STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165213	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - FOREST CITY	606 SOUTH SEVENTH STREET FOREST CITY, IA 50436

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 clinical record review, resident and staff interviews, and policy review the facility failed to appropriately care plan the use of a Wound Vac device, the care and dressing changes required for the wound vac use and the care the resident was receiving at the wound clinic for several chronic [MEDICAL CONDITION]. The facility also failed to initiate a discharge plan on the care plan for 1 of 5 residents reviewed. (Resident # 5). The facility reported a census of 32 residents. Findings Included: A Minimum Data Set ((MDS) dated [DATE] revealed Resident #5 was admitted to the facility on [DATE]. The Brief Interview for Mental Status (BIMS) score of 15, indicated intact cognitive functioning. Resident #5 was independent with decision making and was her own responsible party. The MDS included [DIAGNOSES REDACTED]. Review of Resident # 5's June Treatment Administration Record (TAR) revealed resident had a wound vac device attached to her left heel due to a [MEDICAL CONDITION]. The TAR documented the facility's nurse changed the wound vac dressings on Mondays and Saturday's and the Wound Center changed the dressings on Thursday's during her weekly appointments. Review of Resident #5's comprehensive Care Plan with a revision date of 6/11/20, revealed it lacked documentation for the use of the wound vac, the care the nurses were providing to the wound vac site and that resident was receiving care at a wound center, on a weekly basis. The Care Plan also revealed there was no discharge plan listed. Interview with Resident #5 on 6/16/20 at 10:31 a.m., revealed she was concerned that she wanted to leave the facility but no one at the facility was listening to her nor had they discussed her discharge plans with her. The resident did not know who she needed to talk to in order to voice her needs and request a referral to another facility. Interview with Staff D- Social Service worker (SSW) on 6/16/20 at 10:50 a.m., revealed she was not aware of Resident #5's wish to have a referral to move to another facility. Staff D stated she had just started in her position in May 2020 and had not yet completed any discharge plans or completed a care plan due to her still receiving her orientation to the SSW role. Staff D stated she was aware Resident #5 had wanted to leave the facility and go home once her wounds were healed but had not realized Resident #5 wanted to move to a different nursing facility as soon as possible. Interview with Staff C-Activity Director on 6/17/20 at 9:13 a.m., revealed she had assisted in the SSW department when Resident #5 admitted to facility on 5/6/20. The facility did not have a SSW employed at the facility until mid-May 2020, so Staff C had been asked to help complete the social service assessments until a new SSW was hired. Staff C verified she had completed the initial social services admission assessment, but did not document the discharge plan on the care plan. Staff C stated she was not aware that a discharge plan should be included on the care plan. Interview with the Director of Nursing (DON) on 6/17/20 at 8:51 a.m., revealed she was not aware Resident # 5's Care Plan had no discharge plan included on it. She reported they did not have a SSW at the facility when Resident #5 was admitted to the facility. The DON also stated she was not aware the care plan did not include the use of the wound vac daily, the 3 times per week dressing changes, and that Resident #5 was going out to the wound center weekly on the facility van. The DON stated she did not know why these items were not listed on Resident #5's Care Plan but stated she did not think that information really needed to be on it. The facility's Care Plan Policy, with a revision date of December 2019, stated the purpose was to develop a comprehensive care plan using an interdisciplinary team approach, and to provide guidance to the interdisciplinary team in developing the initial care plan. The Care Plan Policy defined a comprehensive care plan should include: Measureable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The policy stated residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized, person centered, comprehensive plan of care that will include measureable goals and timetables directed towards achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. The plan of care will be modified to reflect the care currently required/provided for the resident. The care plan will emphasize the care and development of the whole person ensuring the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services.
