified medication technician. Check labels to medication administration record. Verify resident, drug, strength, dose, route and hours of administration with medication administration record. Follow manufacturer's directions for medication use. Dispense medication into medication cup. Return medications to cart. Close and lock medication cart. Identify the resident. Administer medication. Assure resident has taken the medication. Sign medication on the medication administration record.	F0684		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = G	Continued from page 4 Based on observation, clinical record review, facility policy and staff and resident interviews the facility failed to appropriately transfer a resident from the bed to chair with the use of a mechanical lift in order to prevent a fall with injury for one of three residents reviewed (Resident #4). The full body lift tipped during Resident #4's transfer, and the resident sustained a bruise and skin tear. The facility reported a census of 47 residents. The facility corrected the deficient practice through past-noncompliance through the following actions: *Staff education completed 12/26/25 and 12/29/25 regarding full body lift safety *Removal of the full body mechanical lift pending inspection *Completion of weekly patient lift inspection Findings include: 1.The MDS (Minimum Data Set) dated 10/23/2025 revealed Resident #4 had no cognitive impairment, required substantial/maximum assistance to transfer from one surface to another and had diagnoses including heart failure, diabetes and pressure ulcer left heel. The Care Plan revised on 1/23/2026, identified the resident had a fall risk. It directed staff to use a full body lift and two staff to transfer the resident to the shower chair. The Morse Fall Scale dated 10/23/2025 revealed the resident had a moderate risk for falls. The facility incident report dated 12/26/2025 revealed Staff A, RN (Registered Nurse) found the resident still hooked to the full body lift with the machine on its side when she entered the room. She found the resident laying on the floor on her back with knees bent. Staff commented that they were turning machine when the machine tipped over sideways. Staff lowered the resident while the other staff tried to hold the machine to keep it from falling on the resident. The lift's crossbar hit the resident's right eyebrow and she sustained a bruise, 2.5 cm (centimeters) by 1 cm to the area. The lateral side of the right great toe had a skin tear that measured 1 cm by 0.5 cm., and a small plaque scab from the resident's psoriasis. The resident denied pain, headache or nausea. Staff A assessed the resident's vital signs and three staff assisted the resident back up into the shower chair using a	F0689		

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F0689 SS = G	Continued from page 5 different full body lift. The resident reported the machine tipped over when staff were transferring her. The 72 hour fall follow up progress note dated 12/29/2025 revealed the resident reported no pain or discomfort. Staff noted a light yellow discoloration of bruise above the right eyebrow. On 1/27/2026 at 2:00 pm, observation revealed the resident, alert and oriented, and in bed watching television. She indicated at the time of the incident everything went great and then suddenly things started collapsing. Two staff were present, Staff B, CNA tried to catch the resident from falling. Staff C., CNA ran the lift and it just tipped over. She bumped her forehead but was not really hurt, and she failed to recall the injury to her toe. On 1/27/2026 at 11:15 am, Staff F, Administrator reported Resident #4's fall happened on 12/26/2025. Staff G, DON (Director of Nursing) called her and informed her that Staff B and Staff C, CNA's did a transfer with the resident with a [Brand name full body mechanical lift] lift from her bed to a shower chair. When they went to turn her into the shower chair, the [full body mechanical lift name redacted] tipped over. Staff B was able to get her safely and lowered her without the lift tipping over on her. The bar that attaches the sling did hit her during that incident. Immediately they pulled the [lift] off of the floor until it could be inspected by Staff E, ADON who was on sight and Staff H, Maintenance when he returned from out of town. The facility rented a second [brand name] lift until that one could be cleared. Staff B and Staff C were interviewed and retrained by Staff E on proper lift use. Staff were re-educated and the entire following week they drilled it in at the 2 pm meetings with all staff training. The education was also written in the communication book. The inspection revealed the lift did work, however the last bit of opening takes longer. Staff failed to make sure the legs of the lift were open wider than the resident. They did not wait for the legs to open completely. They followed the policy except for waiting for the legs to open completely. They handled the situation to the best of their ability and the resident sustained minor injury. On 1/27/2026 at 11:50 am, Staff E, ADON reported he learned Resident #4 had a fall on the following Monday. He indicated staff used a [Brand name redacted] lift and failed to completely open the legs on the lift, causing the imbalance and the lift to tip. Two staff, Staff B and Staff C were present and were able to catch the resident to a point and lower her safely and keep	F0689		

