

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Concord Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 490 West Lyons Street Garner, IA 50438	

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056</p> <p>Based on clinical record review and staff interviews the facility failed to complete a follow-up PASRR and resubmit to ASCEND for reevaluation according to the Preadmission Screening and Resident Review (PASRR) for 1 out of 1 resident reviewed, (Resident #11). The facility reported a census of 36 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #11 documented diagnoses of anxiety disorder, depression, bipolar disorder and schizophrenia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.</p> <p>Review of the medical record revealed Resident #11 was admitted to the facility on [DATE].</p> <p>Review of Resident #11's clinical record revealed that a Level 1 PASRR was completed on [DATE] with an approval period for 60 days that expired on [DATE].</p> <p>Review of Resident #11's clinical record revealed that a Level 1 PASRR was completed on [DATE] with a Level 1 Outcome to refer for Level II onsite.</p> <p>Review of PASRR dated [DATE] revealed that the Level 1 screen was submitted on [DATE] over 4 months after the prior PASRR expired thus causing a compliance issue for the nursing facility.</p> <p>Review of Resident #11's clinical record revealed that a Level II PASRR was completed on [DATE] with a determination of short term approval ending [DATE].</p> <p>Review of Resident #11's clinical record revealed that a Level 1 PASRR was completed on [DATE], after the ending date of [DATE].</p> <p>Review of the Maximus PASRR and Level of Care Screening Procedures for Long Term Care Services revised on [DATE] revealed the purpose of the Level I screen is to identify individuals intended for evaluation through the PASRR Level II process, those individuals with known or suspected mental illness (MI) and intellectual disability (ID) or related condition (RC). The purpose of the Level I screen is to identify individuals intended for evaluation through the PASRR Level II process - those individuals with known or suspected MI and ID/RC. Effective [DATE], the Level I screen must be electronically submitted to Maximus;</p> <p>(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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Before admission to a Medicaid-certified nursing facility (regardless of the applicant ' s method of payment)</p> <p>For residents of Medicaid certified nursing facility (NF) ' s experiencing changes in status that suggests the need for a first-time or updated PASRR LevelIII evaluation as described in Section I.f of this document;</p> <p>Prior to the conclusion of an assigned time-limited stay for individuals with MI and/or ID/RC whose stay is expected to exceed a time-limited approval.</p> <p>Interview on [DATE] at 10:12 AM, with the Administrator revealed that the PASRR ' s were late when being resubmitted because she has been doing the Administrator position and Social Worker position since [DATE] until about 3 weeks ago.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056</p> <p>Based on clinical record reviews, staff interviews and policy review, the facility failed to put effective interventions in place, and provide levels of assistance as directed by the Care Plan for Resident for 1 of 3 residents reviewed, (Resident #21). The facility reported a census of 36 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident # 21 documented diagnoses of Alzheimer ' s Disease, depression, heart failure (inability for the heart to pump), and hypertension (high blood pressure). The MDS showed the Brief Interview for Mental Status (BIMS) score a 4 indicating severe cognitive impairment. The MDS listed Resident #21 as partial or moderate assistance for transfers, ambulation and toilet transfers.</p> <p>The Facility Incident Reports (IR) documented from November 2023 - October 2024 revealed Resident #21 fell on [DATE], 1/17/24, 1/30/24, 7/2/24, 8/2/24, and 10/15/24.</p> <p>The Care Plan with a target date of 11/11/24 revealed Resident #21 is at risk for falls related to gait, balance problems and dizziness. The interventions directed the following:</p> <p>Attach call sensitive call light to resident ' s blanket so that staff can be alerted when the resident attempts to self transfer.</p> <p>Do not leave me in the dining room unattended.</p> <p>Ensure that I am wearing appropriate footwear when I am ambulating, transferring, or mobilizing in a wheelchair.</p> <p>Frequent visual checks for her safety.</p> <p>I am on a diuretic in the AM which puts me at risk for falls.</p> <p>I am to wear slip-on shoes so I am not at risk tying lace shoes.</p> <p>I am unable to use my call light/pendant. Please anticipate and meet all my needs.