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 clinical record review, observation, staff interview and facility policy review, the facility failed to utilize appropriate infection control practices during resident care for 1 of 5 residents reviewed (Resident #5). The facility reported a census of 32 residents. Findings included: The Minimum Data Set ((MDS) dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognitive functioning. The MDS stated she required limited assist of 1 staff with transfers and walking and required extensive assist of 1 staff with bed mobility, dressing and toileting. The MDS included [DIAGNOSES REDACTED]. Observation on 6/16/20 at10:31 a.m. revealed Staff A-Licensed Practical Nurse (LPN) performed wound care and dressing changes on Resident #5. Staff A knocked and entered the room. Staff A washed her hands at sink with soap and water, shutting the faucet off with the soiled paper towels she had just dried her hands with. Staff A stated she had never done Resident #5's leg treatments before and had printed the orders out to look at while she did the treatments. Staff A placed the papers onto the bed and a towel on top of the bedside stand. Staff A opened the closet and removed 3 bins of wound supplies and placed 2 bins on the bedside stand and 1 bin on the residents bed. Staff A applied gloves and pulled a folding chair out of the closet and sat down on it in front of Resident #5. Staff A did not perform handwashing or hand hygiene prior to applying her gloves. Staff A removed stockinette from right lower leg and removed dressing from resident's right shin and from resident's right lateral foot. Staff A discarded the old dressings into the garbage. Staff A removed and discarded her gloves and applied new gloves. Staff A did not perform hand hygiene or handwashing prior to applying her new gloves. Staff A used 4 x4 gauze pads from the bins, wet them with NS and cleansed the open area on right shin, discarded the gauze and proceeded to do the same to the right lateral foot and discarded the gauze. Staff A removed her gloves and looked at the papers she had placed onto the bed. Staff A stated she could not find an order for [REDACTED]. Before she left the room, Staff A applied gloves and applied a gauze dressing to the area on resident right lateral foot and then stated she would be right back. The right shin area was left open to air. Nurse then removed her gloves and left the room. Staff A did not wash her hands before leaving the room. During an observation of wound care on 6/16/20 at 11:30 a.m., DON and Staff A knocked and entered the room. Both staff washed their hands and applied gloves. The DON had Staff A remove the dressing on the right lateral foot. Staff A then removed some [MEDICATION NAME] gauze from the top of the bottle, and cut a small section to pack the wound on right lateral foot per order. Staff A dropped the [MEDICATION NAME] gauze piece on the floor and as the nurse reached down to pick up the gauze from the floor, the DON immediately told her to not use that piece since it had been on the floor. Staff A discarded

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** - Few	(continued... from page 1) the piece that had fallen onto the floor and cut a new piece of the [MEDICATION NAME] gauze. Staff A applied the small piece into the wound on Resident #5's right lateral foot and covered it with a gauze dressing and used cling gauze to secure the dressing. Staff A then removed her gloves and started to apply new ones and DON stated to Staff A that she must wash her hands or use a hand sanitizer in between all glove changes. Staff A did stand up and walk over to the hand sanitizer dispenser in Resident#5's room and sanitized her hands. Staff A applied clean gloves, and cleansed the right shin wound site again with a 4 X 4 gauze and normal saline. Staff A then applied a gauze dressing and cling gauze to secure dressing. Staff A noted to use the same scissors from earlier and did not clean them in between uses with the resident's dressing changes. The DON assisted Staff A to hold up Resident#5's right leg and at 11:48 a.m. Staff A applied stockinette to residents right lower leg and proceeded to wrap the right leg from toes to knee with a compression bandage. Staff A then went to the sink and washed her hands with soap and water, shutting off the faucet with the wet paper towels. Staff A applied new gloves and removed stockinette from left lower leg and removed the old cling gauze to expose the dressings to the leg which included the wound vac dressing to Resident #5's left lateral heel area, a dressing to the left 5th plantar toe, and the left lateral ankle. Staff A attempted to remove the old dressing on the left ankle and DON again reminded Staff A to remove her gloves and hand sanitize before putting new gloves on again. DON noted the wound on Resident #5's left 5th plantar toe was healed and skin was flush with a scab like appearance. DON instructed nurse to cleanse site and cover with a gauze dressing and the physician would be notified today that area was healed and no longer needed packed with gauze. Staff A then removed the old dressing from Resident #5's left outer ankle dressing and then began looking through the supply bins on the table with her contaminated gloved hands. DON immediately prompted nurse to wash her hands before touching things and after she removed soiled dressings. Staff A washed her hands at sink with soap and water and applied new gloves. Staff A cleansed the left outer ankle wound with a 4 X 4 gauze soaked with normal saline. Staff A removed gloves and used the hand sanitizer in resident's room. Staff A applied new clean gloves and applied the medicated ointment to resident's left outer ankle per physician's orders [REDACTED]. Staff A then removed and re-applied a dressing to cushion the wound vac tubing that was coming from the left lateral heel area. Staff A then wrapped the entire foot and shin area with cling gauze and