STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTERVILLE SPECIALTY CARE	**1208 EAST CROSS STREET CENTERVILLE, IA 52544**

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 0641 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of observations, clinical records and interview, the assessment failed to accurately reflect the resident for 1 of 15 sampled (Resident #13). The facility reported a census of 49. Findings include: The MDS for Resident #13 revealed the resident had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #13 had no obvious or likely cavities, broken teeth, inflamed or bleeding gums, or loose natural teeth, no mouth or facial pain, discomfort, and no difficulty chewing. The Care Plan documented Resident #13 had a self-care deficit and directed the staff to prompt Resident #13 to complete his oral cares. An observation on 3/2/20 at 11:50 a.m. revealed Resident #13 had missing teeth. Review of the resident's records showed a consent signed by Resident #13 regarding smoking times. Review of the Dental Visit notes dated 9/5/17, 8/23/18, 2/12/19, and 2/26/19 revealed a dentist visited Resident #13. On 2/12/19, the Dentist documented Resident #13 had a nonpainful broken upper tooth that made eating difficult. The noted revealed Resident #13 had three teeth with gross decay. The Dentist recommended pulling the teeth that day. The Dentist discussed the need for full dentures in the future with Resident #13. On 2/26/19, Resident #13 had a third tooth extracted. During an interview on 3/5/20 at 10:21 a.m., the Minimum Data Set Coordinator stated she was unsure why the MDS failed to reflect Resident #13 had dental health concerns.
F 0656 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of observation, review of clinical records, and interviews, the facility failed to develop and implemented a comprehensive person-centered care plan for 1 of 15 sampled (Resident #33). The facility reported a census of 49. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #33 had [DIAGNOSES REDACTED]. Resident #33 had bowel and bladder incontinence. The Care Plan failed to reflect Resident #33 had incontinence. During an observation on 3/4/20 at 9:50 a.m. revealed Resident #33 incontinent of bowel and bladder and the staff provided incontinence care. During an interview on 3/5/20 at 10:21 a.m., the MDS Coordinator stated she overlooked placing interventions on the Care Plan for Resident #33's incontinence.
F 0657 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to update the Care Plans for 2 of 2 sampled (Residents #22 and #29). The facility reported a census of 49. Finding Included: 1. During an observation on 3/02/20 at 11:12 a.m., Resident#22 had isolation supplies (gloves, gowns, masks, red and yellow biohazard bags) outside the room. During an interview on 3/02/20 at 11:12 a.m., Staff E (Nurse Aide) reported Resident #22 had isolation for Respiratory [MEDICAL CONDITION] (RSV). A Lab Result collected on 2/29/20 documented Resident #22 had RSV detected. The Care Plan failed to reflect Resident #22 had RSV and precautions to follow. During an interview on 3/5/20 at 7:55 a.m., Staff A (Nurse Aide) reported the Care Plan lacked isolation information. Staff A reported when she observed isolation buckets outside the resident's rooms she asked the nurse why the resident had isolation. 2. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident#29 had short and long term memory loss, required extensive assistance of two staff for bed mobility, transfers, and had a foley catheter. The Care Plan initiated on 1/16/20 documented Resident #29 had a foley catheter. During an observation on 3/2/20 at 3:25 p.m., revealed Resident #29 without a catheter. The physician's orders [REDACTED]. During an interview on 3/4/20 at 8:14 p.m., Staff D (Nurse Aide) reported Resident #29 no longer had the catheter. During an interview on 3/4/20 at 9:12 a.m., Staff A (Nurse Aide) and Staff B (Nurse Aide) reported Resident #29 had the catheter removed shortly after admission. During an interview on 3/5/20 at 8:00 a.m., the Care Plan Coordinator reported the foley catheter should have been removed from the Care Plan.