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F0689 SS = G	Continued from page 6 them from hitting anything. Staff E provided one to one education and had Staff B and C demonstrate the safe use of the mechanical lifts prior to using the lifts again. The resident had no injury from the fall. On 1/27/2026 at 2:50 p.m., Staff A, RN revealed when Resident #4 had the fall with the lift, staff called for help. She entered the room and found the resident on the floor on her back. Staff B reported he supported her when she went down and the lift had tilted onto its side. Staff C, CNA managed the lift . They determined the legs on the lift did not open and it tipped. The resident had a bruise on her forehead and a small skin tear on her toe that healed within a few days. Staff A explained they had staff write statements, educated staff and completed the incident report and progress notes. On 1/28/2026 at 8:13 am, Staff G, RN, DON (Director of Nursing) went to Resident #4's room when she heard staff needed help. Staff B and Staff C were transferring her with the [Name redacted] lift bed to shower chair. The [lift] when it was being moved to the shower chair, it tipped. She went down assisted, but she did bump her head on the [lift] bar. She had a bump and bruise on the left side of her forehead and a skin tear on her toe. Staff G explained checked afterwards to see if the legs were spread. The legs did spread but not out all the way. Per the DON, brought the lift out afterwards and tested it, and the legs did spread out completely. The DON explained did education that when moving and turning the machine, the legs need to be completely spread out. Per the DON, the reason they think we said the lift was not working properly was because the legs did not spread as they should have. Per the DON, educated at the meeting at 2 p.m. the aides, all of them, and was is in the communication book. On 1/28/2026 at 8:30 am, Staff C, CNA reported when Resident #4 fell, she transferred her along with Staff B. Staff C called Staff B after she got the sling under the resident. They hooked the sling to the lift. Staff C operated the lift, got the lift up and pressed the button to separate both legs. The grinding noise had stopped and she assumed the legs had fully spread out. Staff C backed up from the bed, and when she went to turn the lift, it began to lean left. She reached out with her left hand in order to grab it and keep it from tipping, but it was too strong for her to stop it. The weight was stronger than her and they started going to the floor. The wheels capsized and lifted into the air. Staff C slid down as gently as she could and Staff B grabbed the resident in order to start steering her	F0689		

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F0689 SS = G	Continued from page 7 into the chair. Staff C's right foot slid and ended up underneath the [brand name lift] wheels. Staff B slid the resident to the ground. Once it started coming down, the whole thing came down. Thankfully, it was a padded lift. The crossbar hit the resident on the left side of the eyebrow and it bruised her. She also had a skin tear on her toe. Staff C believed the DON documented the lift malfunctioned. Staff C did training with Staff E, and she had to demonstrate using the lift. In the end, they determined the [brand name] lift did work correctly. They took that particular [brand name] lift off the floor, somebody checked it out and said it worked correctly. For some reason the legs did not spread out fully. Typically, when she heard a grinding noise it fully opened. The battery was fine so she assumed the legs were spread out. She received coaching and had to demonstrate the procedure. On 1/27/2026 at 4:05 pm, Staff B reported he had just finished across the hall and Staff C said she needed help with Resident #4. Staff C had the [brand name lift] controls and Staff B had the shower chair. Staff C raised the sling up from the bed. Staff B thought the [brand name lift] legs were not open as they should have, the [brand name lift] tipped and the resident hit her head on top of the lift. Staff B had a hold of the sling and tried to lower the resident. Staff B went to get the nurse, she assessed the resident and they got her up off the floor. After the incident he and Staff C were educated regarding safety issues, including the need to make sure the Hoyer legs are open all the way. The also had to demonstrate the procedure. The facility Full Body Lift policy included the following steps: a. Explain procedure to resident, provide privacy b. Appropriate sling size selected c. Two staff members present for transfer d. Sling placed correctly e. Sling correctly attached to the lift f. Resident instructed to cross arms g. One staff manages the lift while the second staff guides the resident, providing support as needed h. Resident positioned for comfort i. Sling removed. Sling may remain under resident in	F0689		

