STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	C 03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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: 3/4/23 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #110109 and #110992 conducted Feburary 2, 2023 to March 3, 2023. Complaint #110109 was substantiated. Complaint #110992 was not substantiated. . See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	**PLAN OF CORRECTION** Accura HealthCare of Carroll denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578	1. In continuing compliance with F 578, Request/ Refuse/ Discontinue Treatment/ Formulate Advanced Directives. Accura Healthcare of Carroll corrected the deficiency by the DON ensuring Res #11, #30, #37, #27 and all like residents had an IPOST, that the IPOST was signed by the physician, and that the IPOST matched the physician orders by 3/2/23. Education was provided on 02/28/23 to DON/ADON by Regional Clinical Quality Specialist on ensuring IPOST are completed on all residents, that they have a physician signature and that IPOST and physician orders match. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 3/2/2023 on completion of the IPOST by the DON. The DON and/or designee will audit IPOST accuracy and completion 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 4 weeks, and then PRN to ensure continued compliance. 3. As part of Accura HealthCare of Carroll's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	3/2/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 3/24/23

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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and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, the Iowa Department of Health and Human Services, and staff interviews the facility failed to initiate the Iowa Physician Orders for Scope of Treatment (IPOST) or advanced directives for 1 out of 16 residents reviewed (Resident #11). The facility failed to ensure the IPOST information coincided with physician's orders for 1 out of 16 residents reviewed (Resident #30). The facility also failed to complete the IPOST form for 2 out of 16 residents reviewed (Residents #27 and #37). The facility reported a census of 40 residents.

Findings included:

1.The Minimum Data Set (MDS) assessment dated 1/18/23 for Resident #11 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact.

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Resident #11's electronic and paper chart lacked an IPOST document.

The Care Plan last revised 2/23/23 documented Resident #11 wished to have Cardiopulmonary resuscitation (CPR) if needed.

In an interview on 3/1/23 at 2:04 PM, the Director of Nursing (DON) reported the facility failed to complete the IPOST for Resident #11. The DON explained that he would work to complete a IPOST for Resident #11.

In an interview on 3/1/23 at 3:07 PM, the Assistant Director of Nursing (ADON), reported that the DON obtained Resident # 11 husband's signature on the IPOST yesterday and still needed to obtain the provider's signature.

2. The MDS assessment dated 11/18/22 for Resident #37 documented a BIMS score of 15 which indicated intact cognition.

Resident #37's undated IPOST reviewed on 2/28/23 at 1:18 PM lacked a physician's signature.

The Care Plan last revised 2/13/23 documented Resident #37 wished to have cardiopulmonary resuscitation (CPR) if needed.

In an interview on 3/1/23 at 3:07 PM, the ADON, reported that she conducted a facility wide audit of IPOST yesterday and acknowledged Resident #37's IPOST still needed to be reviewed, and signed by the physician. The ADON acknowledged the IPOST requirements and stated that she expected staff to initiate, complete

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F 578	Continued From page 3	F 578		

and obtain the physician's signature on IPOSTs for all residents. The ADON reported the facility failed to have an IPOST policy.

The Iowa Department of Health and Human Services website titled, IPOST Form and Guidance, Description of the IPOST form dated 2023, revealed according to the statute, the IPOST form shall be a uniform form and shall have all of the following characteristics:
- Patient's name and date of birth
- Signed and dated by the patient or patient's legal representative
- Signed and dated by the patient's physician, advanced registered nurse practitioner, or physician assistant
- Signed and dated by the facilitator (helper) if the preparation of the form was done by an individual other than the patient's physician, advanced registered nurse practitioner, or physician assistant.

3. The MDS assessment dated 12/12/22 for Resident #27 documented diagnoses of cancer and heart failure. The MDS revealed a BIMS score of 10, indicating moderately impaired cognition.

Resident #27's Physician Orders documented a Do Not Resuscitate (DNR) order effective 11/16/20.

Resident #27's IPOST dated 11/16/20 lacked a physician's signature. The form had both DNR and CPR marked for options.