</p> <p>I have an easy touch call light. Ensure my touch paddle call light is on top of my bed when I am in bed so if I choose to get up on my own, it will alert staff to come help me.</p> <p>I have been screened by occupational therapy (OT) and they have deemed it unsafe for me to have a lift chair. My lift chair in my room has been unplugged for my safety d/t my dementia, I cannot run my lift chair on my own.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>I often choose to self-transfer and not wait for staff to help me. I have a sign on my walker reminding me to take my walker with me wherever I go due to my memory. I forget to take my walker with me at times, this sign reminds me not to forget. Educate</p> <p>me on the need to use a walker for ambulation if I am not using it. I also have a sign on my wall and in my bathroom reminding me to keep my walker with me.</p> <p>I will sit at the nurse station when it is close to meal times.</p> <p>Review information on my past falls and attempt to determine the cause of falls. Record possible root causes. Alter or remove any potential causes if possible. Educate me, my family, caregivers, and the interdisciplinary team as to potential causes.</p> <p>Staff are to assist me with making my bed when assisting me with AM cares.</p> <p>The Progress Notes dated 8/2/24 at 9:52 PM revealed Resident #21 had an unwitnessed fall in the dining room and received a superficial laceration to the left side of her head with a hematoma above it. Resident #21 also received a skin tear to the left elbow. The Progress Notes revealed they will discuss further interventions with the care team at a later date.</p> <p>The Progress Notes dated 10/15/24 revealed Resident #21 was found on the floor beside the wheelchair by staff walking into the dining room. Upon approaching Resident #21 revealed she was attempting to get up to go to the bathroom. The intervention for the fall was staff education provided on current fall interventions related to Resident #21 in the dining room.</p> <p>Review of the facility Care Plan History revealed the intervention of do not leave me in the dining room unattended was put into place as of 6/30/23.</p> <p>The facility policy named Fall Risk Assessment and Intervention with a revision date of 6/25/12 revealed residents will be assessed upon admission, re-admission, and change in condition for potential risk factors associated with falls. Initial interventions specific to the resident will be implemented at the time of the assessment.</p> <p>The assigned nurse will complete the tool on new admission, readmissions, and residents experiencing a significant change in condition.</p> <p>Determine the risk factors placing the resident at risk for falls by highlighting or circling those factors.</p> <p>Determine what interventions could be used, specific to the resident, and highlight or circle the appropriate interventions and or write additional interventions.</p> <p>The nurse completing the fall assessment will be responsible to communicate interventions to appropriate staff.</p> <p>Risk factors and interventions identified on the fall assessment tool should be carried over and used to facilitate development of the resident ' s plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Elicit ideas to reduce the likelihood of falls from the resident family members, therapies, physician and interdisciplinary staff.</p> <p>Orthostatic blood pressure should be taken, if possible, following a fall to determine whether the fall could be related to dizziness associated with sudden drop in blood pressure with position changes.</p> <p>Should the resident experience a fall, an Incident Report and Quality Assurance Investigation form will be completed.</p> <p>Each fall will be assessed to try to determine the cause of the fall.</p> <p>The care plan must be reviewed with each occurrence and new or different approaches added relative to the assessed cause of the fall.</p> <p>Each addition to the care plan will be initialed by the person who added the new intervention followed by the date the new measure was initiated.</p> <p>Should a fall occur, the nurse will be responsible to assess the resident for injuries, notify the family and physician of the occurrence, and document results of findings in the Interdisciplinary notes of the residents medical record.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, resident interview, family interview, staff interviews, facility records and facility policy review the facility failed to provide sufficient staff to meet the needs of residents who resided in the facility for 3 of 3 residents reviewed (</p> <p>Resident #24, #22 and #3). The facility reported a census of 36 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #24 dated 9/20/24 assessment identified a Brief Interview for Mental Status (BIMS) score of 12, indicating intact cognition.