STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165271	A. BUILDING _____ B. WING _____	10/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTWOOD SPECIALTY CARE	**4201 FIELDCREST DRIVE SIOUX CITY, IA 51104**

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 observations, staff interview, and policy review, the facility staff failed to followed infection control practices in order to prevent or reduce the risk of spreading infection and disease, and failed to follow Centers for Disease Control and Iowa Department of Public Health guidelines for infection control measures for residents to mitigate a potential spread of infection. The facility reported a census of 72 residents. Findings include: 1. During observation 10/13/20 at 11:02 a.m., Staff A, Certified Nursing Assistant (CNA), carried soiled linens and a pillow under her right arm and against her uniform from a resident's room to the soiled utility room on the 200 hall. Staff A entered a code into the keypad lock, walked into the soiled hold, and placed the linens into a bag inside a lidded cart. In an interview 10/14/20 at 1:45 p.m., the Infection Preventionist reported she expected soiled linens carried away from the body, not next to the uniform, and soiled linens placed in a bag before transported to the soiled utility room. A policy for Standard Precautions directed staff to prevent contamination of clothing during transport of linens. 2. During observation 10/13/20 at 11:15 a.m., Staff B, Licensed Practical Nurse (LPN), obtained a white basket with blood sugar supplies from the medication cart, and took the supplies to a resident's room on the 600 hall. After Staff B donned a pair of gloves and checked the resident's blood sugar, she picked up the basket of supplies from the overbed table, rolled up the barrier cloth which had been used to place the basket on during the procedure, disposed of the lancet in the sharps container in the resident's bathroom, then placed the basket of supplies in the bowl of the sink. Staff B disposed of the barrier cloth and removed her gloves, then picked the supply basket up and propped it between the sink and the wall. Staff B stated she wasn't sure where she needed to place the basket. Staff B washed her hands, picked up the basket of supplies and the blood sugar machine, unlocked the medication cart, and placed the basket of supplies into a drawer in the medication cart. Staff B then took a Super Sani Cloth wipe, wrapped the wipe around the machine, and placed the machine into the medication cart. In an interview 10/14/20 at 1:45 p.m., the Infection Preventionist reported she expected staff to not place the supply basket in the sink, but rather onto a barrier. The Infection Preventionist stated the supply basket needed disinfected before placed inside the medication cart. In an interview 10/15/20 at 10:15 a.m., the Director of Nursing (DON) reported she expected staff to use a super sanicloth wipe for disinfection of the glucometer. The DON stated staff should disinfect the glucometer machine and then wrap the machine in a super sanicloth disinfectant wipe for at least 2 minutes. A facility policy for Standard Precautions directed staff to cleanse resident care equipment whenever contaminated to prevent transfer of microorganisms to other residents and environments. 3. During observation 10/13/20 at 12:12 p.m., Staff C, Laundry, pushed a cart with hangers from the 300 hall to the 500 hall. Staff C carried a plastic bag with soiled linens in her right hand, bouncing the bag on and off the floor as she walked. Staff C stopped by the soiled utility room in the 500 hall, lying the plastic bag of linens on the floor outside the soiled utility room, entered a code into the keypad lock, and walked into the soiled utility room. At 12:14 p.m., Staff C placed another bag of soiled linens on the floor next to the other bag of soiled linens outside the soiled utility room. At 12:15 p.m., Staff C pushed the cart with hangers, and drug the plastic bags with soiled linens on the floor down the 500 hall toward the exit door to the laundry room. In an interview 10/14/20 at 11:35 a.m., Staff E, Laundry, reported they picked up bags of soiled linens from the soiled utility rooms and transported the soiled linens in a cart to the laundry room. In an interview 10/14/20 at 1:45 p.m., the Infection Preventionist reported laundry staff generally transported soiled linens in a cart from the soiled utility room to the laundry area. A facility policy titled Infection Control revealed the 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. Facility staff should handle and transport linens to prevent the spread of infection. Staff should handle soiled linens in a manner as to contain and minimize aerosolization and exposure to waste products. A policy for Standard Precautions directed staff to transport contaminated and soiled linens in a manner to avoid transfer of microorganisms to other residents and environments. 