4. The MDS assessment dated 11/16/21 for Resident #30 documented diagnoses of cancer, heart failure and chronic obstructive pulmonary disease (COPD). The MDS documented a BIMS

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F 578	Continued From page 4 of 12, indicating moderately impaired cognition. Resident #30's Physician Orders documented a DNR order effective 11/16/21. Resident #30's IPOST signed by the physician on 11/18/21 indicated that Resident #30 requested CPR.	F 578		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview and staff interview the facility failed to provide bathing assistance twice weekly and/or per resident preference for 1 of 8 residents reviewed for bathing (Resident #11). The facility reported a census of 40 residents. Finding Included: The Minimum Data Set (MDS) assessment dated 1/18/23 for Resident #11 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS showed Resident #11 required extensive assistance of 1-2 persons for assistance with personal hygiene, transfers and dressing. Resident #11 required physical help in part of the bathing activity of two persons. The MDS Diagnosis showed disease of the spinal cord, venous insufficiency and morbid obesity.	F 677	1. In continuing compliance with F 677, ADL Care Provided for Dependent Residents. Accura Healthcare of Carroll corrected the deficiency by providing education on 03/02/2023 to DON/ADON by Regional Clinical Quality Specialist on ensuring resident #11 and all like residents receive bathes per their preference or as scheduled. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 3/2/2023 on providing bathing assistance twice weekly and/or per resident preference by the DON. The DON and/or designee will audit bathes 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks, and then PRN to ensure continued compliance. 3. As part of Accura HealthCare of Carroll's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	3/2/2023

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F 677	Continued From page 5 In an Interview on 2/27/23 at 1:46 PM, Resident #11 reported the facility failed to provide assistance with baths twice a week. Resident #11 explained that she preferred to be offered a shower twice a week The Care Plan dated 1/30/23 showed Resident #11 required the assistance of two persons for transfers to the shower. The Bathing Performance documentation dated 2/28/23 at 11:37 AM showed from 1/30/23 through 2/28/23 Resident #11 only received a bath on 2/10/23. Records also indicated the resident refused two baths during the 30 day look back period. In an interview on 3/1/23 at 1:47 PM, Resident #11 recalled that she did decline two baths recently. Resident #11 stated she did not get a bath for the first two weeks at the facility. She explained that her husband had to call them. Resident #11 became tearful then said, they don't like taking care of her at the facility. The January 2023 Documentation Survey Report documented from 1/11/23 through 1/31/23 Resident #11 received only three baths in the first 21 days at the facility. In an interview on 3/1/23 at 2:59 PM, the Assistant Director of Nursing (ADON), stated that she expected staff to assistant Resident #11 twice a week with bathing. The ADON explained staff are expected to document when a bath is offered, but refused by the resident. The ADON reported the facility does not have a policy regarding bath schedules.	F 677		

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F 692	Continued From page 6	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to follow-up on a requested order for a nutritional supplement for a resident with weight loss for 1 of 1 residents reviewed (Resident # 43). The facility reported a census of 40 residents. Findings include: The admission Minimum Data Set (MDS) for Resident #43 dated 1/13/23 documented a Brief Interview for Mental Status (BIMS) of 9, indicating moderately impaired cognition. The MDS	F 692	1. In continuing compliance with F 692, Nutrition/Hydration Status Maintenance. Accura Healthcare of Carroll corrected the deficiency on 03/02/2023 by providing education by the Regional Clinical Quality Specialist to DON/ADON on notifying provider and resident or resident representative of any significant weight changes and ensuring recommendations are responded to in a timely manner for resident #43 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 3/2/2023 on the process of timely communication of recommendations to providers by the DON. A weekly meeting between the clinical team and Registered Dietician began on 3/2/23 for any recommendations and recommendations sent out stays at the nurses station. The DON and/or designee will audit dietary recommendations 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 4 weeks, and then PRN to ensure continued compliance. 3. As part of Accura HealthCare of Carroll's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	3/2/2023

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F 692	Continued From page 7	F 692		

included diagnoses of diabetes mellitus, heart failure and renal (kidney) insufficiency. The MDS further documented the resident required set-up assistance with eating.

The Care Plan initiated 1/6/23 documented Resident #43 had an alteration in nutrition with weight loss, pressure areas, varied meal intake and refusals with a goal he would not have a significant weight change within the next review period. The Care Plan directed staff to encourage intake at meals, do weights per facility protocol, and report any significant weight changes.

