DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165173	A. BUILDING _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE REHAB AND HEALTH CARE CENTER	830 SOUTH FIFTH STREET OSAGE, IA 50461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS - Correction Date: 4/10/2021 The Iowa Department of Inspections and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C, conducted this Medicare Recertification survey. The facility was found to be NOT IN COMPLIANCE. Total residents: 33 Onsite dates: 03/01/21 - 03/11/21	F 000	This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law	
F 557 SS=D	- Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This Requirement is not met as evidenced by: - Based on observation, record review and staff interview the facility filed to ensure the privacy and dignity for 1 out of 1 residents (Resident #3) by failing to cover a urinary drainage bag. The facility identified a census of 33 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment	F 557	F557 – 1) Resident #3's catheter drainage bag was covered on 3/10/21 by the DON. 2) DON completed an audit of residents who have catheters on 3/10/21, to ensure privacy coverage is provided as required. 3) CNA's and Nurses were re-educated by the DON on 3/5/21 on proper placement of catheter bag, dignity and use of privacy coverings for catheter bags. 4) DON or designee will audit weekly for 4 weeks then monthly for 2 months to ensure Catheter Bag privacy and placement continues to be provided as required. Results of these audits will be taken to the monthly QAPI meeting for 3 months for review and recommendations as needed. DON is responsible for monitoring and follow up. Compliance date: 4/10/2021	4/10/2021

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

Administrator

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 557	Continued From page 1 dated 12/08/20 showed the resident with a Brief Interview for Mental Status score of 3 indicating severe cognitive loss. The resident required extensive assistance with transfer, bed mobility, dressing, toileting, and personal hygiene. The MDS identified the resident using an indwelling catheter with diagnoses of obstructive uropathy, renal insufficiency, and non-Alzheimer's dementia. An Order Summary Report signed by the physician on 02/06/21 showed an order for an 18 French suprapubic catheter with 10 cubic centimeter (cc) bulb to bedside drainage bag every shift for obstructive uropathy. The Care Plan revised 02/23/21 directed the staff in the following care: - Catheter: 18 French 10cc bulb (Foley catheter) (tube that drains urine out of the bladder). - Position catheter bag and tubing below the level of the bladder and away from entrance room door. Revised 02/23/21. - Check tubing for kinks with each interaction each shift. Revised 10/22/2020. Observation on 03/01/21 at 1:33 p.m. found the resident laying in bed supine with the Foley catheter bag laying directly on the floor under the bed with no privacy bag visible from the hallway. Observation on 03/01/21 at 2:33 p.m. found the resident laying in bed supine with the Foley catheter bag suspended from the side of the bed without a dignity/privacy cover over the bag. A half-full catheter bag with yellow urine could be seen from the hallway. One resident stood in the hallway at the time of the observation. The catheter tubing looped below the catheter bag.	F 557		

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F 557	Continued From page 2 Observation on 03/02/21 at 8:13 a.m. found the resident laying in bed supine with the urinary drainage bag suspended from the bed frame with moderate amount of dark yellow cloudy urine visible in the bag from the hallway. No privacy/dignity cover covered the catheter bag. Observation on 03/03/21 at 11:31 a.m. Staff A, Occupational Therapist (OT) and Staff B, Physical Therapy Assistant (PTA) walked the resident with a wheeled walk approximately 15 feet to the doorway of the therapy room (across from the dining room). The resident stood in the doorway of the therapy room with the urinary drainage bag, uncovered, visibly, suspended from the front frame of the walker during ambulation. The catheter bag was ¼ full of yellow urine. Two random residents, not included in the sample, were present in the therapy room and five other residents were present in the dining room. Observation on 03/03/21 at 4:21 p.m. found the resident laying in bed supine with the Foley catheter bag suspended from the bed. The catheter tubing looped below the catheter bag touched the floor directly under the bed. During an interview on 03/03/21 at approximately 4:22 p.m. Staff C, Certified Medication Aide, (CMA), working as a CNA on the 2-6 p.m. shift reported catheter bags should never make contact with the floor and should be covered at all times for privacy. On 03/03/21 at approximately 4:23 p.m. Staff D, Licensed Practical Nurse, (LPN), reported catheter bags should be covered at all times. During an interview on 03/04/21 at 10:57 a.m., the Director of Nursing, (DON), reported she	F 557		

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F 557	Continued From page 3 would expect the catheter bag to be covered at all times for privacy. She reported every resident with a catheter has a privacy bag on the bed and wheelchair that should be used. She would expect the catheter bag and tubing to be off the floor and covered. On 03/04/21 at 11:30 a.m., the DON reported the facility did not have a catheter policy. A booklet entitled Resident information and Reference Guide referring to resident rights, notices, policies and procedures, admission and financial agreements, dated March 2020, provided by the facility, documented on Pg. 49 the resident has a right to be treated with respect and dignity. –	F 557		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This Requirement is not met as evidenced by: - Based on personnel file reviews, document review, policy review, and staff interview the facility failed to obtain a complete criminal background check within 30 days prior to the date	F 607	F607 1) Background check for Staff I was completed on 7/31/2020 by the Business Office Manager. 2) An audit was completed by the Business Office Manager on 3/10/21 to ensure background checks were completed for each employee as required. 3) The Administrator on 3-11-21 provided re-education to the Business Office Manager and Director of Nursing related to ensuring background check is completed prior to hire. 4) Administrator or designee will audit monthly for3 months to ensure background checks continue to be completed prior to start date of new employees. Results of these audits will be taken to the monthly QAPI meeting for3 months for review and recommendations as needed. The administrator is responsible for monitoring and follow up. Compliance date: 4/10/21	4/10/2021