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 observation, clinical record review, facility policy, and staff interview the facility failed utilized infection control techniques for 2 of 2 sampled (Residents #25 and #33). The facility reported a census of 49. Findings include: 1. The Minimum Data Set ((MDS) dated [DATE] documented Resident #33 had a [DIAGNOSES REDACTED]. The MDS revealed Resident #33 is incontinent of urine and bowel. During an observation on 3/3/20 at 10:02 a.m., revealed Staff A (Nurse Aide) and Staff B (Nurse Aide) entered Resident #33's room. Staff B touched Resident #33's blanket and then entered the bathroom and washed her hands. Staff A used hand sanitizer and placed a trash bag on the bed side table. Staff A placed disposable wipes inside the trash bag. Staff B unfastened Resident #33's brief and cleansed the anterior perineal area. The staff rolled Resident #33 on his left side. Staff B cleansed the posterior perineal area. Staff B removed Resident #33's brief, removed her gloves, and applied hand sanitizer. Staff B donned gloves and applied lotion to Resident #33's posterior perineal area. Staff B removed her gloves, applied sanitizer and donned gloves. Staff B placed a clean brief under Resident #33 and rolled Resident #33 on his right side. Staff A cleansed Resident 33's left hip and posterior perineal area. The staff rolled Resident #33 on his back. Staff A fastened the clean brief with the same gloved hands used to perform perineal care. Staff A and Staff B removed gloves, threw them away, and replaced Resident #33's blankets. Staff B removed the trash from the waste basket and both staff walked out of the room. The staff failed wash their hands. The Incontinence Care policy dated January 2015 instructed staff to cleanse all soiled areas front to back using clean area of cloth or wipe, turning the resident as necessary. Staff should remove gloves and wash hands before applying moisture barrier and staff should remove and wash hands before touching the resident or the resident's belongings and before leaving. An Infection Care Manual dated April 2018 for Standard Precaution directed staff to wash hands after touching blood, body fluids, secretions, and contaminated items, whether or not gloves are worn, immediately after gloves are removed, between resident contacts and any other item necessary, such as between tasks or procedures on the same resident. During an interview on 3/2/20 at 2:32 p.m., Resident #33's family member stated Resident #33 had two urinary tract infections this year. During an interview on 3/5/20 at 10:15 a.m., the Director of Nurses stated an expectation of staff to change their gloves after cleaning a resident and before exiting the resident's room. 2. The MDS dated [DATE] documented Resident #25 had a [DIAGNOSES REDACTED]. The Care Plan directed Resident #25 independent with a walker and at risk for wandering and elopement. During an observation on 3/2/20 1:22 p.m., revealed Resident #25 wandered into another resident's room and a Laundry staff redirected Resident #25 back to the hallway. The Laundry staff touched Resident #25's walker, to navigate back into the hallway. The Laundry staff

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) returned to folding laundry from the laundry cart and then entered another resident's room. The Laundry staff failed to clean her hands after assisting Resident #25. Resident #25 had isolation precautions for Respiratory [MEDICAL CONDITION] (RSV). The Hand Washing policy dated April 2018, instructed the staff to wash their hands when they have contact with a resident's skin, contact with environmental surfaces in the immediate vicinity of patients and after glove removal. An Infection Care Manual dated April 2018 for Standard Precautions directed staff to wear gloves when touching blood, body fluids, secretions, excretions and contaminated items. Put on clean gloves just before touching mucous, mucous membranes, and non-intact skin. Remove gloves promptly after use and before touching uncontaminated items and environmental surfaces and before going to another resident. Wash hands immediately. During an interview on 3/4/2020 at 1:00 p.m., the DON stated an expectation of staff to wear a mask for droplet precautions. She stated they staff wear a gown as they desire. 3. During an observation on 3/2/20 at 12:01 p.m., revealed Resident #25 attempted to exit her room. Resident #25 had an isolation kit outside her room. Resident #25 stated she felt like she was going to fall. The Administrator summoned a Nurse Aide to assist Resident #25. An unidentified staff entered Resident #25's room with a gown and gloves. The staff failed to apply a mask. The staff assisted Resident #25 to her bed. Resident #25 intermittently coughed getting in bed. An Infection Care Manual dated April 2018 for standard precautions, revealed staff should wear mask, eye protection and face shield to protect mucous membranes of the eyes, nose and mouth from splashes or sprays of body fluids. The manual also stated staff should wear gowns to protect skin and prevent soiling of clothing during procedures and resident-care activities which are likely to generate any type of exposure to splashes or sprays of blood, body, fluids, secretions and excretions. An Infection Care Manual dated April 2018 for standard precautions also revealed for residents with RSV, the precautions should include contact and standard precautions and staff should wear a mask according to standard precautions. During an interview on 3/02/20 at 12:05 p.m., the Administrator stated Resident #25 had droplet precautions and wandered. Review of Resident #25 vitals in the resident records revealed the resident had not had any fevers or temperatures above 99.1 degrees Fahrenheit between 2/26/20 to 3/3/20. According to the Centers for Disease Control website RSV symptoms usually include runny nose, decrease in appetite, coughing, sneezing, fever and wheezing. RSV is spread through droplets from a cough or sneeze in the eyes, nose or mouth. It can also be spread from touching a surface infected with [MEDICAL CONDITION] on it and by touching your face. People infected with RSV are usually contagious for three to eight days. RSV can survive for many hours on hard surfaces and on soft surfaces for shorter amounts of time. People infected with RSV usually show symptoms within 4 to 6 days after getting infected. When an older adult gets RSV infection, they typically have mild cold-like symptoms including runny nose, sore throat, cough, and headache. The Progress Notes dated 2/28/20 revealed Resident #25 had a non-productive cough and refused a temperature check. On 2/28/20, Resident #25 tested positive for RSV and received a corticosteroid for treatment. Review of the Clinical Record of Residents #22, #25 and #150 revealed they had RSV between 2/21/20 to 3/2/20. During an interview on 3/2/20 with the DON and the Corporation Nurse, the Director of Nurses (DON) stated the facility removed Resident #25 from isolation on 3/2/20. The DON stated that residents have to be fever free for 24 hours and be asymptomatic to not be contagious. The Corporation Nurse stated that the information is on CDC website but did not provide information from the website. The DON stated Resident #150 had gone to the hospital on [DATE] for his wound and the emergency doctor decided to run a test for the resident which tested positive for RSV and HKU1. The DON stated the facility does not test resident's roommates unless the resident's roommates show signs and symptoms. The DON stated when resident's are tested positive and placed in droplet precautions, staff will pull the privacy curtain to help protect the resident's roommate from the infection. 2. During an interview on 3/5/20 at 7:55 a.m., Staff A (Nurse Aide) reported the electronic Care Plans failed to direct isolation precautions. If the staff observe isolation buckets, they ask the nurse what precautions to implement.