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F 000	INITIAL COMMENTS Correction date 10•29•2020 An investigation of Facility Reported Incident #93371-I and Complaints #87517-C, #88153-C, #89553-C, 90647-C, 90814-C, and 92814-C ending on 9/29/20, resulted in the following deficiencies Facility Reported Incident #93371-I was not substantiated. Complaint #87517-C was not substantiated. Complaint #88153-C was substantiated. Complaint #89553-C was not substantiated. Complaint #90647-C was substantiated. Complaint #90814-C was not substantiated. Complaint #92814-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. A Focused COVID-19 infection survey conducted in conjunction with the above complaint investigation ending on 9/29/20. The facility was not in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 37	F 000		
F 880 SS=F	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	F 880		

SB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy Tschida | TITLE: Administrator | (X6) DATE: 10-23-2020

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 880	Continued From page 1 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 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	F 880		

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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 clinical record review, observation, staff interview and facility policy review, the facility failed to utilize appropriate infection control practices during resident care for 2 of 3 residents reviewed (Resident #1 and Resident #6). The facility also failed to provide a clean and sanitary, home-like environment due to excessive amounts of bio-hazardous waste stored in the facility for extended amounts of time that created severe odor and created a health risk to the residents. The facility reported a census of 37 residents.

Findings included:

1. Resident #1's Minimum Data Set (MDS) dated 7/24/20 revealed a Brief Interview for Mental Status (BIMS) of 11 which indicated moderately impaired cognitive functioning. The MDS stated

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the resident required extensive assist of 2 staff with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS included diagnoses of: Diabetes Mellitus, Dementia, Renal Insufficiency, and high blood pressure.

Record review of Resident #1's care plan with a revision date of 7/15/20 revealed a focus that resident has diagnosis of diabetes mellitus which placed her at risk for medical complications-insulin dependent. The goal is resident will not exhibit and signs of hypo/hyperglycemia (low/high blood sugar). Interventions included staff to perform blood sugar checks as ordered by the physician and give sliding scale insulin as directed by physician.

Observation on 9/17/20 at 11:35 a.m. Staff B- Licensed Practical Nurse (LPN) performed blood sugar check and administration of insulin for Resident #1. Staff B knocked and entered the room and explained to the resident what she would be doing. Staff B already applied gloves and stated she already washed her hands and then donned her gown. Staff B entered Resident #1's room and placed the glucometer machine on the bedside stand with no barrier noted. Staff B, used a lancet to prick the finger and obtain the blood sample. Staff B then went back to the medication cart and placed the glucometer machine on a tissue on top of the cart. Staff B removed the lancet and glucometer strip and disposed of them into a sharps container. Staff B opened the medication cart and retrieved a bottle of Novolog Insulin for Resident #1. Blood sugar value was 227 mg/dl which indicated Resident required 3 units of insulin. Staff B cleansed rubber stopper of insulin vial with alcohol swab and drew up 3 units of insulin into syringe. Staff

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F 880	Continued From page 4 B then laid the syringe down on the top of the medication cart without a barrier, and applied new gloves. Staff B entered Resident #1's room again and administered insulin to resident after using an alcohol swab to cleanse resident's left abdominal area. Staff B disposed of the needle into the sharps container and removed her gloves, her gown, and entered the bathroom to wash her hands. After Staff B washed hands, she walked back into Resident #1's room and noted the oxygen cannula fell out of resident's nose. Staff B approached the resident and placed the oxygen tubing back into the resident's nose without any gloves on. Staff B then exited the room and recorded she administered the insulin.. Staff B stated she had completed the tasks of glucometer check and insulin administration. Staff B began to walk away from Resident # 1's room and wheeled the medication cart up to the nurses station. Once Staff B parked the medication cart, she picked up the glucometer and placed it into the medication cart with bare hands. Staff B did not wash her hands or apply hand sanitizer after she had left residents room and before touching the glucometer, the drawer of medication cart and the lock on the medication cart. On 9/28/20 at 3:20 pm Staff B revealed she did not know she did not consistently use a barrier for the administration of insulin and while performing glucometer checks during observation on 9/17/20. She stated she tries to use barriers all of the time, but does occasionally forget, especially if she is nervous. Staff B confirmed that she did not disinfect the glucometer machine prior to putting it away into the medication cart. Staff B stated she didn't think it was necessary to disinfect it since the glucometer was used only on	F 880		

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one resident.

On 9/29/20 at 9:00 a.m. the Director of Nurses (DON) and the Administrator revealed they expected all nurses to use a barrier on all surfaces before placing any medical supplies or glucometers on tables, on the medication cart etc. The DON and Administrator also stated they expect all nurses to appropriately wash their hands and should not use bare hands or soiled paper towels to shut off the water.