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F 607	Continued From page 4 of hire for 1 of 5 currently employed staff (Staff I). The facility reported a census of 33 residents. Findings include: The personnel file for Staff I, Certified Nurse's Aide (CNA), documented a hire date of 07/27/20. The file contained a Single Contact License and Background Check with an event timestamp of 07/31/21 at 1:01:59 p.m. The file contained the following information: - Dependent Adult Abuse Registry check completed 07/31/20. - Criminal History check completed 08/03/20. - Sex Offender check completed 07/31/20. - Nurse Aide Registry documented eligible. - Child Abuse Registry check completed 07/31/20. A Position and Status report for employment provided by the Administrator on 03/04/21 documented Staff I's position start date as 07/27/20. On 03/04/21 at 8:40 a.m., the Administrator reported the previous Director of Nursing had started the employee before the background checks had been completed. She reported she did not have a reason as to why this had occurred, but all employee hire information must now go through corporate for review. Review of, "Abuse Prevention Program and Reporting Policy", dated reviewed 8/19, provided by the facility directed screening all potential employees prior to hire for a history of abuse, neglect or mistreating residents, exploitation and/or misappropriation of resident property during the hiring process. Screening will consist of, but not be limited to:	F 607		

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F 607	Continued From page 5 - Inquiries into State licensing authorities - Inquiries into State nurse aide registry/Dependent child/adult abuse registry - Criminal background checks. For those prospective employees and other individual engaged to provide services who hold certificates (e.g. certified nurses' aides), the facility will conduct a check with the appropriate registry to assure that there is no finding of abuse, neglect, exploitation, or mistreatment of residents or misappropriation of resident property. -	F 607	F609 1. Staff member M was re-educated by the Administrator on 3/2/21 & 3/3/21 regarding reporting suspected dependent adult abuse. Resident #30 was immediately assessed upon notification of incident with no areas of concern. Attempted to assess Resident #12 for skin issues upon realization that he had not been changed, but he was combative. Skin assessment was completed a few hour later with reddened area, but skin intact. 2. Resident interviews were completed by the Administrator on 3/3/21 regarding feeling safe and knowing how to report allegation of abuse. 3.The Administrator provided staff re-education on Dependent Adult Abuse, including abuse reporting on 3/3/21 & 3/5/21. 4. The Administrator/Designee will complete audits monthly for 3 months to ensure staff continue to report allegations/suspicious of Dependent Adult Abuse as required. Results of audits will be taken to the monthly QA meeting for 3 months for review and recommendations as needed. Administrator is responsible for monitoring and follow up. Compliance date: 4/10/21	4/10/2021
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		

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F 609	Continued From page 6 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: - Based on facility policy, record review, and staff interviews, the facility failed to ensure that all alleged abuse violations are reported immediately, and not later than 2 hours after the allegation is made for 2 of 2 resident reviewed (Resident #30 and #12). The facility reported a census of 33 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment dated 02/18/21 showed Resident #30 with long/short term memory impairment and severely impaired decision-making ability. The resident required extensive assistance in dressing, eating, and personal hygiene. The MDS listed diagnoses of Alzheimer's disease, hypertension, obesity, atrial fibrillation, and dysphagia (difficulty swallowing). Review of Care Plan documented the resident with limited physical mobility and directed the staff to provide extensive assist with personal hygiene including oral cares with an intervention revision date of 01/17/17. A Documentation Survey Report for February 2021 documented personal hygiene completed on 02/25/21 for Resident #12 by Staff L, Certified Nursing Assistant, (CNA) at 8:46 p.m. A Progress Note dated 03/05/21 documented the Resident's son had been notified regarding an	F 609		

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F 609	Continued From page 7 abuse allegation by the Director of Nursing (DON). Review of, "Five Day Investigation Summary", revealed an incident involving Resident #30 and Staff L occurred on 02/25/21. Staff M, Nursing Assistant, witnessed what she believed to be an alleged violation involving abusive treatment of Resident #30 when Staff L stuck her finger in Resident #30's mouth in an attempt to remove mouthwash from the resident's mouth. Staff M failed to report the alleged abuse within two hours of the incident. During an interview on 03/09/21 at 12:07 p.m. the Administrator reported Staff D, Licensed Practical Nurse, (LPN) had called her the evening of 03/02/21 at approximately 10 p.m. to inform her Staff M had reported an incident regarding Resident #30 and Staff L that had occurred on 02/25/21 that could be abuse. The Administrator directed Staff M to write a statement of the events. She reported Staff M voiced on 03/02/21 at approximately 10 p.m. via phone interview she worried Staff L would retaliate or confront her and it would make it difficult for them to work together. The Administrator reported she reminded Staff M of her responsibility to report dependent adult abuse and keep residents safe. On 03/11/21 at 12:11 p.m., Staff M reported they had just gotten done with supper that on 02/25/21 the day of incident. The Administrator had talked that day about getting the resident's teeth brushed. Staff L called her to assist with Resident #30's transfer. She reported when she entered Resident 30's room, Staff L took a swab toothette and put mouthwash into the resident's mouth two times. She observed Staff L yelling at Resident #30, "Spit it out! Spit it out!" Resident #30 held the	F 609		

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F 609	Continued From page 8 mouthwash in her mouth. When the resident did not spit out the mouthwash, Staff L pinched the resident's nose closed to try to get her to swallow the mouthwash; Staff L pinched the resident's nose for a few seconds. The resident groaned, but did not seem to be in any distress. The resident did not spit out the mouthwash. Staff L and Staff M transferred the resident to bed. Staff M reported she had been walking to the door to leave the room when she turned around and saw Staff L stick her finger of her right hand in the resident's mouth to get her to swallow. Staff M reported she heard the resident swallow and staff L say, "the resident swallowed the mouthwash." Staff M reported she had been afraid to report the situation in as she had reported another situation in and the facility had not done anything about it. She liked her job and did not want her co-worker to retaliate or confront her. She verbalized she should have reported the incident in sooner. On 03/09/21 at 1:55 p.m., the Administrator reported she expected staff to report allegations of abuse immediately or within 24 hours of the incident. 2. The MDS Assessment dated 12/26/20 showed Resident #12 with a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive loss. The resident required extensive assistance with transfer, ambulation, toileting, personal hygiene and documented the resident as frequently incontinent of bowel and bladder. The MDS listed diagnoses of COVID 19, anemia, diabetes mellitus, failure to thrive, and non-Alzheimer's dementia. The Care Plan dated 07/06/18 documented Resident #12 with functional bladder incontinence related to activity intolerance and Alzheimer's	F 609		

