STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165538	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Ridge Care Center	1005 7th Street NE Orange City, IA 51041

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 - Many	Provide and implement an infection prevention and control program. 44420 Based on observation, infection control policy, clinical record review and staff interview, the facility failed to use universal infection control measures and Enhanced Barrier Precautions (EBP) during a drainage of a Foley bag, wound care, and during a peg tube feeding for 3 out of 6 residents reviewed for infection control (Resident #4, #30 and #83). The facility reported a census of 81 residents. Findings Included: 1. Observation on 5/1/24 at 1:14 PM for Resident #4 showed Staff A, Certified Nurse Assistant (CNA), sanitized hands, donned gloves, placed the urine colander with the barrier on the floor, then placed an alcohol wipe packet directly on the floor. Staff A opened the Foley bag drainage valve, sanitized the valve with an alcohol wipe, partially drained the urine, reused the same alcohol wipe to sanitize the drainage valve then placed the valve back into the holder. Staff A next manipulated the measuring container within the Foley bag to allow the urine to drain into the bottom of the Foley bag. Staff A then reopened the Foley bag drainage valve, retrieved the alcohol wipe packet from the floor, opened the alcohol wipe and sanitized the drainage valve. Staff A drained the remainder of the urine then reused the same alcohol wipe to sanitize the drainage valve. Staff A next placed the drainage valve back into the holder then proceeded to place the Foley bag within the privacy bag and rearranged the resident's blanket without removing gloves or performing hand hygiene. During the procedure Staff A also failed to wear a gown as required per Enhanced Barrier Precautions (EBP). In an interview on 5/1/24 at 2:08 PM, Staff A reported she lacked knowledge of enhanced barrier precaution requirements. When asked if Staff A received education about EBP, she responded no. When asked if Staff A received education to wear a gown while draining urine from a Foley bag, Staff A responded, no. In an interview on 5/1/24 at 2:52 PM, the Director of Nursing (DON) reported that she expected staff to avoid placing alcohol wipe packets directly on the floor in preparation of emptying a Foley bag. The DON also expected staff to remove gloves and perform hand hygiene immediately after emptying a Foley bag. The DON explained from her understanding of the latest Centers for Medicare & Medicaid Services (CMS) Quality, Safety & Oversight Group (QSO) that facilities were not required to implement the new guidelines, per the verbage facilities should, therefore the DON ' s facility opted not implement EBP measures because the measures interfered with a home like environment for residents. (continued on next page)

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	The Catheter Care policy last revised August 2019 instructed staff to remove gloves and perform hand hygiene after emptying urine from a catheter bag. 50500 2. On 5/1/24 at 10:00 am, observation of wound care on Resident #83 completed by Staff B, Licensed Pratical Nurse (LPN). Staff B completed appropirate hand hygeine prior to donning gloves. No other EBP was worn. Staff B placed wound care supplies initially on bedside table then transferred to floor without a barrier between the supplies and floor (included scissors, skin prep package, mepilex package, hibicleanse bottle, wound cleanser bottle, tape). Staff B sat on floor to perform cares to Resident #83's left heel. Staff B used gloved hands to balance on floor and did not change gloves. Wound cares completed as per physcian's orders. During cares, Staff B was observed picking up supplies off the floor with gloved hands, opening packages, and continued with cares without changing gloves. Throughout observation, Staff B touched floor with gloved hands (x2) and resumed wound cares. On 5/1/24 at 2:00 pm, interview with Staff B completed. When asked, Staff B was not aware of any residents under EBP. Staff B was able to verbalize where proper personal protective equipment (PPE) was located on the unit. On 5/1/24 at 2:40pm, interview with Cottage Leader for Countryside completed. When asked, stated wound care supplies should not be placed on the floor. Appropriate equipment available to use, for example, bedside tables or plastic bins. 26527 3. On 5/1/24 at 10:00 a.m. Staff C, LPN washed her hands and applied gloves. Staff C checked Resident #30's feeding tube for residual, with none noted. Staff C cleaned the feeding tube insertion site and placed a towel around the feeding tube. She administered 9 medications separately with water flushes through an open ended syringe placed to the feeding tube. After the medications were in, Staff C started administering the formula for the feeding through the open ended syringe. Throughout the procedures, gloves were the only EBP used. 44474 4. Interview on 5/1/24 at 2:02 p.m., with Staff C, LPN revealed if someone was on EBP then the cottage leader would let the staff know and it would be communicated to them. She further revealed there is no one currently on EBP in the cottage. 5. Interview on 5/1/24 at 2:04 p.m., with Staff D, Registered Nurse (RN), Cottage Leader revealed she did not know what EBP were. She further revealed she was not aware anyone was on EBP in the cottage. Review of the facility provided policy titled Infection Control Program, Standard, Transmission, Droplet, Airborn, and Enhance Barrier Precaution with a revision date of 4/24 revealed the purpose is to provide for protection of residents and staff from the spread of infectious illness and disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Enhanced Barrier Precautions definition is the use of Personal Protective Equipment (PPE) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MRDO). Examples include dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and wound care. EBP may be used for a resident with an active targeted MRDO. 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 5/1/24 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. Interview on 5/1/24 at 11:33 a.m., with the Director of Nursing (DON) regarding EBP. She revealed the facility is not currently using EBP on residents as when the facility read the guidance it stated recommend and should and did not the word must. She further revealed the facility has a plan in place for the usage EBP when needed and all residents that would meet the requirements to be using EBP have been reviewed and do not have a MRDO and colonized with an MRDO.