STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165180	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ODEBOLT SPECIALTY CARE	**801 SOUTH DES MOINES STREET ODEBOLT, IA 51458**

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, chart review and interview, the facility failed to maintain sanitary environment to help prevent the transmission of pathogens for 5 of 24 residents reviewed (Residents #1, #2, #4 and #5). The facility also failed to have policies and procedures for infection control that are current with national standards. The facility reported a census of 24 residents. Findings include: 1. According to Minimum Data Set ((MDS) dated [DATE], Resident #1 had a Brief Interview Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Resident #1 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation on 6/11/20 at 8:30 AM revealed Resident #1 sat in a recliner chair in his room. The administrator identified him as one of the five residents in isolation in his room due to no designated area in the facility. The door to the resident's room was open and did not have signage alerting staff to take the extra precautions. There were no containers at the door with Personal Protective Equipment (PPE) for staff use and there were no separate biohazard bins for the resident's dirty laundry. Observation on 6/11/20 at 9:09 AM, revealed Staff A in the resident's room completing a blood pressure, oxygen saturation and temperature check on the resident. Staff A did not wear gloves or a gown. After taking the vitals, she then donned gloves and used the prepackaged wipes; CaviWipes, and wiped down the blood pressure machine, cuff and all around the machine. An observation of the package revealed a list of microorganisms that this product is effective in killing, and SAR-CoV-2 (COVID-19) was not listed. In a review of the product; CaviWipes, on the Environmental Protection Agency's (EPA) web site, on 6/12/20 at 9:00 AM, the EPA Registration number -8, found on the package was not on a list of disinfectants that were found effective in killing SAR-CoV-2 (COVID-19). On 6/11/20 at 12:08 p.m. observation revealed Resident #1 ate lunch on regular dishware. On 6/11/20 at 11:37 a.m., Staff C in dietary stated they do not handle the dishware differently for isolated residents and she did not know which residents were on isolation precautions. 2. According to the MDS dated [DATE], Resident #2 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS indicated that Resident #2 had a BIMS score of 9, indicating the resident had moderate cognitive impairment. On 6/11/20 at 8:30 a.m. , the Administrator identified Resident #2 in isolation. The door to the room for Resident #2 was open, there was no sign to alert staff to the isolation status, no biohazard bins or PPE supplies at the door. 3. According to the MDS dated [DATE], Resident #4 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS recorded that Resident #4 had a BIMS score of 15 out of 15, indicating intact cognition. On 6/11/20 at 8:30 a.m. , the Administrator identified Resident #4 in isolation. Further observation of the rooms for Residents #4's room did not contain signage of isolation, PPE supplies at the door or biohazard bins for laundry. In an observation on 6/11/20 at 8:50 AM Staff B from the housekeeping department was in the room of Resident #4 sweeping the floor and gathering up some trash with ungloved hands. She then left the residents room without washing her hands or using hand sanitizer. Observation on 6/11/20 at 11:57 showed Resident #4 eat lunch on regular dishware. 4. According to the MDS dated [DATE], Resident #5 had a BIMS score of 9, indicating moderate cognitive impairment. The medical record included an admission date of [DATE] with [DIAGNOSES REDACTED]. On 6/11/20 at 8:30 a.m. , the Administrator identified Resident #5 in isolation. The door to the room for Resident #5 was open, there was no sign to alert staff to the isolation status, no biohazard bins or PPE supplies at the door. Policy: In a review of facility policies, it was discovered that the only policy related to droplet precautions was dated April 2018. The policy directed staff to use standard precautions, use a mask when working within 3 feet of the resident. The facility lacked an updated policies related to COVID-19 and extra precautions recommended by Public Health. When asked for staff education provided related to droplet precautions one document dated 4/17/20 was provided and it directed staff to not open window for resident to visit with families. In an email message on 6/11/20 at 4:39 PM, the Administrator stated that none of their residents were on isolation due to exposure to person with positive test results so they changed the verbiage from isolation to quarantine. In a clarification of the difference in terms and how staff is educated, she responded with a document titled Quarantine vs. Isolation definitions. Quarantine was holding one who is at risk of having contracting an ailment, isolation is holding a person that is suffering from a contagious illness to prevent the spread.

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