Resident #43's Weight Summary included the following weights:
a. 2/6/2023 - 207.5 pounds (lbs)
b. 2/3/2023 - 210.0 lbs
c. 1/20/2023 - 221.0 lbs
d. 1/8/2023 - 224.0 lbs
e. 1/7/2023 - 226.5 lbs

The Nutrition/Dietary Notes dated 2/2/23 at 3:30 PM documented by the Registered Dietician (RD) indicated a Quarterly Nutrition Assessment done on 1/25. Resident #43 received a regular, small serving diet with 35% average meal intake and 609 cubic centimeter (cc) average fluid intake. Resident #43 could feed himself without chewing or swallowing issues noted. Resident #43 did not have a supplement in place at the time. The RD recommended on 1/23 (per the nutrition assessment) that the facility start 6 ounces (oz) of Ensure Clear. The facility has not received a response from the primary care provider regarding the request. The RD intended to recommend it again. Resident #43 had 1-2 plus (+) edema noted to his bilateral lower extremities (BLE). Resident #43 continued to have a stage 2

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F 692	Continued From page 8	F 692		

area to his left and right buttocks with a stage 1 area to sacrum. He weighed 221 pounds (lbs) on 1/20, a loss of 16.3lb since his admission. The supplement recommended for weight loss prevention also. The RD planned to continue to monitor.

The Nutrition/Dietary Note dated 2/13/23 at 3:00 PM documented by the RD labeled WEIGHT WARNING: revealed a weight of 207.5 from 2/6/23, indicating an 8.4% weight loss or 19.0 lbs. Resident #43 had a significant 30 day weight loss. The RD indicated that the weight loss likely occurred due to poor
intake and decline despite supplement in place for weight loss prevention and wound healing. Resident #43 discharged to hospital at the time, will re-evaluate if he returns. The RD indicated she knew of the other weight alert on 2/3.

Resident #43's February 2023 Medication Administration Record (MAR) revealed an order date of 2/3/23 for an Ensure supplement.

During an interview on 3/2/23 at 11:04 AM the RD revealed she made the recommendation for the Ensure to the PCP on 1/23/23 and left it in a folder at the facility for the provider. The RD reported that she didn't realize the provider was on vacation for a week to 10 days. The RD stated she then faxed the recommendation to the provider.

During an interview on 3/2/23 at 9:10 AM the Director of Nursing (DON) explained that the recommendation got faxed to the PCP on 1/23/23. The DON added the PCP was on vacation and the other providers did not respond to the recommendation.

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F 692	Continued From page 9 During an interview on 3/2/23 at 11:05 AM the DON revealed he expected staff to follow-up if the facility did not have a response to a fax from a provider within 24 hours. During an interview 3/2/23 at 11:23 AM the Assistant Director of Nursing (ADON) acknowledged a recommendation for a nutritional supplement had been made 1/23/23 for Resident #43 who had weight loss and that the order did not get implemented until 2/3/23. The ADON revealed she would expect a recommendation for a supplement be faxed to the PCP and the recommendation would be in effect 24-48 hours later. On 3/2/23 at 11:34 AM, the DON revealed the facility did not have a policy specific to obtaining physician orders with weight loss as they follow the standards of care.	F 692		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761	1. In continuing compliance with F 761, Labeling and Storage of Drugs and Biologicals. Accura Healthcare of Carroll corrected the deficiency on 02/27/23 by providing education to Staff A on locking medication cart when not near cart and by providing education on 02/28/23 to Staff C on locking medication cart when not near cart. 2. To correct the deficiency and to ensure the problem does not recur nurses were educated on 3/2/2023 on ensuring medication care is locked when left unattended. The DON and/or designee will audit medication carts to ensure they are locked 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 4 weeks, and then PRN to ensure continued compliance.	03/02/2023

