

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 165482	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2020
NAME OF PROVIDER OF SUPPLIER UNITED PRESBYTERIAN HOME		STREET ADDRESS, CITY, STATE, ZIP 1203 EAST WASHINGTON STREET WASHINGTON, IA 52353	
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 - Many	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to implement CMS and CDC recommended infection control screening practices in order to prevent the spread of COVID-19 and failed to carry out infection control practices during cares for 1 of 3 sampled (Resident #1). The facility reported a census of 44. Findings include: 1. During an observation on 6/8/20 at 1:40 p.m., Staff A (Nurse Aide) entered the main entrance of the facility. Staff S explained the screening process at the start of her shifts. Staff A stated she took her temperature and wrote it down and signed her name. Staff A stated there were not any screening questions asked prior to the start of the shift. Staff A then walked from the main entrance through the facility lobby, without a mask on, and walked within 2 feet of Resident #1. During an observation 6/8/20 from 1:45 p.m. to 1:50 p.m., revealed Staff B (Medication Aide), Staff C (Nurse Aide) and Staff D (Licensed Practical Nurse) arrived to work and entered the main entrance. The staff took their own temperatures and wrote it down on a log. The staff then walked through the lobby without a mask on, and walked within 2 feet of Resident #1. The staff failed to answer screening questions prior to entering the facility. 2. During an observation on 6/8/20 and 3:20 p.m., Staff E (Nurse Aide) assisted Resident #2 to her recliner and provided a blanket. Staff E exited the room and failed to perform hand hygiene. The facility Screening Checklist directed the facility to screen employees when they entered the facility by asking if they have a fever, sore throat, or shortness of breath and to inquire if they have traveled internationally within the last 14 days or worked in a health care setting with a confirmed case of COVID-19. The facility document Checklist for Long Term Care Facilities Experiencing COVID-19 Outbreaks, dated 3/27/20, directed the facility to screen all employees for fever and cough/breathing problems at the start and the end of each shift. The facility policy Infection Control COVID-19, dated 3/16/20, directed staff to complete hand hygiene after contact with a resident. During the entrance conference on 6/8/20 at 1:00 p.m., the Director of Nursing (DON) informed the surveyor Resident #2 had isolation precautions due to a recent hospital stay. During an interview on 6/8/20 at 3:20 p.m., the DON provided the Screening Checklist. She stated it fell off the door and staff were supposed to answer screening questions prior to entry. She stated staff had answered screening questions until the sign fell down. She stated she thought they had not been answering the screening questions for the last 2 days. She stated the facility did not keep records of screening questions answered. During an interview on 6/8/20 at 3:25 p.m., Staff D (Licensed Practical Nurse) stated staff did not answer screening questions upon arrival at the facility and had never done so since the start of the pandemic. During an interview on 6/8/20 at 3:28 p.m., Staff F (Nurse Aide) stated staff did not answer screening questions upon arrival at the facility and had never done so since the start of the pandemic. During an interview on 6/9/20 at 5:00 p.m., the Administrator stated a plan to ensure staff had masks on when entering the facility.</p>		
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.