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F 609	Continued From page 9 disease. The Care Plan listed an intervention regarding incontinence for the staff to check before meals and at hour of sleep (HS) and as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. The Care Plan listed a focus problem that Resident #12 could be resistive to care and staff should provide consistency in care to promote comfort with activities of daily living (ADLs). Maintain consistency in timing of ADLs, caregivers and routine, as much as possible. The Care Plan listed an ADL's self-performance deficit and directed the staff Resident #12 required 1-2 assist with toileting. A Document Survey Report x 2 for February 2021 documented the following information for 02/25/21: - Incontinent of urine at 12:01 p.m. and 8:43 p.m. The record lacked documentation between 12:02 p.m. and 8:41 p.m. the resident had been offered toileting according to the plan of care. - Incontinent of a large bowel movement at 8:42 p.m. - The resident received total assistance of two staff with dressing at 8:42 p.m. - The resident exhibited behaviors not directed towards others (physical symptoms such as hitting, scratching self, verbal/vocal symptoms like screaming, disruptive sounds), disrupted care and resident refused cares. - Behavior on 02/25/21 at 9:45 p.m. documented as no behaviors. A review of the Progress Notes dated 02/24/21 - 03/01/21 lacked documentation of an incident or assessment for Resident #12. Timecard provided by the facility for 02/25/21	F 609		

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F 609	Continued From page 10 showed the following: - Staff L punched in at 1:51 p.m., out at 4:36 p.m., in at 5:03 p.m. and out at 10:40 p.m. - Staff M punched in 1:55 p.m., out at 5:10 p.m., in at 5:42p.m. and out at 10:18 p.m. - Staff O punched in at 4:28 p.m. and out at 10:53 p.m. - Staff P punched in at 5:55 p.m., out at 8:44 p.m., in at 9:16 p.m. and out at 6:40 a.m. on 02/26/21. On 03/09/21 Staff M, CNA, reported she had been afraid to report an abuse allegation regarding another resident after she had reported on a situation regarding Resident #12 on 02/25/21 at the end of her shift and nothing had been done. She stated Resident #12 had sat in poop and urine for eight hours on 02/25/21 on the 2-10 p.m. shift because Staff L, CNA, did not get along with the resident. Staff L did not ask any of the other aides to help her with Resident #12 so he had not been offered toileting all shift. Staff M reported she and Staff O, CNA, went to Resident #12's room and noticed a urine and bowel odor when entering the room. They stood Resident #12 from the recliner and noted the recliner soaked with urine. They transferred the resident to bed and Staff M described the resident as soaked with urine and bowel from his back down to his knees. Staff M reported they had to scrub him so hard his skin bled and he complained of pain during peri-care. During a phone interview on 03/10/21 at 12:32 p.m., Staff O reported on 02/25/21 at approximately 9:45 p.m. Staff L asked Staff O to assist Resident #12 to bed. Staff O and Staff M went to Resident #12's room. Staff O reported Resident #12 had been sitting in the recliner in his room and she could smell urine and bowel	F 609		

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F 609	Continued From page 11	F 609		

movement when she entered the resident's room with Staff M. Resident #12 had sat in a recliner soaked with urine. They transferred the resident into bed. The resident had bowel movement (BM) from his mid back down to his knees with some of the BM being dried on his/her skin. Staff O reported the resident had bleeding from his bottom/scrotum with peri-cares. They completed peri-cares and put a clean brief on the resident. Staff O reported she went to the nurses' station and asked Staff L if she had toileted Resident #12 during the shift. Staff L responded, "the resident doesn't like me." Staff L admitted she did not take the resident to the toilet the entire shift and did not ask any other aides to assist the resident until around 9:45 p.m. that night. Staff O stated she reported the incident to Staff P, Licensed Practical Nurse (LPN). Staff P informed Staff O she would have to write up the incident. Staff O reported she spoke to the Administrator the next day. The Administrator had been informed of the incident and planned to follow up with Staff P. Staff O voiced Resident #12 does refuse care. He will not initiate his/her care needs so staff have to be proactive and prompt cares, otherwise he/she will sit in his urine and feces. Staff O reported it is well known that Resident #12 did not like Staff L. Staff L is banned from several resident's rooms, as they do not want her caring for them. There is no direction as to who is to cover the rooms that Staff L is banned from.

During a phone interview on 03/10/21 at 1:32 p.m., Staff P reported on 02/25/21 at approximately 9:55 p.m. Staff M and Staff O, CNA, reported Resident #12's skin as very red. Staff M reported Staff L had not changed Resident #12 all shift and never asked anyone else to assist Resident #12. Staff P reported she asked Staff L when Resident #12 had last been

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OSAGE REHAB AND HEALTH CARE CENTER	830 SOUTH FIFTH STREET OSAGE, IA 50461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 12 toileted. Staff L first replied at 2 p.m. or later, then reported Resident #12 had not been changed or toileted all shift. Staff P reported she told Staff L if Resident #12 did not want her to provide cares, she needed to communicate to the other aides to assist with his care. Staff P reported she tried to assess Resident #12's skin right after the incident, but he swung at her so she could not assess him. She then assessed Resident #12's skin a few hours later noting his skin as reddened, but intact. Staff P stated she couldn't remember if she had completed a written report, but did report the incident to the Assistant Director of Nursing, (ADON) the next morning, 02/26/21 around 6:30 a.m. Staff P verbalized she didn't know what the ADON did regarding the situation. On 03/11/21 at 9:23 a.m., the ADON reported Resident #12 has not liked Staff L to provide cares for him for a long time. They had set up a system where Staff L is to try to provide cares to the resident, but if he does not allow them to, then Staff L is supposed to go get another CNA to provide the care. A directive had been given to Staff L when it first started happening, so it is been several months. She stated she does not remember doing a formal investigation as to why Resident #12 would not allow Staff L to provide cares for him, but the facility had provided abuse in-service training since that time. The ADON stated her expectation is call lights will be answered and if a resident asks for assistance, she expects staff to provide care to the best of their ability. If staff member cannot provide the cares, they need to ask another staff member to provide the care or assist. The ADON stated regarding Resident #12, an incident had happened a week or so ago. Staff P reported early that morning there had been an incident of	F 609		

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F 609	Continued From page 13	F 609		

miscommunication resulting in Resident #12 not being changed until 9:45 p.m. on the second shift (2-10 p.m.) or toileted. She could not honestly say for sure if Staff P had assessed the resident after the incident. She pulled Staff L into her office that afternoon and told her she is to go get another aide to change Resident #12 between meals and at bedtime. She instructed Staff L if Resident #12 will not allow her to do cares, she needed to get another aide on the other hallway and take over their care while they go down to care for the resident. She reported Staff L said she had called on the walkie-talkie for help and no one responded. The ADON said she told Staff L she needed to report to the charge nurse in those situations. The ADON reported the nurse did not file a written report, but in hindsight should have written the situation up. She did inform the Director of Nursing (DON) and Administrator when they came into work the next day. After reviewing the facility abuse policy definition of neglect, the ADON stated in her heart of hearts she knows the situation had been neglect and it should have been investigated and reported to the state.

