STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165330	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Specialty Care	1011 North Roosevelt Cherokee, IA 51012

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to immediately notify the physician and resident representative of a fall with an injury for 1 of 5 residents reviewed (Resident #32). The facility reported a census of 53 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #32 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had diagnoses including diabetes and hypoglycemia. The Care Plan identified the resident had an actual fall related to unsteady gait initiated 10/16/2023. The Progress Notes documented the following: a. On 4/11/24 at 10:21 p.m. documented the resident received Hydrocodone (narcotic)-Acetaminophen 5-325 mg for pain in the right leg. b. On 4/12/24 at 10:06 a.m. the resident received Acetaminophen 325 mg for pain in her right ankle. She rated her pain a 6/10. c. On 4/12/24 at 5:16 p.m. the resident received Acetaminophen 325 mg for complaints of pain in her right ankle. The resident rated her pain a 6/10. d. On 4/12/24 at 5:31 p.m. the resident was on focused charting following an unwitnessed fall on 4/9. The resident denied injuries related to that fall but complained of a sore ankle related to a fall that occurred when out with family on 4/11. Acetaminophen administered and effective. Would continue to monitor and update as needed. Plan of care ongoing. e. On 4/12/24 at 6:28 p.m. the administration of Acetaminophen was ineffective, the follow up pain was 8 (of 10). f. On 4/12/24 at 9:50 p.m. the resident received Hydrocodone-Acetaminophen per request for pain in her right leg and ankle. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. On 4/13/24 at 3:25 a.m. the resident remained on focused charting related to an unwitnessed fall in the dining room. No injuries. Range of motion (ROM) intact, neuros intact. No concerns at that time. h. On 4/13/24 at 4:16 p.m. the resident received Hydrocodone-Acetaminophen per resident request for pain rated 6 out of 10 in ankle. No signs of distress. Plan of care on going. i. On 4/14/24 at 6:43 a.m. the resident received Hydrocodone-Acetaminophen per resident request for pain in right ankle due to previous fall. The ankle appeared swollen with minimal bruising. No signs of distress. Plan of care on going. On 4/14/24 at 2:10 p.m. Communication with the Physician documented while giving medication to the resident in the a.m. the nurse noticed increased swelling with bruising noted to the outer right foot. The resident stated the injury occurred due to fall in the dining room. The resident complained of pain upon movement of the foot, and stated she could walk on it but it was painful. As needed Hydrocodone and an ice pack given for pain. At 4:09 p.m. the resident received Hydrocodone-Acetaminophen per resident request for pain in the right ankle rated 6 out of 10. No signs of distress. The ankle appeared swollen, and ice pack applied. At 4:57 p.m. clarification to the physician the resident stated she fell while on a home visit Thursday 4/11. The Progress Notes on 4/15/24 documented the resident seen for fall when out with family and she stepped in a hole in the ground and fell . She didn't tell anyone at the facility she fell initially but over the weekend her foot was noted to be swollen and bruised. She had been ambulating to go outside to smoke but had a lot of pain to her foot and her ankle was quite swollen and bruised. The provider would send the resident for x-ray of her foot to rule out fracture. The resident was taking Hydrocodone for pain which she said helped a little bit. The resident rested in bed on exam. The x-ray showed acute spiral fracture of the distal fibula. Ordered to send the resident to the emergency room (ER) for evaluation. They placed the resident's foot in a splint and she would be following with orthopedic surgery. The resident was ordered to be strict non weight bearing and keep the foot elevated. The Progress Notes dated 4/15/24 at 7:38 p.m. documented the responsible party phoned. Despite the resident telling staff on 4/12/24 about the fall while out with family, the facility failed to notify the physician until 4/14/24, or the resident representative until 4/15/24. On 7/17/24 at 8:30 a.m. the Assistant Director of Nursing (ADON) stated Staff D wasn't aware she needed to do an incident report for an incident that occurred somewhere else. They had her fill out a report 4/15/24 and date it 4/12/24. Staff were giving the resident pain medication and notified the provider the 14th. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Change in a Resident's Condition or Status revised February 2021, documented the facility promptly notified the resident, his/her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse would notify the resident's attending physician or physician on call the resident, when there has been an accident or incident. Unless otherwise instructed by the resident, a nurse would notify the resident's representative when the resident was involved in any accident or incident that results in any injury including injuries of an unknown source. Except in medical emergencies, notifications would be made within 24 hours.