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F 761	Continued From page 10 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility staff failed to keep medication carts locked while unattended by staff in resident areas. The facility reported a census of 40 residents. Findings include: 1. Observation on 2/8/23 at 2:16 PM in the resident common area near the 200 hallway revealed an unlocked medication cart without staff presence. One staff member walked past the unlocked medication cart during the observation. At 2:21 PM, Staff A, Registered Nurse (RN) approached the unlocked medication cart after being behind a locked door in the nurse's station and stated she had been away from the unlocked medication cart for about 3 minutes. Staff A acknowledged the medication cart should have been locked. The record review revealed of the facility's residents during the time of the observed unlocked medication cart and unattended by authorized staff, four residents resided in the facility that required a Wanderguard due to	F 761	3. As part of Accura HealthCare of Carroll's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 761	Continued From page 11 wandering behavior, 12 residents were deemed moderately impaired and 8 residents were deemed severely impaired based on their Brief Interview for Mental Status (BIMS) score at the time of the incidents. During an interview 3/1/23 at 9:46 AM the Administrator revealed the facility follows the standard of practice and does not have a written policy regarding locking medication carts. During an interview 3/1/23 at 3:25 PM the Assistant Director of Nursing (ADON) revealed it is an expectation that the medication cart is locked at all times when authorized staff isn't present. 2. On 3/1/23 at 6:54 AM observed Staff C, Licensed Practical Nurse (LPN), leave the medication cart unlocked, then entered into Resident #13's room carrying supplies to complete a blood sugar check. The medication cart sat unlocked and unattended for approximately 5 minutes. When Staff C returned to the medication cart, and discovered it unlocked she stated, I'm sorry, I left it unlocked. In an interview on 3/1/23 at 3:25 PM, the Assistant Director of Nursing (ADON), acknowledged that she witnessed Staff C, LPN, step away from the medication cart today during medication pass without immediately engaging the lock. The ADON stated, I already talked with her about locking it every time she is going to step away.	F 761		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		

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	165455	A. BUILDING _____ B. WING _____	C 03/02/2023

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ACCURA HEALTHCARE OF CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

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F 801	Continued From page 12 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.	F 801	1. In continuing compliance with F 801, Qualified Dietary Staff. Accura Healthcare of Carroll corrected the deficiency by RVP educating Administrator on 3/6/23 that a certified dietary manager must be employed by the facility. 2. To correct the deficiency and to ensure the problem does not recur, the current dietary manager has been enrolled in a certified dietary program through DMACC. The Executive Director will audit dietary staff qualifications monthly for 6 months to ensure continued compliance. 3. As part of Accura HealthCare of Carroll's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	3/16/2023

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F 801	Continued From page 13 (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically	F 801		

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F 801	Continued From page 14 qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews, the facility failed to ensure the facility's Dietary Service Manager had the required qualifications in the absence of a full-time dietician. The facility reported a census of 40 residents. Findings include: During an interview on 2/28/23 at 11:24 AM the Director of Nursing (DON) revealed the facility did not have a Certified Dietary Manager (CDM) as expected. The DON further revealed they are actively looking for a CDM and one has not been in place for at least 2 years. On 3/1/23 at 9:46 AM the Administrator revealed the facility does not have a policy in place regarding the expectation to have a CDM as they follow standards of practice. During an interview on 3/2/23 at 12:16 PM the DON revealed the Dietician comes to the facility one time a week on Mondays.	F 801		
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.	F 880		

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F 880	Continued From page 15 §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 must prohibit employees with a communicable disease or infected skin lesions from direct	F 880	1. In continuing compliance with F 880, Infection Prevention and Control. Accura Healthcare of Carroll corrected the deficiency on 03/01/23 by providing education to Staff D and E on proper peri care process, hand hygiene, and infection control practices regarding resident #18 and all like residents by the DON. Education provided on 03/01/23 to Staff F on barriers, hand hygiene, and cleaning of supplies/containers after leaving resident rooms regarding resident #29 and all like residents by the DON. 2. To correct the deficiency and to ensure the problem does not recur nursing staff were educated on 03/02/2023 on proper hand hygiene, peri-care, barriers with supplies relating to but not limited to blood glucometers and cleaning supplies after use by the DON. The DON will complete competencies on all CNAs for peri care by 3/8/23 and hand hygiene by 3/8/23 and competencies for Nurses on glucometers and cleaning supplies after use will be done by 3/8/23The DON and/or designee will audit peri-care, hand hygiene, and barrier use 3 times per week for 4 weeks, 2 times per week for 4 weeks, 1 time per week for 4 weeks, and then PRN to ensure continued compliance. 3. As part of Accura HealthCare of Carroll's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	3/2/2023

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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, infection control policy, clinical record review, and staff interview, the facility failed to provide a resident perineal care in a manner that prevented infection for 1 out of 1 residents reviewed (Resident #18). In addition the facility also failed to conduct a blood sugar test in a manner that protected the resident from blood borne pathogens for 1 out of 1 residents reviewed (Resident #29). The facility reported a census of 40 residents.