Facility Procedure for washing hands:
1. Vigorously lather hands with soap and water and rub them together, creating friction to all surfaces, for a minimum of 20 seconds under a moderate stream of running water, at a comfortable temperature.
2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink.
3. Dry hands thoroughly with paper towels and the turn off faucets with a clean, dry paper towel.
4. Discard towels into trash.

Review of the facility's blood glucose machine and safe injection practices policy revised 11/28/17 stated that the policy is to prevent the spread of infection and blood borne pathogens when using blood glucose testing devices.
Procedure:
1. Prepare insulin in a medication area using the insulin assigned to the individual resident and labeled appropriately.
2. Never reuse needles, syringes or lancets.
3. Be sure to clean and disinfect the blood glucose machine environmental surface with an EPA approved germicide before and after testing the resident's blood glucose and between each

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resident use.

2. The MDS dated 8/16/20 assessed Resident # 6 with a BIMS score of 3 (severe cognitive impairment). The MDS revealed the resident required extensive assist of 2 staff with bed mobility, transfers, walking, dressing, toileting and personal hygiene. The MDS included diagnoses of: Diabetes Mellitus, cancer, wound infection, and high blood pressure.

Review of Resident #1's care plan with a revision date of 9/21/20 revealed a focus area of: skin impairment to skin graft site to left ear due to non-squamous cell cancer. The goal is for residents skin graft site to show signs of healing. Interventions directed staff to encourage him to not pick at scabs on ear, follow up with surgeon as indicated, notify physician/family of any changes to area, and provide treatments as ordered.

Observation of wound care on 9/21/20 at 10:40 a.m. revealed Staff B LPN entered the room after applying her gown and gloves. Staff B gathered the wound care supplies and placed them on a paper towel on Resident # 6's table. Staff B removed the old dressing from left side of head and disposed it into the red biohazard bin. Staff B removed gloves and went into the bathroom to wash hands. Staff B wet her hands at sink, applied soap and after washing hands thoroughly, rinsed the soap off. Dried hands with several paper towels and then shut off the water with her bare hands. Staff B applied new gloves and placed a 4 X 4 gaze dressing into a solution of ¾ peroxide and 1/4 water and applied to the wound on resident's left side of his head. After the dressing soaked on the wound for 15 minutes,

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F 880	Continued From page 7 Staff B removed it and discarded it into the red biohazard bin. Staff B changed her right glove only and stated since she had not soiled the left glove, she would keep that one on. Staff B applied the antibiotic ointment to the wound and applied a clean dressing. Staff B disposed the dressing change supplies into the garbage and removed her gloves. Staff B washed hands with soap and water, drying her hands with paper towels. Used the wet paper towels to shut the water off. Staff D-Certified Nurse Aide (CNA) entered the room to toilet the resident as the call light was on. Staff D appropriately washed hands at the sink and applied gloves and a gown. Staff D and Staff b then assisted Resident # 6 to the bathroom with stand-lift machine. Observation revealed the resident incontinent of urine at this time. Staff D discarded the old brief and applied hand sanitizer to hands and applied new gloves. Staff D completed perineal care while resident sat on the toilet. Staff D removed her gloves and discarded into the trash and pulled up resident's clean brief and pants for the resident. Staff D removed her gloves and washed hands at sink. Staff B also washed her hands at the sink after removing her gloves and again shut the water off with the wet paper towels used for drying her hands. On 9/28/20 at 3:20 pm Staff B revealed she knew she improperly washed her hands and during the observation of wound care for Resident # 6 on 9/21/20. On 9/29/20 at 9:00 a.m., the DON and Administrator stated they expected all nurses to appropriately wash their hands and not use bare hands or soiled paper towels to shut off the water.	F 880		

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Review of the facility's Handwashing Policy/Hand Hygiene policy and procedure, revised on 11/28/2016, stated the facility considers hand hygiene the primary means to prevent the spread of infections.

-All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.

-All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors.
- The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

Facility Procedure for washing hands:

1. Vigorously lather hands with soap and water and rub them together, creating friction to all surfaces, for a minimum of 20 seconds under a moderate stream of running water, at a comfortable temperature.
2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink.
3. Dry hands thoroughly with paper towels and the turn off faucets with a clean, dry paper towel.
4. Discard towels into trash.

3. During a facility walk through on the 800 hall, on 9/22/20 at 5:05 p.m., observation revealed a large accumulation red biohazard waste in the facility's biohazard room. The biohazard bags

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overflowed the biohazard room and the facility created a second biohazard room in an empty resident room adjacent to the biohazard room. Observation revealed approximately 10 large biohazard bags in the smaller biohazard room and approximately 15 bags in the adjacent room with a very strong offensive, rotting smell in the hallway from the biohazardous waste. The facility utilized the 800 hall wing for patient care and was located in the Covid wing of the facility. Further walk through of the building revealed 2 additional rooms on an unoccupied hallway in the 500 hall. The exit of that hallway contained a 5 to 6 foot pile of large red bio-hazard bags with approximately 100-120 bags visible on the floor. In addition, a smaller bio-hazard room attached to the exit hallway appeared full of bio-hazard bags as well. The area contained a strong offensive, rotting smell in the hallway from the bio-hazardous waste.