</p> <p>The Clinical Census revealed Resident #24 resided in room [ROOM NUMBER]-1.</p> <p>On 10/21/24 at 11:38 AM, Resident #24 reported she has waited for her call light to be answered for up to 45 minutes. She stated it has happened on several occasions but could not remember what time of day. She reported she used her phone to time the call light response. She stated she almost had a bowel and bladder accident from waiting for the call light to be answered. She stated she has gotten good at holding her bladder/bowel.</p> <p>A facility call light report for 9/23/24 to 10/23/24 revealed Resident #23 had the following call lights over 15 minutes:</p> <p>9/24/24 at 7:03 PM= 27 minutes</p> <p>9/25/24 at 6:58 PM= 19 minutes</p> <p>9/26/24 at 4:34 PM= 21 minutes</p> <p>9/26/24 at 7:08 PM= 18 minutes</p> <p>9/27/24 at 6:33 AM = 19 minutes</p> <p>9/28/25 at 7:32 AM= 18 minutes</p> <p>9/28/24 at 9:04 PM= 21 minutes</p> <p>9/29/24 at 4:52 AM= 21 minutes</p> <p>9/29/24 at 1:02 PM = 25 minutes</p> <p>10/1/24 at 4:49 PM= 17 minutes</p> <p>10/2/24 at 8:34 AM= 20 minutes</p> <p>(continued on next page)</p>

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/2/24 at 12:56 PM =18 minutes 10/2/24 at 4:34 PM =33 minutes 10/2/24 at 8:32 PM= 17 minutes 10/3/24 at 12:08 AM= 17 minutes 10/3/24 at 4:43 AM= 17 minutes 10/3/24 at 6:51 AM= 18 minutes 10/3/24 at 2:00 PM= 19 minutes 10/3/24 at 7:22 PM= 34 minutes 10/5/24 at 6:52 AM= 32 minutes 10/7/24 at 8:52 AM= 18 minutes 10/9/24 at 10:40 AM= 20 minutes 10/11/24 at 6:34 AM= 19 minutes 10/12/24 at 6:56 PM= 29 minutes 10/13/24 at 7:10 AM= 45 minutes 10/13/24 at 3:26 PM= 21 minutes 10/14/24 at 3:05 AM= 26 minutes 10/14/24 at 6:52 AM= 20 minutes 10/14/24 at 10:14 AM= 20 minutes 10/15/24 at 6:25 PM= 22 minutes 10/16/24 at 7:29 PM=21 minutes 10/17/24 at 6:37 PM= 20 minutes 10/18/24 at 6:41 AM= 23 minutes 10/19/24 at 12:48 PM=21 minutes 10/19/24 at 6:32 PM= 20 minutes (continued on next page)

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10/21/24 at 9:42 PM= 17 minutes</p> <p>10/22/24 at 10:21 AM= 23 minutes</p> <p>10/23/24 at 7:12 AM= 42 minutes</p> <p>2. The MDS for Resident #22 dated 9/18/24 assessment identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition.</p> <p>The Clinical Census revealed Resident #22 resided in room [ROOM NUMBER]-2 Triple.</p> <p>On 10/21/24 at 3:01 PM, Resident #22 ' s Niece/POA reported she had a concern at the facility related to staffing and call light response times. She stated Resident #22 complained of long call lights (20 minutes) on the weekend. She stated the facility had provided call light reports to her in the past. She stated Resident #22 can get anxious and upset quickly regarding her call light. She reported Resident #22 ' s anxiety feeds on itself. Resident #22 ' s niece/POA requested that the surveyor look at a recent call light report while at the facility.</p> <p>A facility call light report for 9/23/24 to 10/23/24 for room [ROOM NUMBER] bed #2, #3 and #4 revealed Resident #22 had the following call lights over 15 minutes:</p> <p>9/23/24 at 7:23 AM= 22 minutes</p> <p>9/23/24 at 12:53 PM= 19 minutes</p> <p>9/23/24 at 7:28 PM= 20 minutes</p> <p>9/24/24 at 10:44 AM= 20 minutes</p> <p>9/24/24 at 6:29 PM= 21 minutes</p> <p>9/25/24 at 6:59 PM= 21 minutes</p> <p>9/26/24 at 8:25 AM= 19 minutes</p> <p>9/26/24 at 4:17 PM= 24 minutes</p> <p>9/26/24 at 5:33 PM= 19 minutes</p> <p>9/27/24 at 8:09 AM= 33 minutes</p> <p>9/27/24 at 6:56 PM =21 minutes</p> <p>9/28/24 at 8:15 AM= 21 minutes</p> <p>9/28/24 at 9:25 AM= 19 minutes</p> <p>9/28/24 at 7:07 PM= 24 minutes</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10/10/24 at 8:09 AM= 22 minutes</p> <p>10/10/24 at 6:57 PM= 21 minutes</p> <p>10/10/24 at 7:23 PM= 22 minutes</p> <p>10/12/24 at 8:08 PM= 19 minutes</p> <p>10/13/24 at 8:35 AM= 33 minutes</p> <p>10/14/24 at 8:27 AM= 23 minutes</p> <p>10/15/24 at 11:26 AM= 19 minutes</p> <p>10/15/24 at 6:35 PM= 20 minutes</p> <p>10/16/24 at 6:41 AM= 49 minutes</p> <p>10/17/24 at 12:37 PM= 23 minutes</p> <p>On 10/23/24 at 3:01 PM, the Administrator reported the facility had started a PIP (Process Improvement Plan) team in September related to an increase in call light times for various reasons.</p> <p>On 10/23/24 at 3:43 PM, the Administrator reported her expectation was for all call lights to be answered within 15 minutes or less. She stated that the goal of the PIP team was for call lights to be answered in under 15 minutes.</p> <p>On 10/24/24 at 8:30 AM, the Administrator acknowledged Resident #22 long call light times. She reported Resident #22 had anxiety and used her call light frequently. She reported Resident #22 was admitted to Hospice level of care this week. She reported the call light PIP team was working on getting back to consistent staff assignments and establishing resident routines to help decrease call light response time. The Administrator also reported there had been some malfunctions with the call light application and she had been working with IT to get the concerns addressed.