Findings included:

1. The Minimum Data Set (MDS) assessment dated 1/11/23 for Resident #18 documented the Brief Interview for Mental Status (BIMS) score of 00 which indicated severe cognitive impairment. The MDS showed Resident #18 required extensive assistance of 1-2 persons for assistance with personal hygiene, transfers,

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toileting and dressing. The MDS Diagnosis showed Alzheimer's Disease, muscle weakness and a need for assistance for personal care.

On 2/28/23 at 9:25 AM observed Resident #18 receive incontinence care, Staff D, Certified Nursing Assistant (CNA), performed front perineal cares, removed their gloves then failed to perform hand hygiene before reapplying gloves. Staff D then assisted Resident #18 onto her left hip, cleansed Resident #13's right hip then cleansed the buttock in the incorrect direction by starting from the top of the buttock crease, then wiped down towards the perineum. When finished cleansing the buttock area, Staff D removed their gloves, failed to perform hand hygiene then assisted to reposition Resident #18 on her back, adjusted her linens and pillows then used the bed controls to reposition the bed. Staff E, CNA, then applied gloves, collected a trash bag from the receptacle, tied a knot then collected an additional garbage bag from Staff D, without removing gloves and performing hand hygiene, Staff E opened Resident #18's door, ambulated to the Dirty Utility room door, entered the lock code on the keypad, turned the door handle, then discarded the trash bags and gloves. Staff E did not perform hand hygiene after she removed gloves, then exited the Dirty Utility Room and proceeded down the hall and entered into resident room 200.

2. On 3/1/23 at 07:24 AM watched Staff F, Licensed Practical Nurse (LPN), entered Resident #29's room with supplies for a blood sugar test including a glucometer, medications including two inhalers and topical medication. Staff F placed the items on a table in Resident #29's room. Staff F failed to place a barrier

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between the blood sugar testing supplies and Resident #29's table. Staff F administered medications to Resident #29. Staff F then applied gloves, cleansed the resident's finger, allowed the solution to dry, then lacented the resident's finger. Staff F then collected a sample of blood using a blood sugar testing strip. Staff F entered the testing strip into the glucometer. Staff F then sat the glucometer on the resident's table without a barrier. After the glucometer measured the blood sugar results Staff F removed the blood sugar strip from the glucometer then discarded the testing strip and her gloves. Staff F failed to perform hand hygiene. Staff F then collected the haler, topical medication and blood sugar testing supplies and placed them on top of the medication cart. Staff F then performed hand hygiene then replaced the inhaler and topical medication into the medication cart without sanitizing the containers.

The General Infection Prevention and Control Surveillance last updated 10/19/22 directed to wash their hands after touching blood, body fluids, secretions, and contaminated items, whether or not gloves are worn, after gloves are removed, between resident contact, and any other time necessary, such as between tasks or procedures on the same resident.

In an interview on 3/1/22 at 3:22, the Assistant Director of Nursing, (ADON),acknowledged that she witnessed Staff D and Staff E fail to perform incontinence care in a manner that prevented infection and witnessed that Staff D failed to perform hand hygiene during Resident #18's incontinence care. The ADON reported that she educated the staff and planned to repeat education with all staff regarding incontinence

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F 880	Continued From page 19 care and performing hand hygiene when removing gloves. The ADON reported the facility failed to have a policy for perineal or incontinence care. The ADON stated, the facility follows the standards of practice. The ADON also acknowledged that she witnessed Staff F's failure to place a barrier for the blood sugar testing supplies and witnessed that Staff F failed to perform hand hygiene after removing her gloves following the blood sugar test. The ADON stated, I already educated her. I will be educating everyone after the survey.	F 880		