STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS 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** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents and CDC (Centers for Disease Control and Prevention) guidelines, observations and staff interviews, the facility did not ensure staff members were aware of isolation protocols in order to consistently implement proper infection control practices for 1 of 1 staff member (Staff G CNA (Certified Nurse Assistant)) who worked with Resident # 1 in an isolation room. In addition, the facility did not ensure masks covered staffs' nose and mouth. Observation showed multiple staff members worked around residents in the facility without wearing their mask properly. The facility reported a census of 66 residents. Findings include: 1. Facility policy titled, Infection Prevention and Control - Addendum: COVID-19 Coronavirus, with revision date of 3/27/2020, indicated that upon admission, the facility would screen resident to determine appropriate placement. The policy also indicated that upon screening and/or identification of symptoms, there will be strict adherence to use of Standard, Contact, and Droplet Precaution, including the use of eye protection. An undated facility document titled, Handwashing and Glove Use Observation Audit, indicated staff should wear gloves when caring for residents and perform hand hygiene after removal of gloves. The facility's current matrix or CMS (Centers of Medicare and Medicaid Services) Form 802, showed that Resident # 1 is a [MEDICAL TREATMENT] patient, newly admitted to facility with an admission date of [DATE], and on transmission-based precautions. During observations on 6/17/2020 beginning at approximately 2:04 PM, Staff G responded to Resident # 1's call for help. Staff G CNA (certified nurse aide) donned a pair of gloves without first performing hand hygiene and entered Room A7 (Resident # 1's room). After 2 minutes, Staff G came out from room [ROOM NUMBER], and while removing gloves from hands, Staff G rolled up the used gloves and threw them in the trash bin inside another resident's room or in Room A5. During interview following the above observations, Staff G stated that when residents are new to the facility they require quarantine but Staff G did not know if [MEDICAL TREATMENT] patients needed quarantined. When asked if Resident # 1 was on any transmission-based precautions, Staff G replied they did not know. Staff G verified bringing out used gloves from Room A7 to throw in the trash container in Room A5. On 6/17/2020 at 3:23 PM, the Director of Nursing acknowledged that staff should not take used items from an isolation room into another room as doing such is a breach in infection control. 2. On 6/17/20 at 3:30 p.m. the Director of Nursing (DON) provided a document titled SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE) with the CDC logo on the bottom of the document, which directed staff on mask use. The document directed staff to wear a mask and secure the ties or elastic bands at middle of head and neck. Fit the flexible band over the nose bridge to cover the nose and ensure a snug fit to the face and below the chin. Observation on 6/17/20 at 12:46 PM showed Staff B CNA walking in the hallway towards the dining room area. Continued observation showed Staff B assisted another staff to pass meal trays to residents sitting at tables in the dining room. While performing these duties, Staff B's nose was exposed and not covered by the face mask. Observation on 6/17/20 at 12:55 PM showed Staff C (CNA) entering Resident #10's room with Staff C's nose and mouth exposed and not covered by the face mask which was positioned below the chin. Continued observation showed Staff C emptied Resident #10's foley catheter (a flexible tube that a clinician passes through the urethra and into the bladder to drain urine, usually into an attached bag) into a container then went to the bathroom and discarded the contents in the container into the toilet. Staff C left Resident #10's room at 1:08 PM. Observation revealed Staff C's nose and mouth was exposed throughout the observation. Observation on 6/17/20 at 1:15 PM showed Staff C (CNA) entered room D11 with Staff C's facial mask positioned below their chin exposing their nose and mouth. Staff C collected garbage bags filled with trash located in D11, tied the garbage bags then left room D11 and went to a room labeled spa room to discard the bag into a receptacle. Throughout the observation, Staff C's face mask remained positioned below their chin. Observation on 6/17/20 at 1:18 PM showed Staff D (CNA) entering room B1. Staff D visited with the resident and removed a meal tray from the residents room and went into the hallway to place the meal tray into a nearby cart. Throughout the observation, Staff D's nose remained exposed with their face mask positioned below their nose. Observation on 6/17/20 at 1:50 PM showed Staff E (CNA) standing in front of the medication cart with their face mask positioned below their chin exposing their nose and mouth while typing on the computer keyboard located on the medication cart. Observation on 6/17/20 at 2:30 PM showed Staff E (CNA) bent over with 2 fingers pressed onto Resident 4's wrist. Staff E's face mask did not cover their nose and was positioned just above their mouth. Observation on 6/17/20 at 2:35 PM showed Staff F (CNA) entering room C11. Further observation showed Staff F left room C11 and went towards the nurse's station. Observation revealed Staff F's nose was exposed with their face mask positioned above their mouth. During an interview on 6/17/20 beginning at 3:20 PM, the DON reported the facility did not have a written policy addressing the use of PPE (personal protective equipment), specifically the use of a face mask. Staff A went on to report, at this time during the Coronavirus/COVID pandemic, the expectation was all staff and residents wear a face mask that covered their nose and mouth at all times. Staff A reported providing frequent education obtained from the CDC addressing the use of all PPE, to include a face mask and and posted information throughout the facility as a reminder.

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.