STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165163	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
On With Life	715 SW Ankeny Road Ankeny, IA 50023

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observations, staff interviews, clinical record review, and policy review, the facility failed to follow enhanced barrier protection practices for residents with indwelling medical devices for 5 of 5 residents reviewed for infection control (Resident #3, #13, #16, #27, and #25). The facility reported a census of 25. Findings include: 1. The Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #3 had diagnoses of traumatic spinal cord dysfunction, multidrug-resistant organism (MDRO), resistance to Vancomycin, paraplegia, and quadriplegia. The MDS assessment documented the presence of an indwelling catheter. The Care Plan dated 10/9/24 revealed Resident #3 had a suprapubic catheter related to his spinal cord injury. The Care Plan directed staff to follow provider orders for catheter cares and to provide catheter cares every shift. This included staff to drain the catheter bag every shift and as needed. The Care Plan lacked directives for staff to use Enhanced Barrier Protection (EBP). During observation on 10/9/24 at 12:15 PM, Staff E Certified Nursing Assistant (CNA) completed catcher cares for Resident #3. Staff E did not wear a gown while performing catheter cares. 2. The MDS assessment dated [DATE] reviewed Resident #13 had the diagnoses of a non-traumatic brain dysfunction, anoxic brain damage, aphasia, and quadriplegia. The MDS documented the resident received tube feedings due to loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, and coughing or choking during meals or when swallowing. The Care Plan revised on 8/7/24 revealed Resident #13 required enteral nutrition as evidenced by presence of a gastrostomy tube and to provide tube feedings and water flushes as ordered. The Care Plan lacked directives for staff to use EBP. During observation on 10/9/24 at 7:45 AM, Staff F, Registered Nurse (RN), did not wear a gown while administering Resident #13's tube feedings and medications via the gastrostomy tube. 3. The MDS assessment dated [DATE] revealed Resident #16 had diagnoses of non-traumatic brain dysfunction and intracranial abscess and granuloma. The MDS documented the presence of also indicated the presence of intravenous (IV) access for medication administration. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan revised on 8/15/24 revealed Resident #16 had a Streptococcus Anginosis infection with multiple intracranial abscesses. The care plan directs staff to administer antibiotics as ordered. The Care Plan lacked directives for staff to use EBP. During observation on 10/09/24 at 7:20 AM, Staff F, did not wear a gown while administering Resident #16 IV antibiotic. 4. The MDS assessment dated [DATE] revealed Resident #25 had diagnoses of cerebrovascular accident, gastrostomy tube, and a Stage 2 pressure ulcer. The MDS documented the resident received tube feedings and had a Stage 2 pressure ulcer. The Care Plan revised on 9/17/24 revealed Resident #25 had impaired skin integrity as evidenced by a pressure ulcer due decreased mobility and decreased sensation from a stroke. The Care Plan also revealed the resident had a g-tube. The Care Plan directed staff to follow physician's orders for treatments. The Care Plan lacked directives for staff to use EBP. During observation on 10/09/24 11:45 AM, Staff F, did wear a gown while completed wound cares to Resident #25's right foot. 34817 5. The admission MDS assessment dated [DATE] revealed Resident #27 had diagnoses of traumatic brain injury, quadriplegia, diabetes, and neurogenic bladder. The MDS indicated the resident had a catheter. The Care Plan revised on 9/30/24 revealed the resident an activities of daily living (ADL) performance deficit related to a spinal cord injury. The resident had a catheter related to urinary retention. The resident also had impaired skin integrity as evidenced by a pressure ulcer. The Care Plan directed staff to provide catheter care each shift. The Care Plan lacked directives for staff to use EBP. During observations on 10/8/24 at 11:27 AM, Staff D, CNA, washed her hands and donned a pair of gloves. Staff D emptied the resident's catheter bag and cleansed the catheter port with an alcohol swab. Staff D removed her gloves and washed her hands after she performed catheter care. Staff D did not wear a gown during the procedure while she handled and cared for the urinary catheter. The resident's room lacked signage regarding the use of EBP or PPE required. During an interview on 10/10/24 at 9:30 AM, Staff B, CNA, reported she looked at the white board in the resident's room to know what cares a resident needed or she looked at the resident's Kardex on the computer. Staff B stated staff told her in report if a resident required special precautions. Staff B reported she looked at the sign posted on the resident's door to know what PPE to put on. Whenever a resident on isolation precautions, a bin placed outside the resident's door with PPE such as gown and gloves, and a trashcan placed next to it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/10/24 at 9:47 AM, Staff C, CNA, reported she looked at the white board on the wall in the resident's room to know what to do for the resident. She also looked at the kardex on the computer but the white board had the most updated information. Staff C reported she received information during shift report about whether a resident required special precautions, such as isolation or PPE required. Staff C stated she donned a gown and gloves or whatever PPE needed before she entered an isolation/precautions room. Staff C reported when she left the resident's room, she removed the PPE outside the room and placed it in the trashcan, and sanitized her hands. Staff C reported a sign on door revealed the what PPE to put on prior to entering the resident's room. Staff C reported she didn't normally put a gown on to empty a resident's catheter unless the resident had an infection. During an interview on 10/10/24 at 11:30 AM, the Director of Nursing (DON) reported they initiated EBP's whenever a resident had an active CDC (Center for Disease Control) targeted MDRO infection. If one resident in the facility had an MDRO, it was considered an outbreak and then EBP's implemented. The DON reported they reached out to the State Department on how to proceed with their resident population. The DON confirmed whenever a resident placed in isolation, a bin with PPE placed outside the room, along with a trashcan. The DON confirmed the trash can outside Resident #32's room did not have a lid over it. The facility's Enhanced Barrier Precautions policy revised 5/2024 revealed EBP utilized as a strategy to decrease transmission of MDRO's. A gown and gloves used for high-contact resident care activities for residents with chronic wounds, indwelling medical devices, or secretions/excretions that are unable to be contained or covered. Persons with acquired brain injury require indwelling medical devices including feeding tubes and/or urinary catheters. All residents who qualified for EBP received education and filled out a consent form indicating their preference for EBP if a MDRO outbreak occurred. Staff donned a gown and gloves during close contact interactions such as wound care, incontinence care/ toileting, and transfers if the resident or guardian indicated they wanted EBP. 6. During observation on 10/7/24 at 10:11 AM, a Contact precautions sign hung on Resident #25's door and a plastic bin with drawers of PPE (gown and gloves) observed outside the resident's room. A trashcan without a lid sat next to plastic bin with drawers. The admission MDS dated [DATE] revealed Resident #25 had diagnoses of MDRO and at an increased risk for facility acquired infections. The MDS revealed the on isolation for an active infectious disease and took antibiotics. The Care Plan initiated 9/25/24 revealed the resident required isolation precautions due to ESBL (Extended spectrum betalactamases). The Care Plan directed staff to don proper PPE when caring for him.