STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165595	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AKRON CARE CENTER, INC	991 HIGHWAY 3 AKRON, IA 51001

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on observations and interviews, the facility failed to have a call light accessible while residents are in bed for 1 of 22 residents (Resident #37). The facility reported a census of 45. Findings: The Minimum Data Set (MDS) for Resident # 37 with Assessment Reference Date (ARD) of 1/30/2020, showed a short and long term memory problem with severely impaired cognition and extensive assistance for bed mobility. During an observation on 3/3/20 at 3:36 p.m., Resident #37 was lying in bed awake which was positioned across the room from the call light location. Call light cord was draped behind a nightstand and button end sitting on top of nightstand located on the other side of the room, which made the call light inaccessible to Resident #37. During an observation on 3/4/20 at 7:25 a.m., Resident #37 was lying in bed awake on her side. The bed was positioned across the room from the call light location. Call light cord was draped behind a nightstand and button end sitting on top of the nightstand making the call light inaccessible to Resident #37. During an observation on 3/4/20 at 3:45 p.m. Resident #37 was seen sitting on the right side of her bed which is against the wall, with her legs between the bed and the wall heating unit. The Director of Nursing (DON) was present during observation and placed a gait belt on Resident #37 and assisted her across the bed to the other side where she could exit the bed. Resident #37 was assisted to the restroom. DON then took call light cord and stretched it over to Residents #37 bed and it would not safely reach. DON stated that they would fix it. During an interview with the DON, she stated it is expected every resident have a call light within reach when they are in their beds.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to accurately complete 1 of 15 resident's Minimum Data Set (MDS) assessments (Resident #27). The facility reported a census of 45 residents. Findings included: According to the 1/9/20 MDS assessment, Resident #27 had a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive or memory impairment. The MDS listed [DIAGNOSES REDACTED]. Review of Resident #27's Care Plan, with revision date of 1/14/20, revealed he had a stage 2 pressure ulcer to his right heel that started on 9/19/19. Rrecord review of Resident #27's Pressure Documentation skin sheet noted he had a Stage 2 pressure ulcer to his right heel that started on 9/19/19. According to Resident #27's 10/10/19 MDS assessment, he had a BIMS score of 3, indicating severe cognitive impairment due to an acute mental status change. The MDS listed [DIAGNOSES REDACTED]. The 10/10/19 MDS lacked documentation of Resident #27's stage 2 pressure ulcer from 9/19/19. During an interview on 3/4/20 at 4:00 p.m., the MDS nurse stated she had not included the stage 2 pressure ulcer for Resident #27's on the MDS and wasn't sure why she had overlooked it. During an interview on 3/5/20 at 8:08 a.m., the Director of Nursing agreed Resident #27's stage 2 pressure ulcer should have been coded on the 10/10/19 MDS.
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 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 3 residents reviewed (Resident# 43) and failed to maintain cleanliness of oxygen tubing for 4 of 4 residents reviewed for oxygen use (Resident #42, #45, #2 and #34). The facility reported a census of 45 residents. Findings included: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #43 had a BIMS score of 8, indicating moderate cognitive impairment. The MDS included [DIAGNOSES REDACTED]. The MDS indicated Resident #43 required extensive assistance of one staff for bed mobility, transfer, and toilet use and he required an indwelling urinary catheter. Review of Resident #43's Care Plan, with a revision date of 2/7/20, revealed he had an indwelling urinary catheter and required staff assistance with catheter cares twice per day. The Care Plan further stated Resident # 43 had a history of [REDACTED].#43 while seated on the toilet. Staff A applied gloves without washing hands, gathered washcloths, peri-wash and an alcohol wipe. Staff A wet the washcloth in sink, applied peri-wash and used left hand to hold tip of penis, and used her her right hand to cleanse it in a circular motion. She moistened the second washcloth and cleansed both sides of groin using an up and down motion. Staff A did not turn the washcloth for a clean surface each time she wiped the Resident #43's perineal areas. Staff A discarded second washcloth into garbage bag and used alcohol swab to cleanse around the tip of the penis at the catheter insertion site. Staff A used the alcohol swab to wipe the catheter tubing all of the way down to the hub of the catheter, (approximately 11 inches). Staff A discarded alcohol swab, kept her soiled gloves on and applied gait-belt to Resident #43. With the same soiled gloves, Staff A placed his walker in front of him, stood him up, pulled up his clean incontinence brief, pulled up his pants, and adjusted his suspenders. Staff A removed her soiled gloves into the garbage and zipped up resident's pants. Staff A then walked Resident #43 out of the bathroom. During interview on 3/5/20 at 8:10 a.m., the Director of Nursing (DON) stated Staff A should have removed her gloves and sanitized her hands during catheter care. She stated she expected CNA's to provide peri-care in a downward motion to decrease risk of infection and to turn the washcloth with each wiping motion in order to have a clean surface. DON stated Staff A