

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2026
NAME OF PROVIDER OR SUPPLIER  Lenox Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  111 East Van Buren Lenox, IA 50851	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, staff interview and policy review the facility failed to utilize enhanced barrier precautions (EBP's) and failed to ensure staff followed infection control practices to protect against cross contamination and potential spread of infection for 2 of 4 residents sampled on EBP's (Resident #1 and #22). The facility staff also failed to use a barrier and utilize appropriate wound care techniques, and failed to handle soiled linens to prevent the potential spread of infection for 1 of 3 residents observed for wound care (Resident #22). The facility also failed to develop a comprehensive water management program and identify areas or devices in the building to reduce the risk and prevent the growth of Legionella or other waterborne pathogens. The facility reported a census of 25 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had diagnoses of heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). The MDS documented the resident had a Brief Interview for Mental Status of 14 out of 15 indicating cognition intact. The MDS indicated the resident required partial to moderate assistance for bed mobility, and dependent for transfers and toileting hygiene. The MDS indicated the resident had an indwelling catheter.</p> <p>The Care Plan initiated 1/19/26 revealed the resident required EBP's related to the presence of an indwelling catheter. The Care Plan directed staff to use EBP's during the completion of high contact activities, and ensure hand hygiene completed prior to and after cares. The Care Plan also directed staff to assist with toileting and provide peri-care as needed, and use a mechanical lift and two staff for transfers.</p> <p>Observations revealed the following: a. On 3/21/26 at 2:20 PM, an EBP sign was posted on the door to the resident's room. The resident sat in a wheelchair and had a catheter in a dignity bag. b. On 3/21/26 at 2:28 PM, Staff A, certified nursing assistant (CNA), and Staff B, CNA, were in Resident #1's room. Staff A and Staff B had gloves on and attached a sling under the resident to the mechanical lift, then placed the resident's urinary catheter by his waist and transferred the resident from the wheelchair to the bed. Staff A placed the resident's catheter on the lower bedframe, then removed the resident's pants and brief and placed a bedpan under the resident. Staff removed their gloves and washed their hands and left the room. At 2:44 PM, Staff A and Staff B re-entered the resident's room. Staff A and Staff B donned a pair of gloves. Staff B performed pericare for Resident #1, then took additional wipes and cleansed around the catheter site. Staff assisted the resident to roll onto his right side and removed the bed pan under him. Staff B took disposable wipes and cleansed the buttocks area. Two foam dressings were observed to the bilateral upper buttocks. Staff B removed the gloves on her hands. Staff A placed a clean brief under the resident, rolled the resident onto his back and attached the brief tabs. Staff A removed her gloves. Staff A and Staff B did not wear a gown during high contact care activities such as when the resident was transferred, catheter was handled and when cares were provided for Resident #1. (continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's Enhanced Barrier Precautions (EBP) Policy date 3/25/24 revealed EBP's are utilized to reduce and prevent the spread of multi-drug resistant organisms (MDROs) to residents. EBP's are indicated for residents with chronic wounds and/or indwelling medical devices. Gloves and gown are applied before performing high-contact resident care activities. High-contact resident care activities requiring the use of a gown and gloves include for transfers, changing briefs or assisting with toileting, and catheter care or use.</p> <p>2. The annual MDS assessment dated [DATE] revealed Resident #22 had diagnoses of diabetes, peripheral venous insufficiency (veins valves are damaged and cause blood to pool in leg), and lymphedema (swelling caused by buildup of lymph fluid between the skin and muscle).</p> <p>The Care Plan revised 6/24/25 revealed the resident had diabetic ulcers on the toes of his left foot. The Care Plan directed staff to administer treatments as ordered and per facility protocol.</p> <p>The Treatment Administration Record (TAR) for March 2026 revealed an order to cleanse the left toes/foot with Vashe solution, apply betadine to the wounds, cover wounds with absorbent gauze, then secure with a dry gauze daily. The TAR revealed Staff H documented treatment completed on 3/23/26.