

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Bishop Drumm Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5837 Winwood Drive Johnston, IA 50131	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>47079</p> <p>Based on observation, staff interview, and policy review, the facility failed to treat residents with dignity by staff arguing with each other in front of 9 residents. The facility reported a census of 120.</p> <p>Findings include:</p> <p>1) On 9/19/24 at 7:55 AM, Staff H, Dietary Attendant and Staff I, Culinary Support argued in the large dining room with 9 residents present. While standing 30 feet outside the large dining room door, the surveyor heard someone yell I don't care. Upon entering the dining room doorway, 1 of the 9 residents in the dining room watched as Staff H walked from the left side of the dining room to the right side and yelled I have to do everything around here. at Staff I. Staff H threw some cloth napkins in a bin on the table near the kitchen entrance and yelled You don't ever help at Staff I. Staff I made an inaudible comment and Staff H yelled I bet you do then grabbed the tray cart and left the dining room.</p> <p>At 2:25 PM, the Director of Dietary stated staff should never have any argument in the dining room. It is not necessary.</p> <p>A policy titled Dignity revised 2/2021 indicated residents are treated with dignity and respect at all times.</p> <p>2) On 9/18/24 at 11:03 AM North Unit rooms 200-217, observed the Certified Nurse Aide, (CNA) charting monitor (Kiosk) open, viewed information for the residents rooms 200 to 205. The Staff K, Licensed Practical Nurse, (LPN) walked by the monitor did not close the screen. At 11:06 AM The Staff L, CNA walked from the Residents #63 room to the monitor and started to access the screen.</p> <p>On 9/18/24 at 11:07 AM The Staff L stated the monitor is how they access and chart the CNA tasks for the residents. The hall way is broken down to three groups. Each CNA is to chart their group, the tasks of Activities of Daily Living (ADL) that they assisted the resident with. The task are individualized for that resident.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/19/24 at 3:12 PM The Executive Director (ED) stated the monitors (Kiosk) should be in locked screen whenever the staff member is not present and using it. The monitors in the hallways are for the CNAs and have the task for ADLs for their residents they are caring for. This is individual residents information for care. Education will be provided to the staff.</p> <p>The facility policy titled Confidentiality of Information and Personal Privacy revised 10/17 instructed the staff the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records and access to resident personal and medical records will be limited to authorized staff and business associates.</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>46873</p> <p>Based on observation, clinical record review, staff interviews and policy review, the facility failed to provide care and services to maintain acceptable parameters of nutritional status for 1 of 3 residents (Resident #69) reviewed for nutrition. This failure resulted in harm due to Resident #69 experiencing a weight loss of 10.4% in an approximate 3 month period. The facility reported a census of 120 residents.</p> <p>Findings Include:</p> <p>The Quarterly Minimum Data Set (MDS) of Resident #69, dated 8/15/24 identified a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS identified a PHQ-9 (Patient Health Questionnaire) score of 13, indicating moderate depression. The MDS documented diagnoses that included: anemia (low red blood cell count), renal (kidney) insufficiency), diabetes, dementia, and depression. The MDS documented a height of 65 inches and weight of 139 pounds. The MDS identified a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, not on a physician-prescribed weight-loss regimen.</p> <p>The Care Plan of Resident #69 identified a Focus Area of Nutrition, dated 6/17/21. An intervention was added 8/13/24 to receive 8 oz of Glucerna (a meal replacement supplement for diabetics) with each meal to promote weight maintenance and prevent further weight loss. No further interventions for weight loss were documented in the Care Plan.</p> <p>The Weight Summary section of the Electronic Health Record (EHR) documented Resident #69 weighed 147.9 pounds on 6/1/24. The Weight Summary documented a weight of 132.5 pounds on 9/9/24, 10.41% weight loss in 15 weeks time. Resident #69 was next weighed one week later, with a documented weight of 131.1 pounds, an additional 1% loss in one week.</p> <p>The following weights were recorded:</p> <p>6/01/24 147.9 pounds</p> <p>7/11/24 149.3 pounds</p> <p>7/23/24 134.0 pounds</p> <p>7/29/24 136.7 pounds</p> <p>8/12/24 145.8 pounds</p> <p>8/26/24 133.9 pounds</p> <p>9/01/24 134.6 pounds</p> <p>9/09/24 132.5 pounds</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>9/16/24 131.1 pounds</p> <p>The Active Orders section of the EHR, reviewed on 9/19/24 at 8:09 am, revealed an order dated 8/2/24 which read Dietitian to eval and offer nutritional supplements. No supplements were ordered except Glucerna three times a day.</p> <p>The Medication Administration Record (MAR) identified a start date of 8/12/24 for the Glucerna Order. The MAR failed to identify any further nutritional supplements.</p> <p>On 9/18/24 at 9:56 am, Resident #69 was observed lying in bed sleeping soundly. A breakfast tray was at her bedside, still covered. Her full breakfast remained on the tray, untouched.</p> <p>The Schedule of Mealtimes documented provided by the facility noted breakfast times to be between 7:30 am and 9:00 am.</p> <p>On 9/18/24 at 9:58 am, Staff M, Certified Nurse Aide (CNA) stated Resident #69 was sleeping when her breakfast tray was brought in but that she would feed her at this time. Staff M stated Resident #69's tray had not been sitting there for very long. She said her tray was delivered separately because she likes to sleep late and the food should still be warm. At 9:59 am, Resident #69 was sitting up in bed and feeding herself breakfast.