On 03/11/21 at 11:07 a.m., the Administrator reported there had been an issue with Resident #12 on 02/25/21 with miscommunication regarding incontinent care. She had become aware of the issue on 02/26/21 and they had discussed interventions to try to handle those types of situations. The aides have assigned hallways, but it is the expectation that all aides will cover all resident care. Resident #12 had been found incontinent of bowel and bladder around 8:30 p.m. that night. She expected if a resident had been incontinent, that a CNA would assist them to change or at least try to check on them. The Administrator reported she did not know if

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F 609	Continued From page 14 Staff P had assessed the resident that night. She would have expected the nurse to have done an assessment on the resident after that situation. If he refused care, she expected them to try different staff members. If they did not provide the care, staff should be wrote up and an investigation should be started. After review of the definition of neglect from the facility policy with Administrator, she reported if the services were not attempted then it would be an issue that would need to be reported to Department of Inspection and Appeals (DIA). The Administrator stated that is not the type of care she wanted the staff to provide and ultimately it is the responsibility of the DON, ADON, and Administrator to monitor and supervise bedside care. A Report communication provided to the Surveyor on 03/11/21 by the facility documented a communication report 02/25/21 at 10:37 p.m. by Staff P which stated: - CNAs you need to be doing checks on your residents! If you know a resident gets irritated with you then you need to speak up and ask your co-workers for help. Resident #12 was not changed since 2 p.m.! This is ridiculous, take care of the residents! I should not nor ANY nurse have to hang over your shoulder to make sure you are doing your job. During an interview on 03/11/21 at 1:30 p.m., Staff L reported if a resident has dementia, they have to check them every couple of hours and call for assistance when needed. She reported Resident #12 would not let her provide care to him. She uses the walkie-talkie and calls other aides to provide his cares. She stated she does not go in his room to provide cares for him. If she tries to go in there, he will raise his fist at her and	F 609		

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F 609	Continued From page 15 start yelling obscenities. She reported she had called on the walkie-talkie before supper for assistance to get him changed at approximately 3:30 p.m. to 4:00 p.m. and no one responded to the call and no came down to the hallway. She reported when no one responded she did not take any further action but all the other aides have walkies and would have heard the message. Staff L reported the day after the incident with Resident #12, the ADON talked to her stating they were going to write her up, but the ADON just talked to her about the situation. The "Abuse Prevention Program and Reporting Policy", dated reviewed 08/19, provided by the facility documented the following under reporting: - Notify the Shift Supervisor immediately if suspected abuse, neglect, mistreatment, or misappropriation of property occurs. Note: a staff member who fails to immediately report alleged abuse, neglect, misappropriation, and/or exploitation of provides false or misleading information during the investigation will be subject to disciplinary action up to and including suspension/termination. - Report the incident immediately to the Administrator and DON. Any staff member with knowledge of the event is responsible for notifying Administrator and/or DON. The Policy directed the following special reporting requirements for suspected criminal conduct: - Report must be made within 2 hours: if the suspected criminal activity results in significant/serious bodily injury, it must be reported immediately, but no later than 2 hours after the suspicion of criminal activity is formed. - Report must be made within 24 hours: if the	F 609		

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F 609	Continued From page 16 suspected criminal activity does not result in serious bodily injury, it must be reported within 24 hours of forming the suspicion. The "Abuse Prevention Program and Reporting Policy", dated 08/19, provided by the facility under Iowa Specific Instruction, Investigation documented the facility will establish and enforce and environment that encourages individuals to report allegations of abuse with fear of recrimination or intimidation. -	F 609		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This Requirement is not met as evidenced by: -	F 693	F693 1) Resident #27 was checked and verified placement of feeding tube on 3/10/21 by the DON. 2) No other residents are receiving tube feeding placement. 3) CMA and Nurses were re-educated by the DON on 4/8/21 related to the requirements of checking tube feeding placements prior to administering medications or feedings. 4) Director of Nursing/Designee will complete observational audits weekly for 4 weeks then monthly for 2 months to ensure nurses and CMA's continue checking placement of tube feeding prior to administering medications or feedings. Results of Audits will be taken to the monthly QAPI meeting for 3 months for review and recommendations as needed. Administrator is responsible for monitoring and follow up. Compliance date: 4/10/21	4/10/2021

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F 693	Continued From page 17 Based on observation, clinical record review, staff interview and document review the facility failed to verify placement of a gastrostomy tube [g-tube] (tube inserted through the abdominal wall into the stomach to provide medication and nutrition) prior to medication and feeding administration for 1 of 1 residents reviewed (Resident # 27). The facility identified a census of 33 residents. Findings include: 1.The Minimum Data Set (MDS) Assessment dated 02/12/21 showed Resident #27 rarely/never understood with long/short term memory impairment and required total assistance in bed mobility, transfer, dressing, eating, toileting and personal hygiene. The MDS documented the resident took 51 percent or more of total calories and 501 milliliters (ml) of fluids per day through a feeding tube. The MDS listed diagnoses of seizure disorder, pneumonia, cerebral palsy, respiratory failure, and encounter for attention to gastrostomy (tube). Review of a Hospital Clinical Summary dated 02/05/21 documented Resident #27 admitted to internal medicine on 02/03/21 with an active diagnosis of a dislodged gastrostomy tube. The document, signed by the physician on 02/05/21 at 10:05 a.m., documented the following transfer orders for the resident to return to the facility: - Residual check before each feeding (per G-tube) - Gastrostomy Tube, 360 ml (1.5 cans) dose per bolus, three time a day (TID), flush with 60 (ml water). Check residual prior to feeding Osmolite (liquid supplemental nutrition) 1.5 cal (cans). A Medication Review Report signed by the physician on 02/05/21 listed the following orders:	F 693		