On 9/23/20 at 7:15 a.m. Staff H-Certified nurse assistant (CNA), identified the facility's bio-hazard bags as "out of control" and oftentimes stacked to the ceiling in the bio-hazard room. The red bags over flowed into the room next to the bio-hazard disposal room.

On 9/23/20 at 6:20 p.m. Staff I-CNA, revealed the bio-hazard room filled up and the smell was horrible and that staff could not even go into the breakroom area as it is located in the same hallway as another biohazardous storage room on the 500 hallway.

On 9/23/20 at 6:33 p.m. Staff J-CNA, revealed the bio-hazard bags started piling up since the beginning of August, if not longer. Staff J stated the facility repeatedly called the bio-hazard

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company to come for the waste but for some reason, the company did not come. Staff J further stated the smell became so bad that it was not safe for the residents or staff.

On 9/23/20 at 5:42 p.m. Staff K-CNA, revealed she was shocked to see the bio-hazard waste in the 800 hallway and they could smell the waste up and down the hallway that resident's were currently lived in. Staff K identified a rotting smell in the 800 and 500 hallways for several weeks. Staff K also identified the bio-hazard waste as back logged for the last 2-3 months and the bio-waste company did not consistently pick up the bio-hazard bags.

On 9/28/20 at 10:05 a.m. Staff C, identified the bio-hazard room as overflowing since early August 2020. Staff C stated that the disposal company would only provide 4 large containers and once the containers filled, they would not take any more of the bio-hazard bags not contained in the bins. The company said it wasn't in the contract for them to take the extra bags. Staff C stated the disposal company had missed a couple of their pick-up days and when the facility had a Covid outbreak in August, it made the situation even worse as the whole facility was placed onto isolation precautions which caused a huge amount of bio-hazardous wastes.

On 9/29/20 at 9:00 a.m. the Administrator stated she knew of the overabundance of bio-hazardous waste stored within the facility. The Administrator acknowledged that the rotting smells and the excessive accumulation of the red bags should not have happened and she would be sure to get rid of the waste sooner and in any way possible.

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F 880	Continued From page 11 The Administrator stated that they did not have a facility policy for the proper disposal of biohazardous waste.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff and resident interviews, review of picture and video footage, and billing records, the facility failed to provide adequate pest control procedures and extermination of bed bugs that were present within the facility from September 2019 through April 2020. The facility had their pest control services withheld for the months of November and December 2019 due to non-payment for services. Lack of professional pest control services created a prolonged risk for the spread of bed bugs throughout the facility which affected the health and safety of all residents that lived at the facility. The facility reported a census of 37 residents. Findings Included: On 9/22/20 at 11:54 a.m., Staff E stated the bed bug issues in the facility all started when a resident brought furniture into the facility after he determined the furniture was infested with bed bugs. Staff E stated he had worked in managing apartment complexes and knew what bed bug droppings looked like and when Resident#12 moved into the facility in July 2019 facility, he saw the evidence of bed bugs and quarantined the	F 925		

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furniture in the basement so it could be sprayed to kill the bugs. Staff E stated, despite knowing this, the Administrator at the time brought the furniture up to the resident's room anyway. Staff E stated after the resident moved from the 800 hallway to the 300 hallway, all of the bed bug issues started as that was when the furniture was brought in. Staff E stated the bed bug issues continued for several months due to the pest control services stopping for a couple of months due to the facility not paying the bill.

On 9/22/20 at 12:35 a.m., Staff G-former maintenance staff, stated he left the facility in April 2020. Staff G identified the bed bug issues in the facility as ongoing since approximately September 2019. Staff G stated they tried to handle the bed bugs on their own but the products they used did not work. Staff G stated the facility did not pay the pest control bill so they could not get the bed bugs under control. Staff G stated eventually, a few months later in February 2020, the facility hired another pest control company to come in and do professional bed bug treatments and the problems started to get better. Staff G found piles of dead bed bugs in the infested resident rooms.

On 9/23/20 at 9:00 a.m., the DON (Director of Nursing) stated staff would leave her cups of bed bugs. The DON stated most of the time the bed bugs were dead. The DON further stated she had not seen any bed bugs since March 2020.

