

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Midlands Living Center L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 2452 North Broadway Council Bluffs, IA 51503	

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 - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46873</p> <p>Based on observations, staff interview and facility policy review, the facility failed to maintain appropriate infection control practices for one of four residents reviewed (Resident #6). The facility reported a census of 68 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) of Resident #6, dated 1/30/25 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognition intact. The MDS recorded the presence of an indwelling catheter. The MDS documented diagnoses which included paraplegia (paralysis of the legs and lower body) and neurogenic bladder (a condition where a person's bladder control is impaired due to damage or dysfunction of the nerves that control bladder function).</p> <p>The Care Plan of Resident #6 identified a Focus Area of Catheter for neuromuscular dysfunction, revision date 6/28/23.</p> <p>The Treatment Administration Record (TAR) for April of 2025 for Resident #16 documented an order which read - Suprapubic cath site: cleanse area, pat dry. Apply split gauze. Every day shift for cath care and as needed for soiling. The TAR revealed documentation of having been performed by the nurse on duty on 4/23/25.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Midlands Living Center L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 2452 North Broadway Council Bluffs, IA 51503	
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 - Few</p>	<p>Observation of catheter cares began on 4/23/25 at 1:44 pm. Staff A, Certified Nurse Aide (CNA) performed catheter cares and the emptying of the catheter downdrain bag with the Assistant Director of Nursing (ADON) in the room for observation. The resident's room had a sign for Enhanced Barrier Precautions with a bin of Personal Protective Equipment (PPE) outside of the room. Staff A donned an isolation gown prior to entering the room. Upon entering the room, with no hand hygiene observed, Staff A placed gloves on his hands. He obtained an alcohol swab and lowered the blankets and raised the shirt of Resident #6 to expose the stoma of the supra pubic catheter (a tube inserted into the bladder through a small incision in the abdomen). The stoma was covered with a split piece of clean, unsoiled gauze. Staff A stated he was not supposed to change the gauze, and moved the gauze, keeping it on the catheter tubing, to cleanse the tubing from the stoma downwards with the alcohol swab. The ADON instructed Staff A to remove the gauze. He replied he didn't think he was supposed to and was again told by the ADON to remove the gauze. The ADON was requested to only observe and not offer coaching by the State Surveyor. Staff A removed the gauze and disposed of it. He then continued to cleanse the tubing with an alcohol swab. The ADON instructed Staff A to place a new dressing on the tubing. He stated he had never done that before. Resident #6 stated the gauze was kept in the top drawer of the night table. Staff A, still wearing the same gloves, opened the top drawer of the night table and obtained a new package of gauze. When opening the gauze, Staff A dropped the package onto the floor. He picked the package up with his gloved hand and continued to open the package. The ADON instructed Staff A he needed to throw the package away and obtain a new one. Staff A did not immediately dispose of the gauze package. The ADON repeated to Staff A he needed to throw the gauze away and start over because it had been on the floor. The ADON was again asked to refrain from coaching and only observe. Staff A disposed of the soiled package, still wearing the same gloves, again opened the top drawer and obtained a new package of gauze. He stated the gauze had not fallen on the floor, it was still in the package and that was why he didn't think it needed to be thrown away. After opening the package, Staff A placed the new split gauze over the tubing. Staff A then opened the cabinet under the sink, still wearing the same gloves. He obtained a graduated cylinder and placed it directly onto the floor near the urinary drain bag. He obtained a new alcohol swab, swabbed the drain, emptied the urine into the graduated cylinder and swabbed the drain again before replacing the drain. He replaced the urine bag on the under rails of the bed. Staff A picked up the cylinder and walked to the restroom. He emptied the cylinder into the toilet. He then returned to the sink, obtained a disposable cup, placed water in the cup to rinse the cylinder, and dumped the rinse water also into the toilet. He disposed of the cup in the garbage and replaced the cylinder under the sink. Staff A then removed his gloves and disposed of them, removed his gown and placed it in the bin for gowns, and then washed his hands.</p> <p>On 4/23/25 at 1:55 pm, the ADON stated she would have preferred Staff A washed or sanitized his hands at the beginning of procedure, and again in between clean and dirty. She stated Staff A should not have attempted to use the gauze after it was dropped on the floor and that she intervened due to resident safety/infection control. She stated Staff A should have started fresh and washed his hands and obtained clean gloves at that time.</p> <p>The facility policy titled Enhanced Barrier Precautions, review date 5/6/24 documented the following:</p> <p>Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve gown</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Midlands Living Center L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 2452 North Broadway Council Bluffs, IA 51503	
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 - Few</p>	<p>and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with chronic wounds, not yet healed surgical incisions, or indwelling medical devices).</p> <p>CDC-targeted MDROs include the following:</p> <p>Indwelling medical devices: examples include central lines, urinary catheters, feeding tubes, and tracheotomies. A peripheral intravenous line that is not a central line is not considered an indwelling medical device for the purpose of EBP.</p> <p>Hand hygiene: Hand hygiene should be performed before and after putting on and taking off PPE, and after contact with blood, body fluids, or other potentially infectious materials.</p> <p>The facility document Catheter Care Audit dated 2023 documented the following:</p> <ol style="list-style-type: none"> 1. Greet the resident and introduce yourself. Perform hand hygiene. 2. Explain procedure, provide privacy 3. Gather supplies. Set 3 bags on the bed (clean, soiled, trash) 4. Apply water and Tena (no rinse) to separate warm washcloths in clean bag. 5. Apply gloves. 6. Position and undress resident/remove brief 7. For Supra Pubic - may use alcohol wipe for cleaning SP catheter 8. (N/A for supra pubic catheters) 9. Remove gloves and perform hand hygiene 10. Apply new gloves 11. Redress the resident/secure a brief 12. Keep drainage bag below level of the catheter 13. Secure catheter with device or strap and secure bag 14. Position patient for comfort and safety. Cover the resident. 15. Remove gloves and perform hand hygiene. <p>(procedure provided does not include emptying of catheter)</p>		