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F 693	Continued From page 18 - Enteral feed order every shift check feeding tube placement via auscultation and aspiration prior to feeding and meds (medications). - Check residual prior for feeding once weekly. One time a day every Monday for tube feeding monitoring. - Elevate the head of the bed (HOB) 30-45 degrees every shift for tube feeding. Monitoring 30 minutes after feedings. - Formula: Osmolite, strength 1.0 480 cubic centimeters (cc) three times a day for tube feeding must be up in recliner chair for feeding and two hours after. Review of the Medication Administration Record (MAR) with a date range of 03/01/21 - 03/31/21 listed the following physician order: - Check residual prior to feedings once weekly. One time a day every Monday for tube feeding monitoring. Order Date 07/21/16 - Elevate HOB 30-45 degrees every shift for tube feeding monitoring 30 minutes after feedings. Order Date 04/14/16. - Enteral feed order every shift check feeding tube placement via auscultation and aspiration prior to feeding and meds. Order Date 04/14/16. - Formula: Osmolite, Strength: 1.0, Bolus: 480cc three times a day for tube feeding. Must be up in recliner/chair for feeding and 2 hours after. Order date 04/14/16. A Care Plan, dated 04/21/16 directed the staff with the following interventions: - Resident requires tube feeding related to swallowing problem prior to admission. - Check for tube placement per policy. Date Initiated: 04/21/16. Revision on: 04/03/17. - Needs the head of bed elevated 30-45 degrees when in bed. Must be fed in sitting position and remain upright for 2 hours after feeding. Date	F 693		

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F 693	Continued From page 19 Initiated: 04/21/16. Revision on: 04/03/17. - See Medical Doctor order for current feeding orders. Date Initiated: 04/21/16. On 03/2/21 at 12:05 p.m., Staff A, Certified Medication Aide (CMA), entered Resident #23's room, set up supplies on a clean barrier, and performed hand hygiene. Resident #27 sat slouched down in the recliner with legs/feet elevated above the trunk of the body and head elevated approximately ten degrees. Staff A put on gloves, opened the g-tube, attached a syringe and flushed the tube with 30 ml of water, administered 5mg of Diazepam (medication for seizures) and flushed the g-tube with 30 ml of water. Staff A failed to verify g-tube placement prior to administration of the Diazepam medication. Staff A administered one box of Osmolite, flushed the g-tube with 60 ml of water, administered the second box of Osmolite, then flushed the g-tube with 60 ml of water. Staff A failed to verify placement of the g-tube prior to the administration of the Osmolite and failed to perform the 60 cc water flush per the physician order prior to the administration of the Osmolite. On 03/2/21 at 12:14 p.m., Staff A reported she had received training on how to administer medication via g-tube in her medication aide course and the Assistant Director of Nursing, (ADON), had worked with her one on one on administering enteral medications. She reported she should have done a (G-tube) placement check prior to the administration of the medication and feeding. She reported she usually does perform a placement check. She stated she did not have the head of the recliner up 30-45 degrees as she has always been trained to give Resident #27's medications and feeding in that reclined position as he doesn't seem to have	F 693		

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F 693	Continued From page 20 problems when he is fed in that position. On 03/02/21 at 3:55 p.m., the Director of Nursing, DON, reported she would expect the staff to check placement before administering any g-tube feedings or medications. She would expect staff to inject air into the tube and listen for a "gurgle." She thought the same employee had missed checking placement when the last audits were done. She stated she had done reeducation with the employee. She reported the resident should have been more upright and is usually in a seated position when the feedings are administered. Reviewed the "Enteral Feeding Policy", revised 5/16, provided by the facility directed the nursing staff in the following steps: Step 7: Assist the resident to a 30 - 45 degree semi-fowler's position. Step 8: Inspect the feeding tube insertion site. Step 9: Evaluate placement of feeding tube. - Instill 10-20ml of air into the feeding tube while simultaneously auscultating over the left upper quadrant of the abdomen with a stethoscope to validate aid movement in the stomach. - Aspirate 2-10ml of gastric contact and re-instill. Step 10: Check for residual: a. Connect a syringe to the feeding tube. b. Gently draw back the plunger of the syringe to withdraw stomach contents. c. Read the amount in the syringe. d. If using a 60cc syringe may need to use a graduate container and repeat the withdrawal twice. e. Inject the contents back into the feeding tube (it contains important electrolytes and nutrients). f. Use the syringe to rinse the feeding tube with 50cc of water. g. If the gastric residual is more than 100cc, delay	F 693		

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F 693	Continued From page 21 the feeding. h. Wait 30 to 60 minutes and do the residual check again. If the residual continues to be high (more than 100cc) and feeding cannot be given, then notify physician. The Medication Administration Procedure, dated 1/13, provided by the facility directed the staff in the following steps with enteral (G-tube) medication administration: Step 9. Verify the head of the bed is 30 - 45 degrees. Step 12. Verify tube placement. - Instill 10-20 cc of air into the tube while simultaneously auscultating over the left upper quadrant of the abdomen with a stethoscope to validate air movement in the stomach Aspirate 2-10cc of gastric content and re-instill.	F 693		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812	F812 1) Staff re-educated on 3-10-21 by the Dietary Manager regarding all food leaving the dining area is covered. 2) The Dietary Manager performed an observational audit of serving on 3/11/21 to ensure food & drinks leaving the dining room was being covered appropriately and staff are handling cups appropriately. 3) The Dietary Manager and Administrator provided re-education for Dietary Staff on covering of food and drinks leaving the dining room area and proper handling of cups. 4) Administrator or designee will complete weekly audits for 3 months to ensure food & drinks leaving the dining room continue to be covered and staff to refrain from touching the lip of drinking cups as required. Results of these audits will be taken to the monthly QAPI meeting x 3 months for review and recommendations as needed. The administrator is responsible for monitoring and follow up. Compliance date: 4/10/21	4/10/2021