</p> <p>On 9/18/24 at 12:23 pm, room trays arrived for Resident #69's hall. When all trays were passed, it was observed Resident #69's tray was included on the same cart as all resident's. Her meal was not separated from other residents.</p> <p>On 9/18/24 at 12:27 pm, the Registered Dietitian (RD) stated the resident is of Bosnian descent and prefers Bosnian food. She stated the Dietary Manager is also Bosnian and is able to assist in translating for interviews to determine what foods the Resident prefers. She stated Resident #69 has some depression and has stated her desire is to return to Bosnia. The RD stated the facility does use fortified foods in the facility (foods with extra butter, brown sugar, etc. to add extra calories to food for residents who experience weight loss). She stated she was not aware if fortified foods had ever been tried for Resident #69. She confirmed no current supplements were in place except Glucerna. She added the facility holds a weekly meeting to discuss resident weights and watch nutrition trends. She was aware the resident weighed somewhere in the 130 pound area and confirmed this to be a significant weight loss with no interventions except Glucerna.</p> <p>On 9/18/24 at 3:05 pm, the Director of Nursing (DON) stated Resident #69 has been facing other health challenges besides just weight loss. She stated she has had a decrease in physical ability and an overall health decline. She stated she is no longer walking to the bathroom or getting up and sitting in her chair. She said she was aware of no interventions put in place except Glucerna. She stated she would look into some cultural and personal interventions that could be done in the weekly weight meeting.</p> <p>On 9/19/24 at 9:05 room trays were delivered to the hallway where Resident #69's room was on. On 9/19/24 at 9:11 am, the breakfast tray for Resident #69 was delivered to her room. Resident #69's tray was not separated from other residents' trays.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 9:19 am, Resident #69 was observed sleeping soundly in bed with her breakfast tray still sitting on her table covered.</p> <p>On 9/19/24 at 9:24 am, the Dietary Supervisor stated Resident #69 had been expressing desires to return to Bosnia over the past year. She stated this is not a possibility for Resident #69's family to accommodate her wishes. She stated Resident #69 likes to sleep late in the mornings. She said Resident #69's tray is sent to the floor the same time as all of the other residents. It is not kept separate. She stated that she had given Magic Cup (a fortified high calorie ice cream) to Resident #69 in the past but she did not like it. She stated it was added to her tray card to try again the previous day. She added super mashed potatoes (fortified food) to her list the prior day as well. She stated the resident has always liked oatmeal and has coffee creamer in her room that she has always added to her oatmeal herself but super oatmeal with extra brown sugar was also added the prior day. She confirmed the additional interventions were put in place on 9/18/24. No mention of special foods, or Bosnian food were specified in the interview.</p> <p>The Encounter Note dated 8/1/24 revealed the Nurse Practitioner was aware of the weight loss and noted for the Dietitian to evaluate and offer nutritional supplements and for the facility to obtain weekly weights.</p> <p>The Progress Notes revealed no Dietary Note was placed with additional supplements until 9/19/24.</p> <p>The facility policy Nutritional Management, revision date 11/28/22 documented:</p> <p>Point 4 - Care Plan Implementation:</p> <p>a. The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care.</p> <p>b. Interventions will be individualized to address the specific needs of the resident. Examples include, but are not limited to:</p> <p>i. Diet liberalization unless the resident's medical condition warrants a therapeutic diet</p> <p>ii. Altered-consistency food/liquids after underlying causes of symptoms are addressed (i.e. new dentures, dental consult, dysphagia therapy)</p> <p>iii. Weight-related interventions</p> <p>iv. Environmental interventions</p> <p>v. Disease-specific interventions</p> <p>vi. Physical assistance or provision of assistive devices</p> <p>vii. Interventions to address food-drug interactions or medication side effects</p> <p>c. Real food will be offered first before adding supplements.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, revised September 2017 documented:</p> <p>Monitoring</p> <ol style="list-style-type: none"> 1. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting). 2. When medical conditions or medication-related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses, goals, wishes, prognosis, and complications. 3. The physician and staff will collaborate to address any ethical issues related to weight and nutrition (for example, possible use of artificial nutrition and hydration) related to severe or prolonged impairment of nutritional status and weight loss. <ol style="list-style-type: none"> a. Such recommendations should be consistent with resident/patient treatment wishes; for example, as expressed through an advance directive. b. The physician and staff should ordinarily not recommend or order a feeding tube until seeking to identify causes and trying other alternatives or identifying them as legitimately not feasible. c. The physician and staff will document the medical and ethical rationale for recommending, not recommending, or discontinuing tube feedings, consistent with the clinical situation and applicable laws and regulations about the withholding or withdrawing of artificial nutrition and hydration.

