STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa City Rehab & Health Care	3661 Rochester Avenue Iowa City, IA 52245

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** 19126 20331 Based on observations, clinical record review, facility policy review and staff interviews, the facility failed to follow standard and transmission-based precautions to prevent spread of infections for 4 of 4 residents reviewed. (Resident #2,#3,#4,#5). The facility reported a census of 45 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #2 had no cognitive impairment, transferred from one surface to another with a mechanical lift, had a surgical wound and diagnoses including orthopedic conditions, viral hepatitis, complete amputation right foot, frostbite hand, and skin graft. The resident's Care Plan identified a Focus area that required EBP (Enhanced Barrier Precautions) related to the presence of skin grafts/frostbite wounds to bilateral hands/feet and incision site to LBKA (below the knee amputation) initiated 2/6/2025. The Care Plan directed staff to use EBP during completion of high contact activities, adhere to the use of EBP once instituted, and protection will be available for facility staff in resident care area. A review of a Health Status Note, dated 3/1/25 revealed Resident #2 returned from the emergency room with an indwelling Foley catheter in place. During an observation on 3/3/2025 at 11:10 A.M., Resident #2's room lacked signage to indicate the need for EBP, and no PPE (personal protective equipment) available outside of the room. Staff C, Certified Nursing Assistant (CNA). and Staff D, CNA. entered the resident's room, donned gloves, adjusted a bed pillow between the resident's legs, position the resident on a sling and transferred the resident from the bed to the wheel chair. The staff failed to donn a gown during the provision of cares. During an observation on 3/3/25 at 1:30 P.M., Staff C and Staff D entered the resident's room, donned gloves. Staff C emptied the resident's Foley catheter bag into a graduated cylinder and emptied the urine in the toilet. The staff failed to donn a gown during the provision of cares. (continued on next page)

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.

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	4. According to the Minimum Data Set, dated dated dated [DATE], Resident #4 had diagnoses which included stroke, diabetes mellitus and obstructive uropathy. The resident required limited assistance of 1 staff for transfers and ADL (activities of daily living). The resident had a Brief Interview for Mental Status score of 13 which indicated he was alert and oriented. The resident had a supra pubic indwelling urinary catheter. Review of the Care Plan dated 10/30/2024 informed the staff the resident requires EBP related to the presence of an indwelling catheter and stated the precautions will be in place until the catheter has been removed. The Care Plan directed staff EBP will be instituted during the completion of high contact activities and the staff will adhere to the use of enhanced barrier precautions once instituted and protection will be available for facility staff in resident care areas. During an observation on 3/3/25 from 9:00 A.M.-4:00 P.M., the interior and exterior Resident #4's room failed to have signage to alert the staff of the need to utilize EBP failed to have personal protective device equipment readily available for the staff's use upon providing cares as per the policy. During an observation on 3/3/25 at 2:00 P.M., Staff G, CNA entered the resident's room with a facial mask and pair of gloves but failed to donn a gown as per policy. Staff G stood the resident, removed his pants and transferred him to his bed in preparation of wound treatment. During an observation on 3/3/25 at 2:26 P.M., Staff E, CNA entered the residents room. Staff E put on a pair of gloves but failed to donn a gown as per policy. She emptied the resident's supra pubic urine collection bag, discarded the urine into the toilet and removed her gloves. During an interview on 3/4/25 at 11:06 A.M., Staff E, CNA stated she didn't know they had any guidelines/rules they needed to wear gowns when you empty a resident's catheter bag. When asked when she should wear a gown and gloves she stated when the resident has an infection like COVID or C-diff (bacterial infection of digestive tract) but stated she was never told or educated on anything called Enhanced Barrier Precautions. During an interview on 3/4/25 at 9:00 A.M., Staff F, Administrator she stated that approximately 1 month ago she lost her Director of Nurses and Assistant Director of Nurses. She stated the Assistant Director of Nurses did the Infection Control for the facility and stated there wasn't any staff to follow up to assure Enhanced Barrier Precautions were being done. She stated she has begun education regarding EBP with her staff last evening (3/3/25). During an observation on 3/4/25, on the outside of Residents #2, 3, 4 and #5 rooms revealed Enhanced Barrier Precautions from the CDC (Center for Disease Control and Prevention) signs which included: Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high contact activities: Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheotomy. Wound Care: any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy for Enhanced Barrier Precautions dated 3/5/24 informed staff EBPs are utilized to prevent the spread of multi-drug resistant organisms to residents. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of a gown and gloves include: a. Dressing b. Bathing/showering c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Indwelling catheter cares h. Wound cares EBP use is indicated for resident's with chronic wounds or indwelling medical devices. The precautions will be in place for the duration of the resident's stay or until resolution of the wound or the discontinuation of the indwelling device. Signs are posted indicating the resident requires EBP and PPE is available.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 19126 Based on clinical record review, staff and resident interviews and observations the facility failed to employ an Infection Prevention Specialist. The facility reported a census of 45. Findings include: Observation of a facility provided list of all staff on 3/3/25 at approximately 10:00 am failed to include an Infection Prevention Specialist or and Infection Control Nurse. During an interview with Staff F-Administrator on 3/4/25 at 9:00 am, she stated that approximately 1 month ago she lost her Director of Nurses and Assistant Director of Nurses. She stated the Assistant Director of Nurses did the infection control for the facility and she did not have anyone to fulfill this role as she left. Staff F stated she has not been able to find an appropriate replacement for the Infection Control Nurse until yesterday.