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F 812	Continued From page 22 standards for food service safety. This Requirement is not met as evidenced by: - Based on observation, policy review and staff interview the facility failed to distribute and serve food under sanitary conditions. The facility reported a census of 33. During an observation of the lunch meal kitchen service on 03/01/21 between 11:45 AM and 1:09 PM, 8 room trays were set up by Staff K and delivered to resident's rooms, individually, with beverage cups uncovered. After delivering trays, Staff K returned and was observed pouring beverages for 1 resident at a table while touching the lip contact rim of the cups. Staff J was observed pouring beverages for 5 residents while touching the lip contact rim of the cups. Review of facility policy titled, "Dining Services Room Service", step 6 directed staff to make sure all items on the tray are covered prior to leaving the kitchen. Review of facility policy titled, "Cleaning and Sanitizing Clean equipment & Utensils, Handling", step 2 directed staff to handle cups so that fingers and thumbs do not contact lip contact surfaces. During an interview on 03/01/21 at 1:10 PM, Staff C, Dietary Manager stated lids were available for use, and she would expect the cups to be covered. She stated in the event they do not have actual lids, they use tissue paper to cover the cups. During an interview on 03/04/21 at 12:37 PM, Staff C, Dietary Manager stated she would expect	F 812		

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F 812	Continued From page 23 cups to be handled by staff from the side with hand below the lip contact rim. She stated she would reeducate, as that is not acceptable practice. -	F 812	F880 1) Staff D, H and G were re-educated on proper hand hygiene and donning and doffing of PPE, transportation & cleaning of treatment supplies, use of barrier for treatment supplies, cleaning the glucometer by the DON/designee on 3/3/21. Staff E was re-educated on proper placement	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880	of catheter tubing on 3/3/21 by the DON. Staff K was re-educated on proper handling of cups/ glasses on 3/3/21 by the Dietary manager. Residents #3, #11, #20, #23, #27 were assessed by the DON/designee on 3/5/21 with no s/s of infection noted. 2) An observational audit was completed by the DON/designee on 3/10/21 & 4/8/21 to evaluate any resident for signs of infection with physician updated as needed. DON/designee performed observational audits on 3/10 -3/12 to ensure other staff members are following infection control practices. 3) Staff were re-educated on the requirements of infection control with focus on PPE and hand hygiene, handling treatment supplies, completed on or before 3/10/21 & again on 4/8/21 by DON/designee. Staff viewed the following infection control videos on or before 4/12/21: "Clean Hands" and "Keep COVID Out". An infection control Root Cause Analysis was completed with the facility QAPI team and reviewed by QIO on or before 4/9/2021. 4) Director of Nursing/designee will complete observational audits weekly for 12 weeks to ensure infection control continues to be maintained with emptying drainage bags and with meal delivery as required. The results of these audits will be presented to the QAPI Committee meetings monthly for 3 months for review. The Director of Nursing is responsible for monitoring and follow up. Compliance Date: 4/10/2021	4/10/2021

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F 880	Continued From page 24 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This Requirement is not met as evidenced by: - Based on observation, record review and staff interview the facility filed to ensure the proper infection control for 5 out of 5 residents (Resident #3, #11, #20, #23, #27) by failing to keep urinary catheter bag from contacting the floor, not using clean barriers under supplies, failing to perform	F 880		

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F 880	Continued From page 25 hand hygiene after gloving and not covering food during transport to resident rooms. The facility identified a census of 33 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment dated 12/8/20 for Resident #3 showed the resident with a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive loss. The resident required extensive assistance with transfer, bed mobility, dressing, toileting, and personal hygiene. The MDS identified the resident using an indwelling catheter with diagnoses of obstructive uropathy, renal insufficiency, and non-Alzheimer's dementia. An Order Summary Report signed by the physician on 02/06/21 showed an order for an 18 French suprapubic catheter with 10cc bulb to bedside drainage bag every shift for obstructive uropathy. The Care Plan revised 02/23/21 directed the staff in the following care: - Catheter: 18French 10 cc bulb (Foley) (tube that drains urine out of the bladder). Position catheter bag and tubing below the level of the bladder and away from entrance room door. Revised 02/23/21. - Check tubing for kinks with each interaction each shift. Revised 10/22/2020. Observation on 03/01/21 at 1:33 p.m. found the resident laying in bed supine with the catheter bag laying directly on the floor under the bed with no privacy bag. Observation on 03/01/21 at 2:33 p.m. found the resident laying in bed supine with the catheter	F 880		

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F 880	Continued From page 26 bag suspended from the side of the bed without a dignity/privacy cover over the bag. A half-full catheter bag with yellow urine could be seen from the hallway. One resident stood in the hallway at the time of the observation. The catheter tubing looped below the catheter bag. Observation on 03/03/21 at 4:21 p.m. found the resident laying in bed supine with the catheter bag suspended from the bed. The catheter tubing looped below the catheter lay touching the floor under the bed. Observation on 03/03/21 at approximately 11:35 a.m. Staff E, Certified Nursing Assistant, (CNA) entered Resident #3's room to empty the urinary drainage bag. Staff E placed a hand towel on the floor and placed alcohol prep pads on the towel. Staff E performed hand hygiene, gloved and removed the urinary drainage bag from the privacy bag and placed the urinary drainage bag directly on the floor without a clean barrier. Staff E held the tubing above the level of the bladder to drain the urine from the catheter tubing into the bag. After emptying the urinary drainage bag, Staff E cleansed the drainage tip with alcohol. Staff F, CNA, emptied the graduate and placed the drainage bag in the privacy bag on the bed. Staff E and F removed gloves and performed hand hygiene. During observation, the DON stated the (urinary) drainage bag could not be placed on the floor and the tubing cannot be held above the level of the bladder. On 03/03/21 at approximately 4:22 p.m., Staff C, working as a CNA on the 2-6 p.m. shift, reported when emptying a catheter a barrier should be placed on the floor under the graduate. The	F 880		