</p> <p>During observation on 3/23/26 at 9:55 AM, an EBP's hung on the door to Resident #22's room. Staff H, Registered Nurse (RN) placed a bottle of Vashe wound cleanser solution and interdry dressing on top of the dressing supply cart. Staff H pushed the cart down the hall, donned a mask, gown and gloves and then pushed the cart into Resident #5's room. Staff H opened two small bottles of saline, then opened the drawer to the cart to obtain a pile of gauze. Staff H closed the drawer to the cart, then proceeded to pour saline onto a gauze. Staff H took the saline soaked gauze and cleansed under the resident's abdominal folds. Staff H took another gauze and cleansed the groin. Staff H changed her gloves, placed a pad and towel on the floor, then removed the resident's sock and soiled dressings (with green and brownish drainage) from the left foot and between the toes. The toes were swollen and had a grayish appearance to the wound between the big and second toe as well as slough by the base of the toes. Staff H changed gloves, poured Vashe wound cleanser onto the gauze and cleansed the toes on the left foot, scrubbing the skin with the gauze. Staff H took a betadine swab and painted the area between the toes. Staff H changed her gloves, then opened the drawer on the cart, took out gauze and kerlix, closed the drawer on the cart then proceeded to place gauze between the toes and over the top of the toes. Staff H took a kerlix roll and wrapped the dressing over the area. Staff H opened the drawer on the cart again, took out a roll of tape, tore off a piece of tape and stuck the tape on top of the cart. Staff H opened the drawers on the cart, then moved the isolation gown and reached into her uniform pocket to get a pen. Staff H wrote the date on the piece of tape that was stuck to the top of the cart, then placed the tape over the dressing on the resident's foot. Staff H applied the resident's sock, she took a box of gloves on top of the cart and placed the box of gloves in a rack on the side of the cart. Staff H picked up the soiled pad and towel from the floor and placed it on the top of the cart, then removed her gown and placed the gown in the trash receptacle on the side of the supply cart. Staff H put supplies she left on top of the cart into the drawers, then pushed the same cart to room [ROOM NUMBER]. Staff H then donned a pair of gloves, picked up the soiled pad/towel on the cart and took them down the hall. The ADON stood in the room with the surveyor during the observation of Staff H.</p> <p>In an interview on 2/23/26 at 10:30 AM, the ADON reported EBP's are used to prevent the spread of germs and to make sure residents and staff were protected. The ADON confirmed the dressing supply cart should not have been taken into the room when a resident was on EBP's. The ADON also (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>confirmed Staff H touched drawers and items in the cart with contaminated gloves. She expected staff to change gloves and sanitize hands when soiled or whenever went from a dirty to a clean area. A Wound Care policy revised 10/2010 revealed wound care completed to promote healing. Place all items to be used during the procedure on a disposable cloth or paper towel as a barrier. Use one gauze and wash the tissue around the wound. Disposable items should be discarded into a designated container. Disposable supplies cannot be returned to the cart.</p> <p>An Infection Prevention and Control Policy dated 1/1/26 revealed all staff are responsible for following all policies and procedures related to infection control. Equipment shall be cleaned and disinfected according to the facility's policy. Soiled linen shall be collected at the bedside and placed into a linen bag, and placed in a soiled utility room.</p> <p>A Handwashing / Hand Hygiene policy revised 8/2019 revealed 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 the spread of infections.</p> <p>3. On 3/23/2026 at 12:00 PM, the Maintenance Director stated he didn't know where the water flow diagram was and didn't know who was responsible for performing Legionella preventative procedures. He also stated he was not sure which part of the building the two (2) water heaters supplied.</p> <p>At 12:20 PM, a facility blueprint review did not identify the service area for each water supply line that entered the facility nor did it provide the location of high-risk stagnant water areas.</p> <p>At 12:30 PM, Staff E, Housekeeping supervisor stated staff flushes the sinks and toilets in the rooms during deep cleaning tasks. She stated it was not on the checklist.</p> <p>An undated facility document titled Deep Clean Checklist did not include toilet or sink flushing.</p> <p>At 12:40 PM, the Administrator stated the whirlpool next to the Director of Nursing's (DON) office was temporarily nonfunctioning and, to her knowledge, it was the last water supplied device in the hall water supply sequence.</p> <p>At 12:44 PM, the Administrator contacted the previous Maintenance Director who confirmed the water heaters' supply destinations. The Administrator confirmed the facility was licensed to house more resident's than their current census.</p> <p>A facility document titled Annual Legionella Environmental Assessment Form dated 1/21/26 revealed the facility had a whirlpool with no filter change or filter backwash documentation. It also revealed the facility had a fish aquarium with water at 77 degrees Fahrenheit ( degrees F) but no maintenance protocol and was last cleaned on 1/15/26.</p> <p>A policy titled Water Management Policy dated 10/2022 indicated the facility will complete an assessment of the water system annually. It also indicated the assessment data will identify where Legionella and other opportunistic waterborne pathogens could grow and spread. It further indicated the assessment will include interventions performed by the facility if risks were identified to prevent the growth of opportunistic waterborne pathogens as well as how the facility will monitor them.</p> <p>On 3/23/26 at 4:11 PM, the Administrator stated the facility could've done better at implementing the water management plan.</p>		