</p> <p>On 10/24/24 at 9:15 AM, Staff A, LPN (Licensed Practical Nurse) reported call light response time can vary depending on the residents and staffing. She stated call lights can go over 15 minutes at times but usually it was because the staff member forgot to turn the light off.</p> <p>On 10/24/24 at 10:23 AM, Staff B, CNA (Certified Nursing Assistant) reported for the most part, she felt the facility was staffed appropriately. She stated there were times when the call lights would go over 15 minutes. She stated she felt the facility was trying to work on staffing and call light response times.</p> <p>On 10/24/24 at 10:26 AM, Staff C, CNA reported staffing and the ability to answer call lights depends on the day and what you walk in to. She reported there was a meeting recently and long call lights (over 15 minutes) were discussed. She stated the Administration told the staff they could ask for help with the call lights when needed. She reported she really has not gotten the help when she has asked for it. She verified call lights go over 15 minutes at times.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Call Light Policy revised 7/26/24 documented it was the policy of the facility to ensure that there was prompt response to the resident's call for assistance. The facility to ensure the call light system was in proper working order. The policy documented the facility shall answer call lights in a timely manner.</p> <p>49056</p> <p>3. Resident #3 's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. Resident #3 required partial/moderate assistance for transfers, personal hygiene. Resident #3 required substantial/maximal assistance for toilet use. The MDS included diagnoses of hypertension (high blood pressure), cancer, heart failure and renal insufficiency.</p> <p>During interview on 10/21/24 at 12:37 PM Resident #3 reported call light times are terrible. Resident #3 reported that sometimes the call light works well and sometimes the staff are not aware it is on. Resident #3 reported they forgot about her for 1/2 hour. Resident #3 reported that she watched the clock and had a terrible time. Resident #3 reported that she has been incontinent of bowel at times.</p> <p>Review of facility call light reports dated from 9/23/24 to 10/20/24 for Resident #3 revealed:</p> <p>a duration of 26 minutes on 9/23/24 at 5:05 PM</p> <p>a duration of 22 minutes on 9/24/24 at 11:31 AM</p> <p>a duration of 36 minutes on 9/25/24 at 9:09 AM</p> <p>a duration of 24 minutes on 9/25/24 at 11:12 AM</p> <p>a duration of 22 minutes on 9/27/24 at 12:36 PM</p> <p>a duration of 26 minutes on 9/27/24 at 9:41 PM</p> <p>a duration of 33 minutes on 9/28/24 at 1:13 PM</p> <p>a duration of 21 minutes on 9/29/24 at 10:59 AM</p> <p>a duration of 25 minutes on 9/30/24 at 7:54 AM</p> <p>a duration of 23 minutes on 9/30/24 at 8:57 PM</p> <p>a duration of 24 minutes on 10/1/24 at 7:37 AM</p> <p>a duration of 23 minutes on 10/1/24 at 6:41 PM</p> <p>a duration of 26 minutes on 10/3/24 at 1:35 PM</p> <p>a duration of 27 minutes on 10/7/24 at 4:54 PM</p> <p>(continued on next page)</p>		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a duration of 26 minutes on 10/9/24 at 11:13 AM a duration of 28 minutes on 10/10/24 at 11:39 AM a duration of 24 minutes on 10/11/24 at 9:16 PM a duration of 29 minutes on 10/14/24 at 1:15 PM a duration of 25 minutes on 10/15/24 at 12:19 PM a duration of 25 minutes on 10/17/24 at 11:14 PM a duration of 26 minutes on 10/18/24 at 2:10 PM a duration of 21 minutes on 10/19/24 at 6:56 AM a duration of 22 minutes on 10/19/24 at 11:00 AM.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Concord Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 490 West Lyons Street Garner, IA 50438	
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 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49056</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on record review, interview, and facility policy the facility failed to have the minimum number of required members for their quarterly Quality Assessment and Assurance (QAA) meetings. The facility reported a census of 36.</p> <p>Findings include:</p> <p>On 10/24/24 at 11:24 AM, review of the facility documents titled QAPI meeting revealed:</p> <p>Document dated 5/7/24 lacked the signature of the Infection Preventionist (IP).</p> <p>Document dated 6/2024 lacked the signature of the IP.</p> <p>Document dated 7/2024 lacked the signature of the IP.</p> <p>Document dated 9/10/24 lacked the signature of the IP.