STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165435	A. BUILDING _____ B. WING _____	07/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCURA HEALTHCARE OF SIOUX CITY, LLC	3800 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** - 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 and document review, the facility failed to ensure staff followed infection control practices and properly disposed of contaminated personal protective equipment (PPE) in order to prevent or reduce the risk of spreading infection and disease, and failed to disinfect a glucometer properly for two of two residents observed. The facility reported a census of 36 residents. Findings Include: 1. Observations on 7/20/20 revealed the following: a. At 11:45 a.m., a yellow isolation gown rolled up in a ball and lying on the handrail in the 100 hallway. At 12:05 p.m., observed the gown no longer on the handrail but had been disposed of in a trashbin attached to the medication cart. b. During observation 7/20/20 at 12:02 p.m., Staff A, Registered Nurse, donned a pair of gloves, took a lancet and poked Resident #4's finger. Staff A placed a drop of blood onto a blood sugar strip in the glucometer machine. Staff A used her gloved hand and opened the resident's door, disposed of the lancet into a sharps container by the medication cart, removed a set of keys from her uniform pocket, unlocked the medication cart, and opened the bottom drawer of the medication cart. Staff A opened the lid of a Super Sani-Cloth germicial wipe container, removed a disinfectant wipe, and cleansed the glucometer machine for 30 seconds. Staff A then removed her gloves. At 12:10 p.m., Staff A took the glucometer machine to Resident #1's room and donned a pair of gloves. Staff A had no isolation gown or gloves prior to entry into the resident's room. A sign labeled Stop - PPE Isolation Precautions hung by the doorframe of the resident's room, and a plastic bin with isolation gowns sat by the door outside of the resident's room. Staff A performed a blood sugar check on Resident #1, then walked down the hall and disposed of the used lancet into a sharps container attached to the medication cart. Staff A removed one glove, took a key and opened the medication cart, removed a disinfectant wipe from the bottom drawer of the medication cart, cleansed the glucometer for 20 seconds, and removed her other glove. At the time, Staff A reported the residents who resided on the 100 hallway were new admissions or residents who left the facility for [MEDICAL TREATMENT] or appointments, and placed on isolation for 14 days due to resident contact at another facility and presumed positive for COVID-19. Staff A reported she used standard precautions and she wore gloves, mask, and goggles whenever had contact with those residents. Staff A reported if she had contact with a resident in isolation, such as whenever performed a dressing change or provided cares, then she donned a gown, gloves, mask and goggles. If a resident had a garbage receptacle in the room, then that indicated a resident on isolation precautions. c. At 12:46 p.m., Staff B, CNA, sat in a chair next to Resident #3 in his room and assisted the resident with eating. Staff B wore a mask, goggles and gloves, but had no gown on. Record review revealed Resident # 3 on transmission-based precautions. d. At 1:20 p.m., laundry staff took clothes into room [ROOM NUMBER], then obtained clothes from a rack and took the clothes to room [ROOM NUMBER]. The laundry staff had a mask and goggles on, but no gown or gloves worn when she entered either of the resident's room. e. At 2:00 p.m., Staff C, Physical Therapy, donned an isolation gown, gloves, mask and goggles, and entered room [ROOM NUMBER]. At 2:20 p.m., Staff C walked down the 100 hallway to the therapy room at least 150 feet wearing the same isolation gown, mask, and goggles. Staff C removed the isolation gown after she entered the therapy room, rolled the gown into a ball, tucked the gown under her left arm against her clothing, pushed a diathermy machine down the 100 hallway, and disposed of the gown in a resident's room. f. During observation on 7/21/20 at 7:50 a.m., the door to rooms [ROOM NUMBERS] found open to the hallway. During an interview 7/20/20 at 12:20 p.m., Staff B, Certified Nursing Assistant (CNA), reported nine residents on the 100 hallway in isolation. The residents in rooms 106, 107A, 107B, 108, 109, 110, 111, 112, and 113 on isolation. During an interview 7/20/20 at 2:25 p.m., Staff C, Physical Therapy, reported a resident placed on isolation for at least two weeks whenever the resident admitted from the hospital. Staff C stated all residents who resided in the 100 hall on isolation due to the resident had left the facility or admitted from the hospital. Staff C explained the residents on the 100 hall treated as if they had COVID-19, and a paper gown, mask, goggles, and gloves worn before she entered the resident's room. During an interview 7/21/20 at 8:10 a.m., Staff D, Housekeeping Supervisor, reported the residents on the 100 hall on isolation but no gown worn unless she had close contact with the resident. Staff D stated she expected a mask, goggles, and gloves worn if staff entered the resident's room. During an interview 7/21/20 at 9:45 a.m., Staff E, CNA, reported she looked at the kardex on each resident to know what cares or tasks needed completed. Staff E reported if a resident on isolation, it was listed on the kardex. Staff E reported all of the residents on the 100 hall in isolation as precautionary due to the resident had left the facility and returned, or admitted from the hospital. Staff E reported whenever staff cared for a resident on the 100 hall, a faceshield, mask, goggles, gown and gloves needed worn. During an interview 7/21/20 at 10:00 a.m., Staff F, CNA, reported she worked in the 100 hall but also floated to other areas of the building and assisted with resident cares. Staff F reported some residents on the 100 hall had a stop sign on the door which indicated the resident on isolation, but a number of residents on the 100 hall in isolation had no stop sign on the door. Staff F reported she knew which residents on isolation. Staff F reported some residents had left the facility or had admitted to the facility and placed on isolation for precautions. Staff F was uncertain of the type of isolation each resident on, but reported she donned a gown and gloves if provided personal cares or changed a resident in bed. During an interview 7/21/20 at 10:25 a.m., the DON reported any resident admitted to the facility placed on isolation for 15 days, and all residents who left the facility such as for [MEDICAL TREATMENT], placed on droplet isolation due to the residents presumed positive for COVID-19. The DON reported nine of the residents on the 100 hall on droplet precautions, three of the residents left the facility three times a week for [MEDICAL TREATMENT] (Rm 109, 112, 113), and six of the residents had admitted to the facility in the past 2 weeks (Rm 106, 107A, 107B, 108, 110, 111). A facility Infection Control Standard Precautions and Isolation procedure revealed precautions designed to reduce the risk of transmission of microorganisms from recognized and unrecognized sources of infection. The policy revealed standard precautions indicated for all residents. Gloves worn whenever had possible contact with blood, body fluids, secretions, or contaminated items. Gloves removed promptly after use and before touched non-contaminated items or environmental surfaces. The policy revealed droplet precautions indicated for a resident known or suspected of infection with microorganisms transmitted by droplets generated by a resident during coughing, sneezing, talking, or during a cough-inducing procedure. Masks worn whenever working within 3 feet of a resident on droplet precautions. The policy indicated gowns discarded into appropriate receptacles after used. Gloves worn when hands likely came in contact with blood, body fluids, or other potentially infectious material, and discarded into a waste receptacle inside the room after use, and hand hygiene performed. In a Center for Disease Control poster on how to safely remove personal protective equipment, located on the 100 hall, revealed all PPE removed prior to exiting the resident's room. The procedural steps included removal of gown and gloves at the same time, only touching the inside of the gown and gloves with bare hand, then gown and gloves placed into a waste container. Hands washed or sanitized with alcohol-based hand sanitizer immediately after PPE removed. A label on the Super Sani-Cloth germicidal disinfectant wipes revealed surface needed to remain visibly wet for two minutes to effectively disinfect equipment or surfaces.

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