| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165527 | A. BUILDING _____ B. WING _____ | 08/25/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| PATTY ELWOOD CENTER | 21668 80TH STREET CRESCO, IA 52136 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, observation and staff interview the facility failed to maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 5 sampled (Resident #1, #3 and #5). The facility reported a census of 24. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 6/29/20, for Resident #1 showed a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive loss. The MDS identified a [DIAGNOSES REDACTED]. A Physician order [REDACTED]. The Care Plan, identified the resident had an Activities of Daily Living self-care performance deficit and required extensive assistance of one staff for toilet use and catheter care. During an observation on 8/17/20 at 12:35 p.m. the resident sat in the wheelchair at a bedside table in the dining room. A uncovered urinary drainage bag hung from the bottom of the wheelchair with the catheter tubing laying on the floor. During an observation on 8/17/20 at 1:45 p.m., the resident sat in the wheelchair at a bedside table in the dining room. A uncovered urinary drainage bag hung from the bottom of the wheelchair with the catheter tubing laying on the floor. During an observation on 8/17/20 at 2:30 p.m., Staff A (Nurse Aide) and Staff B (Nurse Aide)wore medical masks and face shields for resident care. Staff A wheeled the resident to his/her room [ROOM NUMBER] feet with the catheter tubing dragged along the floor. Staff A and B transferred the resident from the wheelchair to the bed. Staff A and Staff B donned gloves without performing hand hygiene. Staff A reached into the garbage can and pulled out a plastic bag from under the garbage bag with the gloved hands. Staff A placed the plastic bag under a graduate on the floor to empty the residents catheter bag. Staff A milked the catheter tubing up and down repeatedly for over 10 minutes to drain the catheter tubing with the same gloves that had touched the garbage can. At 2:40 p.m., Staff A handed the catheter bag to staff B. Staff B lifted the catheter bag above the level of the bladder three times while milking the tubing to drain the catheter tubing. Staff A finished draining the catheter bag and placed the plastic bag with graduate that had been sitting directly on the floor on the counter by the sink to measure. Staff A and B completed cares, removed gloves and performed hand hygiene. During an observation on 8/18/20 at 8:03 a.m., the resident sat in the wheelchair at the dining room table. The catheter bag remained uncovered and the catheter tubing lay on the floor. During an observation on 8/18/20 at 1:40 p.m., the resident lay in his/her low bed. The catheter bag remained uncovered and touched the carpeted floor. During an observation on 8/18/20 at 3:42 p.m., the resident lay in his/her low bed. The catheter bag remained uncovered and touched the carpeted floor. During an observation on 8/19/20 at 8:37 a.m., the resident sat in the wheelchair at the dining room table. The catheter bag remained uncovered with the tubing laying directly on the floor. During an observation on 8/19/20 at 4:00 p.m., the resident sat in the wheelchair at the dining room table. The catheter bag remained uncovered with the tubing laying directly on the floor. During an observation on 8/20/20 at 8:30 a.m., the resident sat in the wheelchair at the dining room table. The catheter bag remained uncovered with the tubing laying directly on the floor. During an observation on 8/24/20 at 8:35 a.m., the resident sat in the wheelchair at the dining room table. The catheter bag remained uncovered with the tubing laying directly on the floor. During an interview on 8/24/20 at 10:05 a.m., Staff C (Licensed Practical Nurse) reported catheter bags should be covered at all times and the tubing should not come into contact with the floor. The staff need to perform hand hygiene before and after cares with hand sanitizer used between glove changes once in the room. Staff should perform hand hygiene and change gloves after touching the garbage can before performing care. During an interview on 8/25/20 at 10:15 a.m., the Director of Nursing (DON) reported she would expect the catheter bag to be covered and the tubing to be kept off of the floor for infection control. Staff should perform hand hygiene before and after cares. Staff should have performed hand hygiene and glove change after touching the garbage can. The Catheter Care Policy, undated, provided by the facility identified the purpose of catheter is to prevent infection and to reduce irritation. The policy listed the following procedure for steps 1-3: 1. Wash your hands, gather equipment and take to the bedside. 2. Explain procedure to resident and provide privacy for the resident. 3. Put on gloves. Step #14 identified the following: Empty the drainage bag once per shift. Wash hands and put on gloves. Place container on top of a paper towel or other barrier. Empty contents of bag into container. Take care not to allow tip to touch any other surface. Once empty, close clamp, use alcohol wipe on tip of drainage tube. Place back into holder on bag. Measure urine and dispose of in toilet. Wash hands. 