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F0689 SS = G F0865 SS = E	Continued from page 8 chair if addressed in resident care plan QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices;	F0689 F0865	**TAG F0865 – QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)** *Deficiency:* *Based on staff interview and CMS 2567 review, the facility failed to ensure an effective QAPI process to identify previously identified deficiencies, resulting in a repeated deficiency cited on the current survey and cited in the previous survey. The facility reported a census of 47 residents.* **Plan of Correction** **1. Corrective Action for Residents Affected** • The Administrator, Director of Nursing, Infection Preventionist, and QAA Committee reviewed all current and prior deficiencies to ensure corrective actions were completed. • QAA Committee held an emergency meeting to address the repeated deficiency and establish immediate oversight procedures. **2. Identification of Residents with Potential to Be Affected** • All 47 residents had potential to be affected by an ineffective QAPI program. • A facility-wide audit of all quality systems, performance indicators, incident logs, previous survey findings, and PIPs was completed to identify any unresolved or insufficiently monitored issues. **3. Systemic Changes to Prevent Recurrence** • Revised written QAPI Plan and QAA Committee charter. • Implemented standardized tracking logs for deficiencies, audits, incidents, and PIPs. • Provided comprehensive QAPI and root cause analysis training to all department heads. • Governing Body now receives monthly QAPI progress reports for 6 months. • Updated leadership expectations for ongoing monitoring, sustainability, and accountability. **4. Monitoring to Ensure Compliance** • Administrator will review QAPI tracking logs weekly for 12 weeks and monthly thereafter. • DON and IP will track clinical indicators weekly. • Findings reviewed during QAA and Governing Body meetings. • Any declining trends will trigger immediate performance improvement projects.	**Date of Compliance:** **02/17/2026**

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F0865 SS = E	Continued from page 9 §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.	F0865		

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F0865 SS = E	Continued from page 10 §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and Centers for Medicare and Medicaid Services (CMS) 2567 review, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to identify previously identified deficiencies, resulting in a repeated deficiency cited on the current survey and cited in the previous survey. The facility reported a census of 47 residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) 2567 form dated 9/25/2025, reflected a deficiency identified for staff failure to use Enhanced Barrier Precautions while doing resident cares for those identified as a risk. During the current complaint survey and facility reported incident survey dated 1/28/26, the team identified the same deficiency, Infection Control (F880). During an interview with the Administrator on 1/28/26 at 2:30 pm she reported she monitors and audits the effectiveness of the QAPI process and confirmed the concern related to the pattern of a deficiency at F880.	F0865		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	**TAG F0880 – INFECTION CONTROL AND ENHANCED BARRIER PRECAUTIONS (EBP)** *Deficiency:* *Based on observations, clinical review, staff interviews and policy review, the facility failed to utilize Enhanced Barrier Precautions (EBP) for 1 of 3 sampled residents (Resident #1). The facility reported a census of 47 residents.*	**Date of Compliance:** **02/17/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165440	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