tape using the scissors to cut the tape. Staff A applied the stockinette over the top of all of the dressings on Resident #5's left lower leg and wrapped the left leg with a compression bandage from the toes, to just below the knee. Staff A removed her gloves after completed all of the treatments at 12:25 p.m. Staff A then used her bare hands to put all of the supply bins back into the closet and then went to the sink and washed her hands with soap and water and again shut off the water with the wet/soiled paper towels. Staff A did not disinfect the scissors before, during or after any of the treatments she completed. During interview on 6/17/20 at 8:51 a.m. the DON stated Staff A should have removed her gloves and sanitized her hands after the removal of old dressings, after picking up items from the floor and with all glove changes. DON further stated she expected nurses to clean and disinfect the scissors in between uses when caring for multiple wounds. DON stated Staff A should have removed her gloves and washed hands before touching the clean items in the wound supply bins, before and after she had touched the papers while in the room. DON stated she expected all nurses employed at the facility to follow basic infection control practices when they completed dressing changes. Review of the facility's Hand Hygiene Handwashing Policy, revised 4/14/20, stated the purpose of the policy was to ensure appropriate hand hygiene technique for clinical use. The background of the policy was regular handwashing with soap and warm, not hot water is one of the best ways to remove germs. Avoid getting sick and prevent the spread of germs to others. The goal of handwashing and glove use for patient care was to prevent the spread of infection between residents. Handwashing and changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. Sanitizers are used in patient care areas. The facility's procedures during patient care included: 1. Wash hands with plain soap and water or with an anti-microbial soap and water: a. If hands are visibly soiled. b. If hands are visibly contaminated with blood or bodily fluids. c. Before eating. d. After using the restroom. e. When a build-up of [MEDICATION NAME] (moisturizers such as ointments, lotions or creams) is felt on hands (usually after five to ten applications of a gel). 2. If hands are not visibly soiled or contaminated with blood or bodily fluids, use an alcohol based hand rub for routinely cleaning hands: a. Before having direct contact with residents, patients and children. b. After having direct contact with another person's skin. c. After having contact with bodily fluids, wounds or broken skin. d. After touching equipment or furniture near the resident/patient. e. After removing gloves. 3. Alternatively, hands may be washed with an antimicrobial soap and water in clinical situations described above.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility policy review, the facility failed to follow up on a wound culture of resident's left foot done on 5/21/20 that resulted in a [MEDICAL CONDITION] (MRSA) infection. (Classified as a Multi-Drug Resistant Organism) (MDRO). The resident did not receive appropriate antibiotic treatment and follow up within the facility's Antibiotic Stewardship Program as required per regulation for 1 of 5 residents reviewed. (Resident #5). The facility reported a census of 32 residents. Findings included: A Minimum Data Set ((MDS) dated [DATE] revealed Resident #5 was admitted to the facility on [DATE]. A Brief Interview for Mental Status (BIMS) score of 15, indicated intact cognitive functioning. The resident required limited assist of 1 staff with transfers and walking and required extensive assist of 1 staff with bed mobility, dressing and toileting. The MDS included [DIAGNOSES REDACTED]. Clinical record review on 6/16/20 of Resident #5's chart revealed a Wound Center Note dated 5/21/20, that instructed nursing home staff of a wound culture taken from resident's wound on her left lateral foot. The wound clinic also sent a signed physician's orders [REDACTED].-125 mg. 1 tablet, twice per day for 7 days. The [MEDICATION NAME] order and wound culture information was documented in a Progress Note by the charge nurse upon resident's return to the facility on [DATE] at 5:01p.m. Per further chart review, there was no wound culture report found in Resident #5's chart from 5/21/20. Resident #5's Medication Administration Record [REDACTED]. twice per day for 7 days for [DIAGNOSES REDACTED]. During an interview on 6/16/20 at 4:00 p.m., the Director of Nurses (DON), provided a faxed copy of the 5/21/20 wound culture report. The facility had received the report on 6/16/20 at 3:47 p.m. per the DON's request. DON stated the wound culture was positive [MEDICAL CONDITION] infection. Reviewed Resident #5's wound culture report and noted [MEDICATION NAME] was not listed on the report as an effective antibiotic to treat resident'[MEDICAL CONDITION] infection. DON stated when she had done her antibiotic tracking reviews as the facility's Infection Preventionist, she had missed that the wound culture had been done at the wound center. DON stated she would have to be more careful when doing her antibiotic reviews going forward. Review of the facility's Antibiotic Stewardship Program revised on 12/2019, stated in part the purpose of the policy was to provide guidance to the organization's facilities for antibiotic stewardship plans and also to decrease the incidence of multi-drug resistant organisms.(MDRO). The policy stated the background of the policy was to improve the use of antibiotics to protect residents and reduce the threat of antibiotics as both a national and organizational priority. The policy defined the Antibiotic Stewardship Plan as a set of commitments and actions designed to optimize the treatment of [REDACTED]. (CDC definition). The facility failed to appropriately monitor, follow up on and treat Resident #5'[MEDICAL CONDITION] infection