STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165329	A. BUILDING _____ B. WING _____	**06/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINGSLEY SPECIALTY CARE	**305 WEST THIRD BOX 10 KINGSLEY, IA 51028**

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 record review, observation, staff interview and policy review the facility failed to ensure infection control practices maintained after direct resident contact for 2 of 3 current residents reviewed, (Resident #1 and #2). The facility identified a census of 37 current residents. Findings include: 1. According to the Minimum Data Set ((MDS) dated [DATE], Resident #1 had [DIAGNOSES REDACTED]. The MDS identified the resident had a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The resident required limited assistance with transfer, walking in room, and extensive assistance with dressing and toilet use. The Care Plan dated 5/14/2020, directed staff to provide assistance of 1 staff with all transfers and use of a walker with ambulation. Observation on 6/19/2020 at 10:00 AM revealed Staff A, CNA (certified nursing assistant) provided toilet assistance and transfer/ambulation for the resident. Staff A washed his hands and donned gloves. He removed the resident's oxygen nasal cannula and assisted the resident with toileting. He assisted the resident to a standing position and provided peri care and pulled the resident's brief and pants up. Staff A continued to wear the contaminated gloves and touched the resident's walker and gait belt and assisted with ambulation to the lift chair. The resident requested the oxygen put back on. Staff A placed the oxygen nasal cannula on the resident and positioned the pillow and blanket for comfort while continuing to wear contaminated gloves. 2. According to the MDS, dated [DATE], Resident #2 had [DIAGNOSES REDACTED]. The MDS identified the resident had a BIMS score of 12, which indicated moderate cognitive impairment. According to the MDS the resident required limited assistance with dressing and personal hygiene and extensive assistance of 1 staff with toilet use. The Care Plan, dated 6/19/2020, identified the resident in isolation due to an emergency room visit. Observation on 6/19/2020 at 10:15 AM revealed Staff A, CNA donned a gown, gloves and face mask and entered the resident's isolation room. He took the resident's used cup out of the isolation room and filled the cup with ice from the multi use ice chest located outside the resident's room in the hallway. He then went to the snack cart located in the hallway and removed a snack and reentered the resident's room and gave it to the resident. During an interview on 6/19/2020 at 12:00 PM the Administrator stated the ice chest used for all residents in the facility. According to the facility policy titled, Standard Precautions, dated April 2018, handle used resident-care equipment soiled with blood, body fluids, secretions or excretions to prevent skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments. Clean reusable equipment and discard disposables. Perform hand hygiene. According to the facility policy titled, Droplet Precautions, dated April 2018, In addition to Standard precautions, use Droplet precautions for a resident known or suspected to be infected with microorganisms that can be transferred by droplets that are generated by the resident during coughing, sneezing, talking or during cough inducing procedures.

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.