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F 880	Continued From page 27 graduate should not be placed directly on the floor. Catheter bags should never make contact with the floor and should be covered at all times for privacy. On 03/3/21 at approximately 4:27 p.m. Staff D, reported any supplies taken to a resident's room should be placed on a clean barrier. Items should not be on the floor and catheter bags should be covered at all times. During an interview on 03/04/21 at 10:57 a.m. Director of Nursing, DON, reported she would expect a barrier to be used under the catheter bag or any other supplies. She reported every resident with a catheter has a privacy bag on the bed and wheelchair that should be used. She would expect the catheter bag and tubing to be off the floor and covered. On 03/04/21 at 11:30 a.m., the DON reported the facility did not have a catheter policy. 2. The MDS dated 02/20/21 showed Resident #20 with long and short-term memory impairment requiring extensive assistance with bed mobility, transfer, dressing, personal hygiene, and toileting with incontinence of bowel and bladder. The MDS listed diagnoses of renal insufficiency, Alzheimer's disease, anxiety, depression, and COVID 19. The Care Plan dated revised 01/21/21 documented Resident #20 with a pressure ulcer and directed the staff to administer treatments as ordered and monitor for effectiveness daily. A Medical Doctor (MD)/Nursing Communication Sheet, signed by the Provider on 01/27/21, showed a physician order for a change of	F 880		

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F 880	Continued From page 28 treatment to cleanse (coccyx wound) with normal saline, apply Maxorb 2 after cut to size, cover with Optiform border and change daily. The Treatment Administration Record (TAR) with a date range of 03/1/21 - 03/31/21 listed the following treatment: - Area to coccyx: cleanse with normal saline, apply Maxorb 2 after cut to size, cover with Optifoam border, and change daily until healed. One time a day for wound care. Observation on 03/02/21 at 2:35 p.m. Staff D performed hand hygiene and set up basic wound care supplies on a clean barrier and placed a box of gloves directly on the resident bedside stand. Staff D cleansed the stage 2 pressure injury to the coccyx and cut the Masorb dressing to fit the wound area with scissors. After finishing the wound treatment, Staff D placed the used scissors directly into her uniform pocket without disinfecting. Staff D placed her fingers inside the top of the glove box to pick up the box. Staff D walked to the medication cart, placed the box of gloves directly on top of the treatment cart, and performed hand hygiene. Staff D obtained treatment supplies for the treatment in room #23A and proceeded to put a bottle of hydrogen peroxide and a cup of normal saline in her right uniform pocket with the dirty scissors. Observation on 03/02/21 at approximately 3:00 p.m. Staff D came out of another resident's room after completing a skin treatment. She took the scissors out of her right uniform pocket and placed them inside the treatment cart on top of a stack of scissors without disinfecting. Staff D reported she had training on hand hygiene and the use of clean barriers. She reported she should not have put dirty scissors in her pocket	F 880		

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F 880	Continued From page 29 with other wound care supply items without cleaning the scissors first. During an interview on 03/04/21 at 10:57 a.m., the DON reported she would expect that all supplies should be placed on a clean barrier. She would expect the staff to clean equipment after use before storing. 3. The Minimum Data Set dated 02/12/21 showed Resident #27 with long and short-term memory impairment totally dependent in bed mobility, transfer, dressing, eating and personal hygiene. The MDS identified the resident utilized a gastrostomy tube for 51% or more of calories, 501 cc of fluids or more a day, and had a skin treatment of application of ointments/dressings other than to feet. Review of the Care Plan dated 04/21/16 directed the staff to provide local care to gastrostomy tube (g-tube) site as ordered and monitor for signs/symptoms of infection. A TAR with a date range of 03/01/21 - 03/31/21 documented the following treatment: - Cleanse stoma site with 1/2 hydrogen peroxide ½ water 2-3 times a day. -Order Date - 10/24/18 Observation on 03/02/21 at 2:45 p.m. Staff D entered Resident#27's room, took the hydrogen peroxide bottle and normal saline cup out of her pocket and placed wound care supplies directly on the bedside table without a clean barrier. Staff D Performed hand hygiene, gloved up, mixed the solution of hydrogen peroxide and normal saline, and cleansed around the gastrostomy site. Staff D removed the glove to the left hand, donned a new glove without performing hand hygiene, and dried the stoma area after cleansing. Staff D	F 880		

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F 880	Continued From page 30 removed glove to the left hand, donned a new glove without performing hand hygiene, opened a package of split gauze, and placed the split gauze around the base of the g-tube. Staff D removed gloves, placed packages in garbage, and placed the peroxide bottle in a basket on the dresser. Staff D then placed tape over the split gauze at the g-tube site to secure in place. On 03/02/21 at 2:51 p.m., Staff D performed hand hygiene, went to the treatment cart, and sat the bottle of hydrogen peroxide and box of gloves on top of the cart without a barrier underneath. Staff D pulled the dirty scissors out of her right uniform pocket that had been used on another resident's wound care treatment and placed in the treatment cart on top of a stack of other scissors. On 03/02/21 at 3:00 p.m., Staff D reported she had training on hand hygiene and the use of clean barriers. She stated she did not use a clean barrier for Resident #27's treatment since the surface of the bottle did not touch any surfaces in the room. She reported there was a few times that she only changed one glove to her hand and did not perform hand hygiene. She reported she should not have put dirty scissors in her pocket without cleaning along with other wound supplies. During an interview on 03/04/21 at 10:57 a.m., the DON reported she would expect that all supplies should be placed on a clean barrier. She would expect the staff to clean equipment after use before storing and follow proper infection control for hand hygiene. On 03/04/21 at 11:30 a.m., the DON reported the facility did not have a wound care policy. 4. During an observation on 03/01/21 at 11:40	F 880		