</p> <p>Document dated 10/8/24 lacked the signature of the IP.</p> <p>Review of the facility provided document titled Quality Assurance Performance Improvement (QAPI) Plan with an effective date of March 1, 2024 revealed the QA meetings are held at minimum on a quarterly basis; more frequently, if necessary with Medical Director, Director of Nursing, Administrator, Infection Preventionist and additional members including social services, therapy, housekeeping, laundry, maintenance, dietary manager and pharmacy consultant.</p> <p>During interview on 10/24/24 at 12:10 PM, the Administrator acknowledged and verified the IP was not at the QAPI meetings. The Administrator stated that the IP was probably working the floor during the QAPI meetings. The Administrator revealed that they went over the IP ' s information during the meetings.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents reviewed for pressure ulcers, (Resident #33). The facility reported a census of 36 residents.</p> <p>Findings include:</p> <p>Resident #33's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 05, indicating severely impaired cognition. The MDS identified Resident #33 required partial/moderate assistance with transfers including to the toilet. The MDS documented Resident #33 was occasionally incontinent of urine. Resident #33 's MDS included diagnoses of hypertension (high blood pressure), legally blind, and anxiety disorder. The MDS documented Resident #33 had one stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed).</p> <p>The Care Plan with target date of 9/11/24 revealed Resident #33 had a pressure ulcer on the coccyx related to immobility. The care plan documented Resident #33 required staff assistance for her toileting needs.</p> <p>On 10/21/24 and 10/22/24, observation revealed a enhanced barrier precaution sign was not on Resident #33's door.</p> <p>On 10/22/24 at 3:28 PM, observed Staff D, CNA (certified nursing assistant) and Staff E, CNA transfer Resident #33 to the commode using a gait belt and a pivot disk. Staff E reported Resident #33 's incontinent brief was a little wet. Staff E removed the dirty brief and threw it in the garbage. Staff E removed his gloves and sanitized his hands. Staff D applied a new brief, removed his gloves and washed his hands. The DON (Director of Nursing) offered to pull back the wound dressing on the buttocks so the surveyor could see the pressure ulcer when Resident #33 stood up. Staff E reapplied the gait belt. Staff D applied gloves. Staff E stood Resident #33 up using the gait belt and a pivot disk. Staff D cleansed the front perineal area. While Resident #33 was standing, the DON partially removed the wound dressing on the buttocks enough to visualize the wound and then replaced the dressing. Staff D then completed peri care in the back. Staff D removed his gloves. Staff D did not complete hand hygiene after completing peri care and removing the gloves. Staff D then pulled up Resident #33 brief, pants and assisted Staff E with transferring Resident #33 to the recliner. Staff D moved the table next to the recliner and assisted Staff E with scooting Resident #33 back in the recliner. Staff D then put on a pair of gloves without completing hand hygiene and handed a blanket to Staff E to place on Resident #33. Staff E gathered up the trash with his gloved hands and took it to the bathroom. Staff E then removed his gloves and washed his hands. During observations both the CNA's and the DON did not wear a gown during high contact resident care activities.</p> <p>On 10/22/24 at 3:45 PM, the DON acknowledged and verified enhanced barrier precautions were not in place related to Resident #33 's chronic pressure ulcer. She reported that the staff should have worn gowns. The DON also acknowledged hand hygiene should have been completed after peri care was completed and the gloves removed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Concord Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 490 West Lyons Street Garner, IA 50438	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Infection Prevention and Control Program Guidelines reviewed 1/5/24 documented hand hygiene should be performed before and after assisting a resident with toileting (hand washing with soap and water) and after removing gloves.</p> <p>The policy reported Enhanced Barrier Precautions was an approach of targeted gown and glove use during his contact resident care activities, designed to reduce transmission of staphylococcus aureus and multi drug resistant organisms. The policy documented enhanced barrier precautions may be applied to residents with chronic wounds. The policy further documented high contact resident care activities that required a gown and gloves for enhanced barrier precautions included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care.</p>		