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47079</p> <p>Based on observation, staff interview, and policy review, the facility failed to secure Electronic Health Record information for 16 residents. The facility reported a census of 120.</p> <p>Findings include:</p> <p>1) On 9/17/24 at 8:15 PM, a northeast hall report sheet with 21 residents' information was observed laying face up on a medication cart.</p> <p>At 8:17 PM, the Director of Nursing (DON) stated the resident's information (NE report sheet) is usually under the binder and should not be face up on top of the cart.</p> <p>A policy titled Confidentiality of Information and Personal Privacy revised 10/2017 indicated the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079</p> <p>Based on observation, record review, staff interview, and policy review, the facility failed to implement infection control practices to minimize cross-contamination for 9 of 9 resident staff interactions reviewed for infection control observations (#31, 52, 61, 63,64,113, 114, and 324). The facility reported a census of 120.</p> <p>Findings include:</p> <p>1) On 9/18/24 at 8:34 AM, Staff D, Certified Nurse Aide (CNA) and Staff E, Certified Nurse Aide (CNA) transferred Resident #31 from her bed to her wheelchair. Staff D hung the resident's indwelling catheter bag on the spreader bar (center bar between grip handles) above the resident's bladder.</p> <p>The Minimum Data Set (MDS) dated [DATE] indicated Resident #31 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of Heart Failure, peripheral vascular disease, kidney disease, obstructive uropathy (blocked urine flow), anemia, and Atrial Fibrillation (irregular heartbeat). It revealed the resident was dependent with bed-to-chair transfers, bathing, and toileting hygiene. It included the resident's use of an indwelling catheter.</p> <p>The Care Plan directed staff to position the catheter bag and tubing below the level of the bladder.</p> <p>On 9/18/24 at 9:07 PM, Staff E stated the catheter bag should be positioned to make sure urine doesn't flow back into the resident and should not be above the resident's bladder.</p> <p>On 9/18/24 at 9:24 PM, Staff D stated her indwelling catheter training included instructions that staff should not position the indwelling catheter to allow urine to flow back into the resident. She stated she felt the spreader bar was the safest place to hang the drainage bag but added she felt it wasn't an appropriate place to hang the catheter bag.</p> <p>On 9/19/24 at 2:51 PM, the DON stated staff should've followed her training and hung the bag at a location that was lower to the bladder.</p> <p>A policy titled Catheter Care dated 5/10/23 directed staff to ensure the drainage bag is located below the level of the bladder to discourage backflow of urine.</p> <p>2) On 9/17/24 at 8:38 PM, Staff F, Certified Medicine Aide (CMA) entered a resident's room who was on contact isolation and Enhance Barrier Precautions (EBP). Staff F did not perform don Personal Protective Equipment (PPE) or perform hand hygiene. He grabbed a Styrofoam cup off of the resident's bedside table, threw the straw away, and carried the cup to the galley (unit-based room with an ice machine) and threw the cup in the trash. He filled another cup with ice and carried it to the resident and performed hand hygiene. He stated the resident was on contact precautions because of pressure ulcers.</p> <p>(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 - Some</p>	<p>At 8:50 PM, Staff G, Registered Nurse (RN) stated the resident was on contact precautions due to Clostridium Difficile (C-Diff) and EBP due to having an indwelling catheter. She stated staff must wear PPE at all times when inside the resident's room.</p> <p>On 9/19/24 at 2:54 PM, the DON stated staff should have asked the resident from the door threshold what he needed and gotten the ice prior to entering the resident's room. PPE should have been applied prior to entering the resident's room.</p> <p>A policy titled Personal Protective Equipment dated 3/02/23 indicated the facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff.</p> <p>A policy titled Transmission-Based (Isolation) Precautions dated 10/24/22 directed healthcare personnel caring for residents on Contact Precautions to wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment.</p> <p>50500</p> <p>3. The Minimum Data Set (MDS) dated [DATE] revealed Resident #52 had a Brief Interview for Mental Status score of 13, indicating intact cognition. Diagnoses on the MDS include history of urinary [NAME] infections, diabetes, benign prostatic hyperplasia, obstructive uropathy, and renal insufficiency, renal failure, or end-stage renal disease. The MDS indicated presence of an indwelling catheter.</p> <p>During observation 9/18/24 at 10:30 AM, Staff A, Certified Nursing Assistant (CNA), donned gloves and gown upon entering Resident #52's room to empty catheter urinary bag and complete pericare. Staff A picked up the call light from the floor, rearranged bed blankets, and moved the bed control to declutter the care area. Staff A proceeded to empty Resident #52 urinary catheter bag, which included use of a new alcohol swab to cleanse the catheter port.