On 9/28/20 at 10:05 a.m., Staff C-RN (registered nurse) revealed the facility bed bug infestation started when Resident #12 moved into the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165540	A. BUILDING ______ B. WING ______	C 09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTH CARE CENTER	**6120 MORNINGSIDE AVENUE SIOUX CITY, IA 51106**

(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 925	Continued From page 13	F 925		

in July 2019. Staff C stated she remembered seeing bed bugs crawling on resident's beds, on the floors and at the nurses station. Staff C stated if bed bugs were identified in a resident's room, they would call the pest control company to come in and spray and after the rooms got sprayed, she could see bed bugs running away from the rooms that were sprayed and they eventually started to infest the nurses station and the living room areas. Staff C stated the facility did try to manage the bed bugs on their own for a couple of months but that it wasn't effective and they had to hire a new pest control service.

On 9/28/20 at 12:30 p.m., Staff M- Medical Director stated that he had been made aware of the on-going issues of bed bugs within the facility and several residents had rashes possibly caused by bed bug bites.

On 9/29/20 at 9:00 a.m., the Administrator stated she could find no record of pest control services provided to the facility in the months of November and December 2019 to help reduce the bed bugs within the facility. The Administrator verified the facility did not pay the bill in a timely fashion which caused the pest control company to withhold their services for November and December. The Administrator verified the outbreak lasted from approximately September 2019 through April 2020 and the facility would receive routine monthly services going forward so this would not happen again.

Review of the facility's Pest Control Policy revised on 8/2011 stated:
1. The following routine actions will be taken to minimize the risk of pest infestation.
-Staff should report identified pests immediately

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F 925	Continued From page 14 to Maintenance Department. -Buildings should be of sound structure and well maintained, drains should be covered, and leaking pipe work repaired and damaged surfaces made good. Defects should be reported to the Maintenance Department. 2. Pest control services will be provided (usually on a monthly basis except for special circumstances) and as needed. 3. The maintenance man or the HFA(health facility administrator) need to be informed of all pest control problems so a determination can be made to contact the service provider for emergent services if needed. The facility provided records of Pest Control Visits for all services received for from September 2019 through May 2020. The facility's pest provider performed pest management services on September 19th, October 2nd, 4th and 8th. There were no pest control services received for the months of November 2019 and December 2019. Pest control services resumed on January 16th and 20th and on February 13th.	F 925		

Countryside Health Care Center – Plan of Correction for Complaint survey 9/16/2020-9/29/2020

F 925: Maintains Effective Pest Control Program

Maintain an effective pest control program so that the facility is free of pests and rodents.

The facility will report any findings of pests immediately to the Maintenance Department. Pest control services will be provided on a monthly basis, except for special circumstances, and as needed. The maintenance man needs to be informed of all pest control problems so a determination can be made to contact the service provider for emergent services if needed.

a) Resident #12 was identified to be affected by deficient practice. However, all residents have the potential to be affected.
b) All furniture is inspected by the Maintenance department prior to being delivered to resident's room. An audit was created to inspect any pieces of furniture brought by new residents before the furniture is delivered to the resident's room and to complete a walk-thru throughout the facility in search of signs of pests.
c) Licensed Nursing/Nurse Managers and the maintenance department have been educated on what bed bugs look like and different signs associated with bed bugs. These parties have also been educated on who to report to if they do notice signs of pests and to notify immediately.
d) Administrator and Maintenance department will perform monthly audits of these processes and bring to the IDT to review for on-going basis with results forwarded to QA&A Committee for further review.
e) Responsible Party: Administrator/Designee
f) Compliance Date: 10/29/2020

F 880: Infection Prevention and 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.

The facility will ensure that an effective system is meeting the requirements for preventing, identifying, reporting, investigating, and controlling infection and communicable diseases for all residents, staff, visitors, and other individuals providing services under a contractual arrangement.

a) Resident #1 and Resident #6 was identified to be affected by deficient practice. However, all residents have the potential to be affected.
b) A Root Cause Analysis was completed for this tag for the hand hygiene and glucometer usage along with a separate Root Cause Analysis for the biohazard. A glucometer audit and education were conducted for all Licensed nurses and Certified Medication Aides. A hand hygiene education and audit were completed for all staff. Audits will continue to be conducted with staff and will be ongoing. Five employees will be audited daily times

seven. Audits completed by Administrator/DON/Designee on the biohazard rooms will be conducted weekly times seven to ensure proper containment. We created an off-site containment area to control the odor that was produced from the biohazardous waste and will be pursuing a new company to manage the waste.

c) All staff have been educated and audited on hand hygiene and have watched the provided YouTube video on Clean Hands. A glucometer audit was conducted for all Licensed nurses and Certified Medication Aides.
d) DON/Designee will perform routine audits of these systems and IDT to review for on-going basis with results forwarded to QA&A Committee for further review.
e) Responsible Party: Director of Nursing/Designee
f) Compliance Date: 10/29/2020