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F 880	Continued From page 31 a.m. Staff G, Certified Medication Aide, (CMA), performed hand hygiene, placed two wax paper barriers on top of the cart, then took a blood sugar meter and placed on top of the mouse pad (not on clean barrier) and checked the order for the blood sugar on the computer. Staff G knocked on the resident's door, random resident not included in the sample, entered, and placed the blood sugar meter on the bedside table without a clean barrier underneath. Staff G completed the blood sugar, exited the room, and placed the blood glucose machine on top of the cart without a clean barrier underneath. Staff G wiped down the blood glucose monitor with a Lysol wipe for 10 seconds and placed the meter back in the cart. Staff G reported the Lysol needed to stay on the meter for 10 seconds to disinfect. On 03/02/21 at 11:33 a.m. Staff H, Licensed Practical Nurse, (LPN), completed a blood sugar test for Resident #26. Staff H exited the resident's room and placed the blood sugar meter on the computer mouse pad without a clean barrier. Staff H wiped the meter with a Lysol wipe, wrapped the meter and placed in the medication cart for approximately two minutes. Staff H reported she did not know the contact time for the Lysol to disinfect the meter. Staff H failed to perform hand hygiene after completing the blood sugar procedure. On 03/03/31 at 4:27 p.m., Staff D reported a clean barrier should be used under blood glucose meters when on the medication cart and when taken to a resident's room. Any supplies taken to a resident's room should be placed on a clean barrier. Items should be placed on a clean barrier on the cart until the item is cleaned.	F 880		

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F 880	Continued From page 32 During an interview on 03/04/21 at 10:57 a.m., the DON reported she would expect that all supplies should be placed on a clean barrier. She would expect the staff to clean equipment after use before storing and follow proper infection control for hand hygiene. On 03/04/21 at 11:30 a.m., the DON reported the facility did not have a policy/procedure regarding the use of barriers for infection control or a procedure on how to perform a blood sugar. On 03/08/21 at 9:46 a.m., the Administrator reported she would expect the staff to follow the manufacturer directions for the correct wet time to disinfect the blood sugar meters. The Lysol Disinfecting Wipes, Environmental Protection Agency number (EPA#) 777-114, manufacturer package directions state the following to sanitize and disinfect: - Pre-clean the surface. Use enough fresh wipes to thoroughly wet the surface. Surface must remain wet for the entire contact time. - To sanitize allow to remain wet for 10 seconds. - To disinfect allow to remain wet for 4 minutes. Allow surface to air dry. 5. During an observation on 03/01/21 at 11:45 a.m. Staff K delivered a room tray to resident, opened door to resident room, moved over bed table, closed resident room door when leaving the room. She returned to the dining area, opened a hall linen closet, took out clothing protectors, and set them on the microwave. She placed silverware, drinks, and ice cream on a room tray. Staff K cleared a dirty place setting on a dining room table, returned to the serving area, picked up a room tray, and delivered it to a resident, opening and closing the resident's door. Staff K	F 880		

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F 880	Continued From page 33 returned to the dining room and set up a clean place at the table including silverware and drinks. She placed a clothing protector on the resident at the table. She proceeded to clear another dirty place setting. Hand hygiene was then completed. 6. During an observation of dressing changes for Resident #23 on 03/03/21 at 09:48 a.m. Staff H had all supplies gathered and on top of the treatment cart. Hand hygiene was completed and gloves applied. Two pieces of precut split back tape were part of supplies gathered. Staff H picked up supplies to take to resident room and dropped 1 piece of tape on the floor. She picked the tape up off the floor and with the rest of the supplies entered the resident's room. She placed the supplies directly on over bed table with no barrier. Staff H placed the ordered ointment on the ordered dressing and placed both pieces of split back tape on the dressing. Staff H decided to measure wound. She reached into her pocket with her gloves on, took keys out of her pocket, opened the resident's door, opened the treatment cart, removed a sealed cotton swab, closed the treatment cart returned to resident's room, closed the door and returned the keys to her pocket. She measured the wound using the sealed cotton swab and applied the dressing to the resident's buttock. She removed gloves and performed hand hygiene. 7. During an observation of a leg treatment for Resident # 23 on 03/03/21, immediately following buttock treatment, Staff H gathered supplies from treatment cart and placed on over bed table in the resident's room with no barrier. Staff H applied gloves and removed right ankle/leg dressing by cutting gauze with scissors. Staff H returned to the treatment cart with gloves on opened the drawer took out new scissors, cut clean kling	F 880		

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F 880	Continued From page 34 wrap, cleansed the wound with wound cleanser, and removed gloves. She reapplied gloves without performing hand hygiene, squeezed Bactroban out of the tube onto gloved finger, applied to leg, and then recapped the Bactroban with hand used to apply to wound. She covered the wound with a 4x4, kling wrap and secured with tape. She removed the resident's right sock and touched right foot and ankle. Staff H pulled left sock down opened Bactroban and put Bactroban on gloved finger and rubbed into skin. She pulled the sock up and recapped the Bactroban. She removed gloves and performed hand hygiene. 8. During an observation of a dressing change on Resident # 11 on 03/03/21 at 10:17 a.m. Staff H had supplies gathered on top of the treatment cart. She applied gloves, entered the resident's room, and closed the door. She lifted resident shirt to reveal red area on right upper chest. Supplies were set on over bed table with no barrier. Staff H applied triple antibiotic ointment directly to gloved finger and applied to reddened area. She covered the wound with telfa and secured with paper tape. She pulled the resident's shirt, removed gloves, and performed hand hygiene. Review of the facility policy titled, "Infection Prevention", handwashing instructions showed the staff are to perform hand washing after the removal of gloves. During an interview on 03/09/21 at 1:26 p.m., the Administrator stated they have no glove use policy. During an interview with Staff H on 03/03/21 at 10:23 a.m., she stated she does normally apply	F 880		

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F 880	Continued From page 35 ointment with her gloved finger so she can control exactly where it goes to prevent further irritation. During an interview on 03/04/21 at 12:52 p.m., the DON (Director of Nursing) stated she would expect staff to wash hands before and after glove use. She stated she would expect both gloves to be changed and clean hands in between pairs of gloves. She stated she would expect Bactroban to be applied with cotton swab and it is not acceptable practice to apply with gloved finger. The DON stated she would not expect supplies that had dropped onto the floor to be used on a resident. She stated she would expect gloves to be removed before leaving the room. She stated she would not expect nurses to recap ointment with soiled gloves and she would expect a barrier to be placed between over bed table and treatment supplies.	F 880		