</p> <p>After the collection graduate emptied and rinse, Staff A removed gloves and donned on a new pair. No hand hygiene observed prior to donning of the gloves. Staff A verbalized there was no hand sanitizer in the room. Staff A cleansed the area around the suprapubic catheter site. Pericare completed next, which include application of a barrier cream and incontinence brief change. After cares completed, Staff A repositioned Resident #52, rearranged blankets and pillows, and ensured the call right was in reach. Staff A then removed gloves and washed hands.</p> <p>During interview on 9/19/24 at 12:20 PM, the Director of Nursing, DON, voiced the expectations that gloves are changed immediately after completion of pericare and before the start of new tasks/touching of items in the room. DON unclear on facility's procedure if gloves should have been changed after Staff A touched various surfaces prior to the start of emptying the catheter bag.</p> <p>The Hand Hygiene policy dated 5/9/23 outlines staff to complete hand hygiene before applying and removing personal protective equipment, including gloves.</p> <p>The Personal Protective Equipment policy dated 3/2/23, direct staff to change gloves and perform hand hygiene</p> <p>(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 - Some</p>	<ol style="list-style-type: none"> 1. Between clean and dirty tasks 2. When moving from one body part to another 3. When heavily contaminated 4. When torn <p>4. 9/18/24 at 9:09 AM The Staff J, Certified Medication Aide (CMA) did not complete hand hygiene, gathered the Resident #324 medication cards, looked at the electronic medication administration record (EMAR), verified the medication with the EMAR, and then one at a time dispensed the tablet or capsule into the medication cup. The Staff J verified again all the medication in the medication cup, placed the medication cards in the medication cart, locked the medication cart, locked the computer screen. The Resident #324 was at the nurse station, the Staff J handed the medication cup to the Resident #324, handed the water cup to the Resident #324, the Resident #324 administered the medications and handed the Staff J the emptied cups. The Staff J disposed soiled cups in the trash. The Staff J verified with the EMAR, gathered the artificial tear bottle, tissue paper, informed the Resident #324, administered the artificial tear, dabbed the Resident #324 with the tissue paper each eye, disposed the tissue paper in the trash, returned artificial tears bottle to the medication cart. The Staff J did not complete hand hygiene with completion of tasks.</p> <p>5. 9/18/24 at 9:32 AM The Staff J, CMA did not complete hand hygiene, gathered the Resident #61 medication cards, looked at the electronic medication administration record (EMAR), verified the medication with the EMAR, and then one at a time dispensed the tablet or capsule into the medication cup. The Staff J verified again all the medication in the medication cup, placed the medication cards in the medication cart, locked the medication cart, locked the computer screen. The Staff J walked to the Resident #61 room, knocked on the door, waited for permission to enter, informed the Resident #61 of the medications. The Resident #61 took the medication cup, the Staff J handed the Resident #61 glass of water, the Resident #61 administered the medications and handed the Staff J the emptied cups. The Staff J disposed soiled cups in the trash. The Staff J completed hand hygiene at the medication cart.</p> <p>6. 9/18/24 at 9:48 AM The Staff J, CMA did not complete hand hygiene, gathered the Resident #113 medication cards, looked at the electronic medication administration record (EMAR), verified the medication with the EMAR, and then one at a time dispensed the tablet or capsule into the medication cup. The Staff J prepared liquid medication in a medication cup. The Staff J verified again all the medication in the medication cup, placed the medication cards in the medication cart, locked the medication cart, locked the computer screen. The Staff J walked to the Resident #113 room, knocked on the door, waited for permission to enter, informed the Resident #113 of the medications. The Staff J administered a couple tablets at a time, provided sips of water, completed administration of tablets, provided sips of water, administered liquid medication, and provided sips of water. The Staff J disposed soiled cups in the trash. The Staff J completed hand hygiene at the Resident #113 sink prior to exiting room.</p> <p>(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 - Some</p>	<p>7. 