2. The MDS assessment, dated 5/28/20, for Resident #3 showed a BIMS score of 3, indicated severe cognitive loss. The MDS identified the resident a [DIAGNOSES REDACTED]. The Care Plan, revised 7/27/20, identified the resident with an Activities of Daily Living self-care performance deficit and listed the resident as dependent upon staff for eating meals. During an observation on 8/18/20 at 8:44 a.m., Staff D (Paid Nutritional Assistant) had a medical mask and face shield when assisting the resident with breakfast. Staff D touched the resident's toast with her bare hands three times so the resident could finish eating his/her toast. During an interview on 8/25/20 at 9:40 a.m., Staff H (Nurse Aide) reported she had training in meal assistance and resident food should not be touched with bare hands. She stated food should be handled with utensils or with a gloved hand. During an interview on 8/25/20 at 9:45 a.m. Staff I (Licensed Practical Nurse) reported resident food should not be touched with bare hands. She would expect staff to use the utensils or a gloved hand. During an interview on 8/25/20 at 10:15 a.m. the Director of Nursing (DON) reported she would expect staff to use a gloved hand to handle resident food or cut the food into smaller pieces, then use a fork or spoon for the resident's meal assistance. Staff should not touch resident food with bare hands. The Food Production and Service Policy, June 2020, provided by the facility failed to address staff should not touch food with bare hands. 3. The Minimum Data Set (MDS) Assessment, dated 5/14/20, showed a Brief Interview for Mental Status Score of 00, indicating a severe cognitive loss. The MDS identified a [DIAGNOSES REDACTED]. The MDS listed the resident as always incontinent of bowel and bladder. The Care Plan identified a focus problem of mixed incontinence related to dementia and impaired mobility. A intervention, dated 10/15/15, instructed staff to provide incontinence care before and after meals. During an observation on 8/17/20 at 1:25 p.m., Staff E (Nurse Aide) and Staff F, C.N.A., wore medical masks and face shields into room, performed hand hygiene and transferred the resident to bed using a mechanical lift. Staff E and Staff F completed hand hygiene, donned gloves and set up perineal care supplies. Staff E touched the garbage can to pull two plastic bags out of the garbage can and place both bags at the foot of the residents bed. Staff E removed gloves, performed hand hygiene and donned new gloves. Staff D and F removed brief heavily soiled with urine. Staff E cleansed the anterior perineal area and touched the soap bottle three times to apply to the wash cloth with the same gloves used to cleanse the frontal perineal area. Staff E touched the resident with dirty gloves to assist to roll onto the left hip. Staff E finished cleansing the right hip, gluteal fold and part of the left buttock. Staff E placed a clean brief under the resident with the dirty gloves. Staff E and F rolled the resident onto his/her back and finished applying the adult brief. Staff E touched the bedside table and hoyer lift with the dirty gloves before removing. Staff E and F failed to cleanse the left full buttock and hip. During a interview on 8/20/20 at 10:55 a.m., Staff G (Nurse Aide) reported she received training for perineal care. She had been trained to cleanse the low abdomen, perineal care area, both hips and buttocks. She reported perineal care should be completed front to back and hand hygiene should be done before and after perineal cares. |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 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.

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>During an interview on 8/24/20 at 1:45 p.m. with Staff C (Licensed Practical Nurse) reported the staff should cleanse the low abdomen, groin, both buttock and hips as part of perineal care. Hand hygiene should be completed before and after cares with hand sanitizer used between glove changes. She reported staff should change gloves and perform hand hygiene after touching a garbage can. During an interview on 8/25/20 at 10:18 a.m., the DON, reported she expected staff to cleanse the low abdomen, anterior perineal area, gluteal fold, both buttocks and hips, front to back as part of perineal care. She stated she expected staff would not touch perineal care supplies or other surfaces with dirty gloves. The Incontinence Procedure, revised 3/25/19, provided by the facility identified the following steps: 1. Assemble equipment. 2. Explain procedure to the person served. 3. Provide privacy by closing doors and/or pulling the curtains. 4. Hand hygiene. 5. Put on gloves. 6. Remove soiled pads, linens, and clothes. 7. Put dirty linen into bag. 8. If gloves are soiled, remove and complete hand hygiene and /or apply hand sanitizer. Reapply clean gloves. 9. Place towel or soaker under perineum. 10. Men - if uncircumcised, cleanse penis by pushing back foreskin and gently washing. Gently wash around the penis and scrotum. Return foreskin to its natural position. Women - gently separate labia, wash down one side then the other (wash front to back). 11. Change cloth or cloth surface with each wipe. 12. Place soiled wash clothes into bag. 13. Turn person served to side. Wash buttocks and upper thighs. 14. Wash anal area, front to back with warm water or use disposable wipes. Place soiled linens into bag or dispose of wipes into garbage bag. 15. Rinse and dry skin thoroughly. 16. Remove towel from under perineum and place into soiled linen bag. 17. Apply moisture barrier if applicable. 18. Clean and put equipment away. 19. Remove gloves. 20. Hand hygiene. 21. Offer to wash person served hands. 22. Make sure clothing and linens are clean and dry. 23. Make person served comfortable and safe. 24. Place call light within in reach. 25. Report any unusual findings. 26. Document procedure in charting books. 27. Dispose of dirty linen bag and garbage in the soiled utility room. 28. Hand hygiene. |