should have removed her gloves and washed hands before touching the clean items- gait-belt, walker, brief, pants and suspenders. Review of the facility's Handwashing Procedure, dated 2015, revealed staff is to be educated, trained, and monitored for proper hand washing as follows: -When hands are visibly soiled (hand washing with soap and water); before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); -Before and after assisting a resident with toileting (hand washing with soap and water); -After removing gloves or aprons. Review of the facility's Nurse Aide Skills checklist for catheter care, dated 2012, stated CNA's are to: assemble equipment, perform hand hygiene, cleanse around the meatus (urinary opening), then wash from the meatus using soap and water, 4 inches down the tubing. Remove gloves and complete hand hygiene. Review of the facility's Nurse Aide Skills checklist for Handwashing using soap and water, dated 2012, stated CNA's are to: Wet hands completely, apply soap, hold hands lower than elbows, work up a good lather, clean your nails, perform hand hygiene by using a rotating, rubbing motion, rubbing palms and between fingers for minimum of 15-20 seconds. Wash at least 3-4 inches above wrist, rinse washed areas well, hands should not touch sink, dry hands thoroughly with paper towel, and turn of faucet. Take dry paper towel and turn off faucet, discard paper towel in wastebasket. Staff A failed to perform appropriate hand hygiene during catheter care for Resident #43. 2. The MDS completed for Resident #42 with an ARD of 2/6/2020, showed a BIMS score of 7, indicating moderate cognitive impairment. The MDS listed [DIAGNOSES REDACTED]. During an observation on 3/4/20 at 10:20 a.m., Resident #42's oxygen tubing was dated for 2-19-20. During record review of Resident #42's Treatment Administration Record (TAR) on 3/4/20 at 11:12 a.m.,, noted an active order for the oxygen tubing to be changed every Wednesday. The next date the tubing was due to be changed was 3/4/20. During record review of the TAR on 3/5/20 at 7:33 a.m., Resident #42's oxygen tubing was signed off as completed by the nurse on 3/4/20. During an observation in Resident #42's room on 3/5/20 at 7:42 a.m., noted the date of 2/19/20 remained on the oxygen tubing, which indicated the tubing had not been changed. During an observation in Resident #42's room with the DON on 3/5/20 at 8:00 a.m., DON verified the date

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) on the tubing was 2/19/20. DON stated the nurse's had changed only the cannula (prongs for in the nose) piece of the tubing and not the extension part of the oxygen tubing. DON further stated the facility did not have a policy on changing the tubing weekly and she would be sure to get this fixed to assure nurses changed all of the oxygen tubing, which included the extension tubing piece. 3. The MDS completed for Resident #45 with an ARD of 2/13/2020, showed a BIMS score of 15, indicating no cognitive impairment. The MDS listed [DIAGNOSES REDACTED]. During an observation on 3/4/20 at 10:30 a.m., Resident #45's oxygen tubing was dated for 2/19/20. During record review of Resident #45's TAR on 3/4/20 at 11:22 a.m., noted an active order for the oxygen tubing to be changed every Wednesday. The next date the tubing was due to be changed was 3/4/20. During record review of the TAR on 3/5/20 at 7:33 a.m., Resident #45's oxygen tubing was signed off as completed by the nurse on 3/4/20. During an observation in Resident #45's room on 3/5/20 at 7:38 a.m., noted the date of 2/19/20 remained on the oxygen tubing that indicated the tubing had not been changed. During an observation in Resident #45's room with the DON on 3/5/20 at 8:00 a.m., DON verified the date on the tubing was 2-19-20. 4. The MDS completed for Resident #2 with an ARD of 11/21/2019, showed a BIMS score of 15, indicating no cognitive impairment. The MDS listed [DIAGNOSES REDACTED]. During an observation on 3/4/20 at 10:25 a.m., Resident #2's oxygen tubing was dated for 2/25/20. During record review of Resident #2's TAR on 3/4/20 at 11:17 a.m., noted an active order for the oxygen tubing to be changed every Wednesday. The next date the tubing was due to be changed was 3/4/20. During record review of the TAR on 3/5/20 at 7:38 a.m., Resident #2's oxygen tubing was signed off as completed by the nurse on 3/4/20. During an observation in Resident #2's room on 3/5/20 at 7:32 a.m., noted the date of 2/25/20 remained on the oxygen tubing that indicated the tubing had not been changed. During an observation in Resident #2's room with the DON on 3/5/20 at 8:00 a.m., DON verified the date on the tubing was 2/25/20. 5. The MDS completed for Resident #34 with an ARD of 1/30/2020, showed a BIMS score of 8, indicating moderate cognitive impairment. The MDS listed [DIAGNOSES REDACTED]. During an observation on 3/4/20 at 10:20 a.m., Resident #34's oxygen tubing dated for 2/19/20. During record review of Resident #34's TAR on 3/4/20 at 11:12 a.m., noted an active order for the oxygen tubing to be changed every Wednesday. The next date the tubing was due to be changed was 3/4/20. During record review of the TAR on 3/5/20 at 7:33 a.m., Resident #34's oxygen tubing change was signed off as completed by the nurse on 3/4/20. During an observation in Resident #34's room on 3/5/20 at 7:40 a.m., noted the date of 2/19/20 remained on the oxygen tubing that indicated the tubing had not been changed. During an observation in Resident #34's room with the DON on 3/5/20 at 8:00 a.m., DON verified the date on the tubing was 2/19/20. DON stated the nurse's had changed only the cannula (prongs for in the nose) piece of the tubing and not the extension part of the oxygen tubing piece.