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to review and revise the comprehensive care plan for 1 of 18 residents reviewed (Resident #38). The facility reported a census of 53 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #38 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had frequent incontinence of bladder, and a urinary toileting program had not been attempted. The resident had diagnoses including a stroke, a seizure disorder, and chronic obsrtuctive pulmonary disease (COPD). The MDS history of the resident's urinary incontinence showed she had been frequently incontinent since 2/13/23, and no urinary toileting program had been attempted while in the facility. The Care Plan revised 6/3/22 identified the resident had occasional bladder incontinence. The interventions included assisting the resident to the bathroom or commode as needed, and assisting with perineal cleansing as needed. On 7/17/24 at 8:33 a.m. the Assistant Director of Nursing (ADON) stated the resident had been incontinent frequently on the (MDS) look back time frames. She said the care plan should show she was incontinent, not the occasional (incontinence).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for a resident with a change of condition for 1 of 5 residents reviewed (Resident #32). The facility reported a census of 53 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #32 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had diagnoses including diabetes and hypoglycemia. The Care Plan identified the resident had an actual fall related to unsteady gait initiated 10/16/2023. The Progress Notes documented the following: a. On 4/11/24 at 10:21 p.m. the resident received Hydrocodone (narcotic)-Acetaminophen 5-325 mg for pain in the right leg. b. On 4/12/24 at 10:06 a.m. the resident received Acetaminophen 325 mg 2 tablets for pain in her right ankle. She rated her pain a 6/10. c. On 4/12/24 at 5:16 p.m. the resident received Acetaminophen 325 mg for complaints of pain in her right ankle. The resident rated her pain a 6/10. d. On 4/12/24 at 5:31 p.m. the resident was on focused charting following an unwitnessed fall on 4/9. The resident denied injuries related to that fall but complained of a sore ankle related to a fall that occurred when out with family on 4/11. Acetaminophen administered and effective. Would continue to monitor and update as needed. Plan of care ongoing. e. On 4/12/24 at 6:28 p.m. the administration of Acetaminophen was ineffective, the follow up pain was 8 (of 10). f. On 4/12/24 at 9:50 p.m. the resident received Hydrocodone-Acetaminophen per request for pain in her right leg and ankle. g. On 4/13/24 at 3:25 a.m. the resident remained on focused charting related to an unwitnessed fall in the dining room. No injuries. Range of motion (ROM) intact, neuros intact. No concerns at that time. h. On 4/13/24 at 4:16 p.m. the resident received Hydrocodone-Acetaminophen per resident request for pain rated 6 out of 10 in her ankle. No signs of distress. Plan of care on going. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. On 4/14/24 at 6:43 a.m. the resident received Hydrocodone-Acetaminophen per resident request for pain in her right ankle due to a previous fall. The ankle appeared swollen with minimal bruising. No signs of distress. Plan of care on going. On 4/14/24 at 2:10 p.m. Communication with the Physician documented while giving medication to the resident in the a.m. the nurse noticed increased swelling with bruising noted to the outer right foot. The resident stated the injury occurred due to a fall in the dining room. The resident complained of pain upon movement of the foot, and stated she could walk on it but it was painful. As needed Hydrocodone and an ice pack given for pain. At 4:09 p.m. the resident received Hydrocodone-Acetaminophen per resident request for pain in the right ankle rated 6 out of 10. No signs of distress. The ankle appeared swollen, and ice pack applied. At 4:57 p.m. clarification to the physician the resident stated she fell while on a home visit Thursday 4/11. The Progress Notes on 4/15/24 documented the resident seen for a fall when out with family and she stepped in a hole in the ground and fell . She didn't tell anyone at the facility she fell initially but over the weekend her foot was noted to be swollen and bruised. She had been ambulating to go outside to smoke but had a lot of pain to her foot and her ankle was quite swollen and bruised. The provider would send the resident for x-ray of her foot to rule out fracture. The resident was taking Hydrocodone for pain which she said helped a little bit. The resident rested in bed on exam. The x-ray showed acute spiral fracture of the distal fibula. Ordered to send the resident to the emergency room (ER) for evaluation. They placed the resident's foot in a splint and she would be following with orthopedic surgery. The resident was ordered to be strict non weight bearing and to keep the foot elevated. The Progress Notes dated 4/15/24 at 7:38 p.m. documented the results of the x-ray showed an acute spiral fracture of the distal fibula. The resident sent to ER for splinting. The responsible party phoned. Despite the resident telling staff on 4/12/24 about the fall while out with family, and the resident complaining of pain to her ankle the facility failed to adequately assess the ankle and notify the provider for treatment until 4/14/24. The Care Plan added a fall at a family member's house on 4/11/24 due to unsteady grounds outside. Interventions included on 4/15/24 an x-ray and Ice pack for swelling, as needed pain medications, non weight bearing (NWB) to right foot. On 4/16/24 may bear weight with boot starting 5/29/24. Major injury form signed stating resident should make a full recovery after treatment. On 7/16/24 at 1:49 p.m. Staff D Registered Nurse (RN) stated she kind of remembered it. The resident had fallen while out with family and ended up with a fracture. The resident didn't tell them she fell for awhile. Staff D said she didn't know you needed an incident report if the incident happened somewhere else. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 8:30 a.m. the Assistant Director of Nursing (ADON) stated Staff D wasn't aware she needed to do an incident report for an incident that occurred somewhere else. They had her fill out a report 4/15/24 and date it 4/12/24 (the day the resident told staff about the incident). Staff were giving the resident pain medication and notified the provider the 14th (of the incident). They had been doing fall follow ups from a fall that occurred 4/9/24. The facility policy, Change in a Resident's Condition or Status revised February 2021, documented the facility promptly notified the resident, his/her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse would notify the resident's attending physician or physician on call when there had been an accident or incident involving the resident. Prior to notifying the physician or health care provider, the nurse would make detailed observations and gather relevant and pertinent information for the provider. Except in medical emergencies, notifications would be made within 24 hours.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review and staff interview, the facility failed to assure a resident who was incontinent of bladder received appropriate treatment and services to restore continence to the extent possible for 1 resident reviewed (Resident #38). The facility reported a census of 53 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #38 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had frequent incontinence of bladder, and a urinary toileting program had not been attempted. The resident had diagnoses including a stroke, a seizure disorder, and chronic obsrtuctive pulmonary disease (COPD). The MDS history of the resident's urinary incontinence showed she was occasionally incontinent of bladder on the admission MDS and she had been consistently, frequently incontinent since 2/13/23, and the MDS history of a toileting program documented no urinary toileting program had been attempted while in the facility. The Care Plan revised 6/3/22 identified the resident had occasional bladder incontinence. The interventions included assisting the resident to the bathroom or commode as needed, and assisting with perineal cleansing as needed. On 7/15/24 at 11:34 a.m. the resident stated she had a problem with incontinence. On 7/16/24 at 9:45 a.m. the resident was in the hall with staff. The resident was trying to say something, but the words were not making sense. After listening for a short time, staff asked the resident if she needed the bathroom and she said that too. Staff told her they would assist her. On 7/17/24 at 8:33 a.m. the Assistant Director of Nursing (ADON) stated the resident had been incontinent frequently on the look back time frames. She said the care plan should show she was incontinent, not the occasional (incontinence). She also said they had not tried her on a toileting plan. On 7/17/24 at 9:37 a.m. Staff E Certified Nursing Assistant (CNA) took the resident to the bathroom. She removed her wet incontinent pad. Staff E stated the resident sometimes took herself to the bathroom, but she needed 1 assist. She had difficulty verbally expressing her needs that day. The facility policy Urinary Continence and Incontinence - Assessment and Management revised September 2010 documented the staff and practitioner when appropriate, would screen for, and manage, individuals with urinary incontinence. Management of incontinence would follow relevant clinical guidelines. The physician when appropriate, and staff would provide appropriate services and treatment to help residents restore or improve bladder function. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If the individual remained incontinent despite treating transient causes of incontinence, the staff would initiate a toileting plan.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on observation, resident interview, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 4 of 15 residents reviewed (Residents #1, #5, #35, and #39). The facility reported a census of 53 residents. Findings include: 1. Review of Resident #1's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. In an interview on 7/15/24 at 11:37 AM Resident #1 revealed the food is cold when it should be hot. Resident #1 further revealed that room trays are not delivered until everyone in the dining room has been fed. 2. Review of Resident #5's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. In an interview on 7/15/24 at 1:48 PM Resident #5 revealed foods are often cold when they should be hot. 3. Review of Resident #35's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. In an interview on 7/15/24 at 11:56 AM Resident #35 revealed he has been here for four years and the food has been bad the entire time. Resident #35 further revealed the food is often cold when it should be hot. 4. Review of Resident #39's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. In an interview on 7/15/24 at 1:09 PM Resident #39 revealed the food is often burnt and then served cold. Continuous observation on 7/16/24 from 11:45 AM until 12:48 PM dining service was completed in the dining room. Post meal temperature was obtained on the food items in the steam table before room trays were sent to Residents. Post temperatures revealed Chicken and dumplings were 156 degrees, green beans were 146 degrees, chicken tenders were 138.6 degrees, cheese sauce was 123 degrees, and mashed potatoes were 118 degrees. During observations on 7/16/24 at 12:47 PM the first room tray was placed onto the meal cart for room service and was sent out to be delivered to Resident rooms after the meal tray was filled with trays. A sample room tray was obtained, and a temp check at 1:09 PM was completed revealing chicken and dumplings to be 113.9 degrees, and green beans were 86.4 degrees. