STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCURA HEALTHCARE OF POMEROY, LLC	**303 EAST 7TH STREET POMEROY, IA 50575**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to provide appropriate infection control for one of three residents reviewed (Resident #1). The facility reported a census of 29 residents. Findings include: A Minimum Data Set for Resident #1 with an Assessment Reference Date of 3/27/20 showed a Brief Interview for Mental Status score of 00, indicating severe cognitive impairment. The resident had [DIAGNOSES REDACTED]. The resident required the assistance of one staff with bathing. Observation on 6/15/20 at 8:50 AM, revealed Resident #1 seated in a the whirlpool chair with Staff A, Certified Nurses' Aide (CNA), and Staff B, CNA in attendance. Staff A removed gloves and sanitized her hands. Staff B placed a standing mechanical lift sling behind the resident. Staff A used a towel without gloves and dried the resident's backside from buttock to lower back then threw the towel onto the floor with the rest of the dirty laundry. The floor did not contain a barrier. The resident became weak and needed to sit down. Staff A did not cleanse her hands and patted the resident's shoulder to calm the resident down. Both CNAs again attempted to stand the resident with the standing mechanical lift. After the resident stood, the resident urinated onto the floor. Staff A sanitized her hands and donned a pair of gloves. Staff A obtained a package of wipes and began to clean the resident. Staff A removed wipes from the package after each wipe to cleanse the resident. Staff A and Staff B dressed the resident and placed the resident into the wheelchair, rolling the wheelchair through the urine. Staff B movds the standing mechanical lift out of the way to allow the resident to leave the whirlpool room while pushing the mechanical lift through the urine with the leg strap on the floor. Staff B picked up the leg strap and placed it onto the standing mechanical lift and moved the lift into the hallway. Staff B parked the standing mechanical lift to the south of the whirlpool door and Staff B walked away to help another resident. Staff A pushed the resident out of the whirlpool room into the hallway. The Director of Nursing (DON) stopped Staff A halfway down the hall. The DON instructed Staff A to stop and clean the wheelchair wheels and when finished, clean the hallway due to the urine on the floor from the whirlpool room. Staff A went into the whirlpool room and came out to the wheelchair with cleanser. Staff A sprayed cleanser onto a washcloth and then cleansed the wheelchair wheels. After completion of the cleaning of the wheelchair wheels, Staff A enter the whirlpool room and did not return to the hallway. On 6/15/20 at 10:00 AM, the DON stated she expected staff to cleanse the floor and wheelchair pedals before leaving the whirlpool room. The DON stated Staff A received education regarding the dirty laundry on the floor, the lack of gloves when wiping a resident's backside, and failure to clean the floor and wheelchair wheels following an incontinent epsiode. The DON stated the facility did not have a policy and her expectations were standards of care.

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