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F0880 SS = D	Continued from page 11 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	**Plan of Correction** **1. Corrective Action for the Resident Affected** • Resident #1 was immediately placed on appropriate Enhanced Barrier Precautions (EBP). • Direct care staff caring for Resident #1 were re educated regarding EBP requirements and PPE procedures. **2. Identification of Residents with Potential to Be Affected** • Facility-wide audit of all 47 residents was completed to confirm: – Accurate identification of residents requiring EBP. – Correct EMR, kardex, and care plan documentation. – Appropriate PPE availability and usage. • Observational audits conducted on all units to verify compliance. **3. Systemic Changes to Prevent Recurrence** • EBP policy reviewed, updated, and redistributed to staff. • Provided mandatory facility wide EBP training, including: – High-contact care tasks – PPE donning and doffing – Indications for EBP vs Contact Precautions – EBP requirements for therapy and shared shower rooms • Ensured PPE supply availability inside or outside resident rooms. • Installed alcohol-based hand rubs and trash cans at proper PPE disposal locations. • Therapy department educated on EBP protocols for gym and mobility tasks. • Infection Preservationist integrated enhanced monitoring and EMR alerts into daily processes. **4. Monitoring to Ensure Compliance** • IP will conduct EBP observation rounds three times weekly for 12 weeks. • DON will audit PPE availability weekly for 12 weeks. • Results reviewed during monthly QAA Committee meetings. • Non-compliance will result in immediate re education and QAPI follow up.	**Date of Compliance :** **02/17/2026**

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F0880 SS = D	Continued from page 12 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical review, staff interviews and facility policy review, the facility failed to utilize Enhanced Barrier Precaution (EBP) for 1 of 3 sampled residents reviewed (Resident #1). The facility reported a census of 47 residents. Review of the Minimum Data Set (MDS) dated 10/23/25 revealed Resident #1 had diagnoses which included heart failure, diabetes, non-Alzheimer's dementia, vascular disease and a stage 3 pressure ulcer (full thickness skin loss), and received pressure ulcer/injury care. The resident required substantial assistance from staff for toileting, bathing, and partial assistance for ambulation. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident had severe cognitive impairment. Review of the Care Plan dated 9/8/25 indicated the resident needed Enhanced Barrier precautions due to a wound. The Goal section informed staff the precautions would reduce the spread of infectious agents and minimize the transmission of infection. The Care Plan interventions dated 9/8/25 directed the staff to wear a gown and gloves for high contact activities and to have personal protective equipment (PPE) available for staff near the entrance of the resident's room. Additional interventions dated 9/8/25 directed staff to maintain signage on the outside of the resident's door regarding the precautions needed, required PPE, and high contact resident care activities, and to practice good hand hygiene. Observations on 1/27/26 at 1:50 pm revealed the resident's bedroom door did not have a PPE sign hanging on it and the room did not have PPE available for staff	F0880		

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F0880 SS = D	Continued from page 13 use. Staff J, Registered Nurse (RN) entered the resident's room to complete her daily dressing change. Staff J failed to put on a disposable gown as she assembled the needed supplies. Staff elevated the resident's foot and removed the soiled dressing which appeared to have a dark substance on it and then proceeded to perform wound measurements and completed the wound treatment. Staff J re-dressed the resident's wound and cleaned up the room. Staff J completed all of these tasks without having on a disposable gown as directed by the EBP requirements. During an interview with Staff J, RN on 1/27/26 at 4:00 pm, the RN stated she did not wear a disposable gown per policy while completing the wound treatment earlier today at 1:50 pm. She stated she forgot to put it on because the resident's room did not have a sign on the door indicating a need for PPE and the resident recently had a room change. During an interview with Staff E, Assistant Director of Nursing on 1/28/26 at 2:30 pm, Staff E was informed about Staff J not wearing a gown when completing the wound dressing change yesterday for Resident #1. Staff E stated he re-educated her after the last survey regarding this issue. Staff E stated the resident recently changed rooms and the staff must not have not brought the sign and PPE with her. Review of the policy for Transmission Based Precautions updated on 4/1/24 informed the staff Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The policy directed the staff to use personal protective equipment such as gloves and gowns. The staff should don the protective equipment prior to high-contact care activities. The policy identified high-contact activities: wound care: any skin opening requiring a dressing.	F0880		