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/16/24 at 12:57 PM with Staff C Dietary Service Manager revealed her expectations would be for food temperatures to be at the appropriate temps when served. In an interview on 7/16/24 at 1:12 PM with the Administrator revealed that her expectation would be for food served to be at appropriate temperatures. Review of a facility provided policy titled, Food Preparation and Service, with a revision date of April 2019 documented: a. Food service/distribution - Proper hot and cold temperatures are maintained during food service.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48004 Based on observation, staff interview, and policy review the facility failed to prepare, serve and distribute food in accordance with professional standards. The facility reported a census of 47 residents. Findings include: During continuous observation on 7/16/24 from 12:15 PM to 12:45 PM Staff B dietary cook was observed wearing no gloves or hand hygiene completed when Staff B opened the freezer and obtained a box of frozen hamburger patties. Staff B then opened the box after cooking with a spatula and used the same hand to obtain a frozen hamburger patty. Staff B was observed to do this three times with no hand hygiene being completed. Staff B then proceeded to touch multiple items (lids for bowls, cabinet handles, spatulas, freezer door handles) in the kitchen with no hand hygiene being completed. In an interview on 7/16/24 at 12:57 PM with Staff C Dietary Service Manager revealed her expectations were for staff to wash hands at appropriate times while in the kitchen. In an interview on 7/16/24 at 1:12 PM with the Administrator revealed that her expectation would be staff complete hand hygiene at appropriate times while in the kitchen preparing foods. Review of a facility provided policy titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, dated October 2017 documented: a. Employees must wash their hands before coming in contact with any food surfaces, after handling raw meat, and after handling soiled equipment or utensils.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44420 Based on record review, interview, and facility policy the facility failed to have the Infection Preventionist at quarterly meetings for their quarterly Quality Assessment and Assurance (QAA) meetings. The facility reported a census of 53 residents. Findings include: The following Quality Assurance Committee Meeting Sign-In showed the Director of Nursing (DON) as the Infection Preventionist that attended the quarterly meetings for the following dates: a. 12/15/23 b. 3/8/24 c. 5/31/24 The Quality Assurance and Performance Improvement (QAPI) Program policy dated March 2020 identified the Infection Preventionist served on the committee. In an interview on 7/18/24 at 8:40 AM, Staff D, Registered Nurse (RN) reported she obtained certification as an infection preventionist. When asked if she attended QAPI meetings, Staff D replied, no. In an interview on 7/18/24 at 8:58 PM, the DON reported she completed the infection preventionist course but failed to realize the infection preventionist certification required succession completion of the infection preventionist certification test.

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(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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on observation, clinical record review, resident interview, staff interview, and policy review the facility failed to use universal infection control measures and Enhanced Barrier Precautions (EBP) during PICC line (peripherally inserted central catheter) cares and medication administration for 1 of 3 residents reviewed for infection control (Resident #205). The facility reported a census of 53 residents. Findings include: Review of Resident #205's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status score of 15 indicating intact cognition. The MDS further revealed diagnosis of cancer, heart failure, urinary tract infection, and MRSA (methicillin-resistant Staphylococcus aureus). Review of Resident #205's Electronic Health Record (EHR) profile page revealed that Resident #205 was on EBP. In an interview on 7/15/24 at 12:13 PM Resident #205 revealed she is receiving antibiotic treatment via PICC line for treatment of a UTI and that she had (MRSA). Observation on 7/17/24 at 7:43 AM Staff A Licensed Practical Nurse (LPN) charge nurse completed hand hygiene and donned gloves. Staff A then cleansed the port of the PICC line with alcohol and flushed the line with saline. Staff A then attached the ordered antibiotic to the PICC line. Staff A then doffed her gloves and completed hand hygiene. During the procedure Staff A failed to wear a gown as required per Enhanced Barrier Precautions (EBP). In an interview on 7/17/24 at 7:48 AM Staff A revealed that she should have worn a gown since the resident is on enhanced barrier precautions. In an interview on 7/17/24 at 7:55 AM with the Director of Nursing (DON) revealed that she expects staff to wear gloves, gowns, and proper PPE for residents on enhanced barrier precautions. Review of the facility provided policy titled, Enhanced Barrier Precautions, dated 3/28/24 documented: a. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. b. High-contact resident care activities include: device care or use (central lines, urinary catheters, feeding tubes) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165330	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Specialty Care	1011 North Roosevelt Cherokee, IA 51012

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 - Few	Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 7/17/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.