

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Ennoble Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Pasadena Drive Dubuque, IA 52001	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874</p> <p>Based on observation, resident, family, and staff interviews the facility staff failed to knock and be acknowledged before entering a resident's room for 5 of 5 residents (Residents #1, #5, #17, #33 and#39). Facility reported census of 61 residents.</p> <p>Findings include:</p> <p>Resident #17's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive response. The MDS documented Resident #17 as independent (Resident completes the activity by themselves with no assistance from a helper for self-care). The MDS listed diagnoses of anxiety disorder, depression, coronary artery disease, and hypertension.</p> <p>During an interview on 07/15/24 at 11:02 AM, Resident #17 reported she was getting dressed one time and the staff just walked in. Resident #17 voiced she would like them to knock before entering.</p> <p>On 07/16/24 at 7:23 AM, observed Staff C (housekeeper) enter room D1 without knocking. Resident #17 and Resident #39 were present in the room.</p> <p>On 07/16/24 at 7:39 AM, observed Staff C enter room R15 without knocking. Resident #5 was present in the room.</p> <p>On 7/17/24 at 9:00 AM, observed Staff C enter room R17 without knocking. Resident #33 was present in the room.</p> <p>On 7/17/24 at 9:02 AM, observed Staff C enter room R13 without knocking. Resident #1 was present in the room.</p> <p>During review of personnel records on 07/17/24 at 9:34 AM, page 3 of Staff C's position description indicated she should knock before entering a resident's room. Staff C signed the position description on 06/14/23. An updated position description was provided to Staff C documenting the resident rights functions and knock before entering a resident's room. Staff C signed the position description on 03/20/24.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/17/24 at 10:24 AM, the Director of Nursing (DON) reported staff were to knock on the door and identify themselves prior to entering a resident room. Training on resident rights was provided upon hire and annually.</p> <p>During an interview on 07/17/24 at 10:30 AM, the Administrator reported resident rights training was provided on 09/24/23. Staff C was in attendance for the training. Resident privacy and confidentiality were discussed in the facility policy.</p> <p>During an interview on 07/17/24 at 1:35 PM, Staff C reported staff were to knock and identify themselves before entering a resident room.</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** 37072</p> <p>Based on observation, record review, and staff interview the facility failed to keep Foley catheter and tubing off the ground to maintain infection control for 1 out of 2 catheters reviewed (Resident #28). The facility also failed to wear appropriate personal protective equipment when handling dirty linens and failed to properly cover linens when transporting. The facility reported a census of 61 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] identified Resident #28 as mildly cognitively impaired with a BIMS (Brief Interview for Mental Status) of 12 out of 15. The MDS listed the following diagnoses Anemia, Renal Insufficiency, and Neurogenic Bladder. It also identified Resident #28 required total assist of staff with personal hygiene, bathing, and toileting. The MDS indicated the resident had an indwelling catheter.</p> <p>Review of the final urine culture dated 6/16/24 indicated Resident #28 had a urinary tract infection and was started on Keflex (antibiotic) 500 milligram three times a day for seven days.</p> <p>Review of the Care Plan with a date initiated 6/20/24 indicated Resident #28 had an indwelling Foley catheter. The interventions directed staff to check tubing for kinks, position catheter bag and tubing below the level of the bladder, monitor and report to medical doctor for signs and symptoms of urinary tract infection. The Care Plan failed to address placement of tubing or Foley bag from touching the ground/floor.</p> <p>On 07/15/24 at 11:57 AM observed Staff pushing Resident #28 down the center hall in her wheelchair. The Foley catheter tubing and bag were touching the ground. The catheter bag had a privacy cover on it.</p> <p>On 07/15/24 at 12:25 PM observed Resident #28 in her wheelchair in the assisted dining room her Foley catheter bag on the ground and tubing was touching the ground under her wheelchair.</p> <p>On 07/16/24 at 7:55 AM Resident #28 observed sitting in her wheelchair in the assisted dining room catheter bag under the wheelchair resting on the ground and tubing on the ground.</p> <p>On 07/16/24 at 9:44 AM Resident #28 observed sitting in wheelchair in her room the catheter bag with privacy bag resting on the ground with tubing touching the ground.</p> <p>On 07/17/24 at 12:25 PM Resident #28 sitting in her wheelchair at the table in the dining room. Catheter tubing was lying on the ground below the chair.</p> <p>On 07/18/24 at 07:55 AM Staff A, Certified Nursing Assistant (CNA) stated the Foley bag and tubing should all be kept down below the level of the bladder. The catheter bag should be in the dignity bag underneath the wheelchair and it should not be touching the ground. The tubing should be looped and in the bag clipped up under the wheelchair and when in the bed the tubing should be clipped and secured so it does not touch the ground.</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>On 07/18/24 07:58 AM Staff E, Licensed Practical Nurse (LPN) stated for a Foley catheter the tubing should be twisted up and off the floor and the bag should be off the floor. The tubing should never be kinked and kept below the bladder with the dignity bag covering it and make sure the tubing is off the floor.</p> <p>On 07/18/24 at 8:02 AM the Director of Nursing stated she would expect the Foley catheter bag to be kept inside the dignity bag unless they are in bed. The tubing should be off the ground and the tubing should be coiled up and in the dignity bag. When they are in bed laying down it should be beside down them and off the ground.</p> <p>The facility provided a policy titled Emptying a Urinary Drainage Bag with a revised date October 2010 which directed staff to keep the drainage bag and tubing off the floor at all times to prevent contamination and damage.</p> <p>49976</p> <p>2. In an observation on 7/17/24 from 8:32-8:44 AM Staff D, Housekeeper wheeled laundry down the hall and began to distribute it. Only the top shelf of the cart was covered with a sheet. Personal items were exposed on the lower two shelves with resident names visible. This was observed again at 12:45 PM.</p> <p>In an observation on 7/17/24 at 9:42 AM Staff D wore gloves and failed to wear a gown when she took linens and Personal Protective Equipment (PPE) gowns from a bin and placed them in the washing machine.</p> <p>In an interview on 7/17/24 at 8:11 AM the Environmental Services Supervisor (ESS) explained laundry staff gown up just when washing items coming from isolation rooms.</p> <p>During an interview on 7/17/24 at 12:30 PM the ESS explained she was not aware gown and gloves must be worn for all dirty laundry. She was aware that the laundry cart needed to be completely covered when transporting clean linens.</p> <p>The policy titled Standard Precautions, revised September 2022 instructed staff: linen soiled with blood, body fluids, secretions, excretions are handled and processed in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments.</p> <p>The policy titled Laundry Management, dated 1/01/2021 instructed staff: clean linen must be transported from the laundry to the clinical area on a clean covered cart. The policy failed to indicate the need for a gown when handling all dirty linens.</p>		