4. Observations on 10/13/20 revealed the following: a. At 11:55 a.m., contact and droplet precautions sign hung on the door of rooms 107, 210, 212, 508, 701, 706, and 710. A plastic bin with 3 drawers sat outside each of those room, which contained faceshields, blood pressure cuff, stethoscope, box of gloves, and red bags. b. At 11:55 a.m., a faceshield sat by the handrail in the 500 hall by room [ROOM NUMBER]. c. At 11:55 a.m., the lid of trash bin in the room [ROOM NUMBER] up and had trash inside. A soiled gown hung outside of the soiled linen cart. d. At 11:58 a.m., room [ROOM NUMBER] had a large cart with a red biohazard bag inside the doorway full of garbage and the lid of the cart open. Used gloves, a cardboard box, and other trash was visible. e. At 1:25 p.m. room [ROOM NUMBER] had a linen cart with a yellow bag full of soiled linens and the lid of the cart partially open. f. At 1:32 p.m., room [ROOM NUMBER] had a cart with a red biohazard bag full of garbage and used gloves inside the doorway of the resident's room. A soiled resident's gown was lying partially outside the soiled linen cart. g. At 1:35 p.m., room [ROOM NUMBER] had a pink plastic basin and cardboard boxes on top of the cart with a biohazard red bag inside the cart. The red biohazard bag designated for garbage. h. On 10/14/20 at 10:50 a.m., a pile of clean wash cloths and towels sat on top of the lid of the cart with a yellow bag inside room [ROOM NUMBER]. In an interview 10/15/20 at 10:15 a.m., the DON stated she expected staff place a new yellow or red bag inside the soiled linen and trash carts in the isolation rooms whenever the bags were full. 5. During observation 10/13/20 at 12:05 p.m., three female residents sat in the doorway visiting on the 200 hall and did not wear masks. The residents were spaced only 3-4 foot apart. Staff G, LPN (licensed practical nurse), stood across the hall by the medication cart and conversed with the residents but did not encourage social distancing or for the residents to don a mask. 6. During observation 10/14/20 at 10:35 a.m., seventeen residents and the activities director observed in the dining room area attending a music activity. Three residents sat in wheelchairs next to each other less than two feet apart. Several residents sat at or by tables in the dining room. None of the residents wore masks. At 10:42 a.m., two staff entered the dining room and began moving residents around. Staff F, CNA, told the residents she had to move them during the activity because they needed to socially distance. At 11:00 a.m., three female residents sat at a table in the dining room. Only one resident wore a mask and the residents sat less than three feet apart. In an interview 10/14/20 at 11:50 a.m., Staff F, CNA, reported staff encouraged residents to wear a mask whenever they left their room but did not know what happened this morning during the activity held in the dining room, with multiple residents seated nearby each other. Staff F reported they usually only had one resident at a table or spread apart at least 6 feet. In an interview 10/14/20 at 1:45 p.m., the Infection Preventionist reported staff encouraged residents to wear a mask whenever out of their rooms and staff tried to keep residents apart and socially distanced in order to decrease the residents' risk for getting the Coronavirus. In an interview 10/14/20 at 10:15 a.m., the DON reported she spoke to staff yesterday about the need for residents to maintain social distancing and the number of residents limited in the dining room or activity at a time. The facility's COVID Preparedness Plan dated 4/22/20, revealed group activities modified to less than 10 residents, and residents spaced six feet apart. The IDPH Guidance on Phased Easing of Restrictions for Long-Term Care Facilities updated 6/30/20 revealed group activities may be conducted in facilities not currently experiencing an outbreak for COVID-19 (for negative or

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) asymptomatic residents only) with social distancing, hand hygiene, and use of a cloth face covering or facemask. These activities may be indoor or outdoor, and limited to no more than ten in the group. 7. During observation 10/14/20 at 11:05 a.m., Staff D, CNA, removed her surgical mask and placed the mask on the handrail in the hallway next to room [ROOM NUMBER]. Staff D donned an N95 mask and faceshield, donned a gown inside the resident's room, and entered the resident's room. At 11:15 a.m., Staff D removed the N95 mask and faceshield and placed the mask and faceshield into a plastic bag, and placed the bag inside the drawer of a plastic bin by the resident's room. Staff D then donned the surgical mask by the handrail. During the same time, Staff A, CNA, exited room [ROOM NUMBER], removed faceshield and N95 mask and placed them inside a plastic bag, then placed the bag inside a drawer of the plastic bin outside the resident's room. Staff A sanitized her hands and donned a surgical mask and goggles. In an interview 10/14/20 at 1:45 p.m., the Infection Preventionist reported masks should not be stored on the handrail in the hallway. The Infection Preventionist stated staff generally stored masks and faceshields in a plastic bag when not in use. In an interview 10/14/20 at 11:15 a.m., Staff A reported she stored her N95 mask and faceshield in plastic bag and kept it in the 3 drawer plastic bin outside a resident's quarantine/isolation room, then re-used the mask during the shift. Staff A reported she did not have her name on the bag, but knew which 95 mask and faceshield belonged to her. Staff A confirmed other supplies stored in the plastic bin drawers, too. In an interview 10/15/20 at 10:10 a.m., Staff D, CNA, reported she stored her used mask and faceshield in a plastic bag and placed it inside a drawer in the plastic bin stored outside the resident's room. Staff D reported a gown, mask, and faceshield issued to her each day. In an interview 10/15/20 at 10:15 a.m., the DON reported staff should use the plastic bin with drawers to store additional PPE supplies such as gowns, gloves, masks, and faceshields. The DON reported she expected staff not to store used masks and faceshields in the drawers of the plastic bins, but instead hang the mask and faceshield on a hook inside the resident's room. A staff communication dated 6/12/20 revealed the facility had baggies for staff to store the N95's in when not with an isolation resident. Staff should put their name on it and keep it. The staff communication also informed staff they could not wear the N95 mask outside of the isolation rooms.