9/18/24 at 11:12 AM The Staff K, Licensed Practical Nurse (LPN) reviewed the EMAR for the Resident #63, gloved, knocked on the Resident #63 door, walked into the room, informed the Resident #63 of medication administration, obtained blood pressure, obtained graduate and syringe, filled graduate with water, placed on side table, checked the formula and pump, informed the Resident #63 to return with medications. The Staff K exited the room, removed the gloves, reviewed the EMAR, prepared the liquid medications, gloved, walked into the Resident #63 room, placed medication cups on side table, placed the feeding on hold, noted head of bed at appropriate level, located the gastrostomy tube (g-tube), placed the connector on hold, filled syringe with 30mls of water, connected the syringe to the g-tube port, turned the connector to administer, flushed the g-tube with 30mls of water, placed the connector on hold, disconnect the syringe, filled the syringe with medication, connected the syringe to the g-tube, turned the connector to administer, administered the medication, placed the connector on hold, disconnect the syringe, filled syringe with 30mls of water, connected the syringe to the g-tube port, turned the connector to administer, flushed the g-tube with 30mls of water, placed the connector on hold, disconnect the syringe, filled the syringe with medication, connected the syringe to the g-tube, turned the connector to administer, administered the medication, placed the connector on hold, disconnect the syringe, filled syringe with 30mls of water, connected the syringe to the g-tube port, turned the connector to administer, flushed the g-tube with 30mls of water, placed the connector on hold, and disconnect the syringe. The Staff K placed the pump on start mode, disposed the soiled medication into the trash, rinsed the syringe and graduate, disposed gloves, and exited the room. The Staff J did not complete hand hygiene prior or completion of task. The Staff J did not following Enhanced Barrier Precautions with gowning.</p> <p>8. 9/18/24 at 12:00 PM The Staff K reviewed the EMAR and recent blood glucose for the Resident #114, gloved, gathered the lispro insulin flexpen from the medication cart, cleansed the port of flexpen with alcohol pad, attached the flexpen needle, primed the flexpen, set the flexpen to the required units of insulin to be administered, gathered an alcohol pad, walked to the Resident #114 room, knocked on the door, waited for permission to enter, informed the Resident #114 about the administration of insulin, permission granted and site stated, area cleansed with alcohol pad, administered the insulin, disposed the needle, completed hand hygiene, exited room. The Staff K did not complete hand hygiene prior to administration of insulin.</p> <p>9. 9/18/24 at 12:07 PM The Staff K reviewed the EMAR and recent blood glucose for the Resident #64, gathered the lispro insulin flexpen from the medication cart, gloved, cleansed the port of flexpen with alcohol pad, attached the flexpen needle, primed the flexpen, set the flexpen to the required units of insulin to be administered, gathered an alcohol pad, walked to the Resident #64 room, knocked on the door, waited for permission to enter, informed the Resident #64 about the administration of insulin, permission granted and site stated, area cleansed with alcohol pad, administered the insulin, disposed the needle, completed hand hygiene, exited room. The Staff K did not complete hand hygiene prior or completion of task.</p> <p>On 9/19/24 at 3:12 PM The Executive Director (ED) stated the staff should be following the Enhance Barrier Precautions, Hand Hygiene, and Medication Administration policies. The staff should be washing their hands before and after providing cares, medications, etc. The staff should be wearing a gown and gloves while taking care of the residents with g-tubes. The staff will be further educated so they understand.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Bishop Drumm Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5837 Winwood Drive Johnston, IA 50131	
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 - Some</p>	<p>The facility policy titled Medication Administration reviewed 5/3/22 instructed the staff to wash hands prior to administering medication per facility protocol and product, observe resident consumption of medication, wash hands using facility protocol and product.</p> <p>The facility policy titled Administering Medications through an Enteral Tube revised 11/18 instructed the staff follow the medication administration guidelines in the policy entitled administering medications, wash your hands (administering), verify placement of feeding tube, and wash your hands (completion).</p> <p>The facility policy titled Enhanced Barrier Precautions (EBP) revised 8/10/22 instructed the staff Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increase risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The policy stated all staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions. High-contact resident care activities include: Device care or use: feeding tubes. EBP should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed.</p>		