STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165431	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Titonka Care Center	312 First Avenue NW Titonka, IA 50480

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46875 Based on record review and staff interview, the facility failed to report Payroll Based Journal (PBJ) during the 1st quarter of fiscal year 2024. The facility reported a census of 13 residents. Findings include: Review of the PBJ report provided by the Center of Medicare and Medicaid Services (CMS) for Fiscal year (FY) 2024 quarter one, indicated the facility did not submit PBJ data. Review of CMS Submission Report titled PBJ on Demand Final File Validation Report dated 2/12/24 revealed the data file was rejected as the reporting period selected on the upload screen did not match submitted XML. On 4/30/24 at 3:28 PM, the Director of Nursing (DON) reported the previous Business Office Manager (BOM) submitted the PBJ data on 2/12/24 but there was a fatal error and the file was rejected. The DON stated the BOM resigned on 2/14/24 and the error was not followed up on. The DON reported she now has access and was educated on the PBJ process. On 4/30/24 at 5:30 PM, the DON reported the facility did not have a PBJ policy but does now.

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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, 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 2 of 2 residents reviewed (Residents #1, #8). The facility failed to complete hand hygiene after removing gloves and did not complete an annual review of the infection control policies/procedures. The facility reported a census of 13 residents. Findings include: 1. Resident #1 ' s Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment. The MDS identified Resident #1 was independent with bed mobility and required substantial/maximal assistance with transfers and toileting. Resident #1 ' s MDS included diagnoses of Alzheimer's dementia, non-alzheimer ' s dementia, anxiety, depression, bipolar disorder, and an open wound to the left shoulder. A Physician Order dated 1/16/24 for Resident #1 directed staff to cleanse the left shoulder wound with normal saline, pat dry, apply bacitracin (antibiotic ointment) and ABD (abdominal gauze pad), secure with tape every day and as needed. A Hospital form titled Microbiology Reference dated 4/26/24 documented Resident #1 ' s wound culture from the left shoulder wound revealed organism of Staphylococcus Aureus(gram positive bacteria) was present in the wound. A Physician order dated 4/29/24 directed staff to administer Linezolid (antibiotic) 600 mg (milligrams) one tablet by mouth two times a day for 7 days for an infection to the left shoulder. On 5/1/24 at 9:30 AM, observed Staff A, RN (Registered Nurse) complete a dressing change to Resident #1 ' s left shoulder wound. Staff A set up the wound care supplies on top of a barrier on a tray table which did not include hand sanitizer. Staff A applied a gown before entering Resident #1 ' s room. Staff A washed hands in the room and applied gloves. Staff A removed the old dressing that was not labeled/dated from Resident #1 left shoulder. Staff A removed/discarded gloves and washed her hands with soap and water. Staff A applied a new pair of gloves and took the wound cleanser and sprayed the cleanser on the gauze pads. Staff A cleansed the left shoulder wound two times. After cleansing the wound, Staff A removed/discarded gloves and applied a new pair of gloves without completing hand hygiene. Staff A applied bacitracin ointment to her gloved finger and then proceeded to open up the ABD package and cut the ABD pad in two with a pair of scissors resulting in the ointment being smeared on her gloved hand. Staff A then applied bacitracin directly to the ABD pad and applied it to the wound. Staff A removed/discarded her gloves and applied a new pair of gloves without completing hand hygiene. Staff A took the roll of tape, tore pieces of tape off the roll and secured the ABD pad with the tape to the left shoulder. Staff A acknowledged and verified she did not complete hand hygiene after removing the gloves during the wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Resident #8 ' s Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 12, indicating intact cognition. The MDS identified Resident #8 required substantial/maximal assistance with bed mobility. The MDS further documented Resident #8 was dependent on staff for transfers and toileting. The MDS identified Resident #8 had a colostomy (bag that holds stool). Resident #8 ' s MDS included diagnoses of anemia, hypertension, ulcerative colitis (chronic, inflammatory bowel disease), and anxiety. On 04/30/24 at 10:15 AM observed Staff A, RN empty Resident #8 ' s colostomy bag. Resident #8 was sitting on the toilet. Staff A washed hands and applied gloves. Staff A used a graduate to empty stool contents from the colostomy bag. Staff A placed a barrier on the floor to sit graduate on while she cleansed the end of the bag with a incontinent wipe and then placed a clamp on the end of the bag. Staff A removed/discarded gloves, adjusted the resident's brief and applied new gloves without completing hand hygiene. Staff A then took the covered graduate with stool contents outside of the room to be emptied. 3. Review of the Infection Control Policy and Procedures revealed the facility did not review the policies annually. The following policies documented the following dates: a. Standard Precaution Policy- No revised or reviewed date b. Contact Precaution Policy- Revised 2/29/16 c. Airborne Precaution Policy- No revised or reviewed date d. Droplet Precaution Policy- No revised or reviewed date e. Infection Control Program Policy- No revised or reviewed date f. Infection Control Precautions Guidelines Policy- dated 12/2016 g. Infection Control Program Surveillance System- dated 12/2016 h. Pneumococcal Vaccination Policy- dated 12/2016 i. Influenza Vaccination Policy- dated 12/2016 On 5/1/24 at 11:25 AM, The Director of Nursing (DON) reported she would expect hand hygiene to be completed when removing gloves and when going from a dirty to clean task. On 5/1/24 at 3:15 PM, The DON reported the infection control policies were a work in progress and that she tried to review the policies annually. The DON stated the policies are kind of a mess. The DON verified that the Medical Director had not reviewed the infection control policies. The undated facility policy titled Standard Precautions directed staff to complete hand washing immediately after gloves are removed. The policy further documented it may be necessary to wash hands between tasks and procedures on the same resident to prevent cross contamination.