

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165575	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Harmony Utica Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 Commerce Blvd Davenport, IA 52807	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855</p> <p>Based on observation, clinical record review and staff interview, the facility failed to implement infection control standards during wound care. After providing wound care, nursing staff did not remove an isolation gown prior to exiting a residents room to access a common medication cart drawer for supplies, and did not change gloves between wound care tasks for one of three residents observed (Resident #4). The facility reported a census of 84 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS), dated [DATE], diagnoses list included: obstructive uropathy (urine flow obstructed), septicemia (infection in blood), and non-Alzheimer's Dementia. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating a severe cognitive impairment. The MDS assessed Resident #4 dependent on staff for mobility, and transfers; and required substantial/maximal assistance with toileting, showers and repositioning. The MDS identified Resident #4 had one Stage II pressure ulcer, utilized an indwelling catheter, and incontinent of stool.</p> <p>The Care Plan, dated 5/21/24, included a Focus Area to address Risk for unavoidable alteration in skin integrity related to chronic neuropathy, unplanned weight loss, low albumin/protein, recent history of skin breakdown.</p> <p>A review of Physician Orders revealed the following wound care orders:</p> <ol style="list-style-type: none"> a. Wound Coccyx: Cleanse with NS (normal saline), apply calcium alginate w/(with) silver and cover with foam, every day shift. Start date 7/19/24. b. Wound Left Lateral Foot - unstageable - Cleanse with NS, apply calcium alginate w/silver to wound bed, cover with foam dressing every day shift for wound care. Start date 7/19/24. c. Wound Right big toe: Apply iodine topically, allow to dry. Leave OTA (open to air) every day shift for wound care. Start date 6/7/24. d. Wound Right heel wound: apply iodine, apply ABD (absorbent pad) and Kerlix dressing every day shift for wound care. Start date 6/20/24. e. Wound Right Lateral Foot: apply betadine topically, allow to dry. Cover with ABD/Kerlix every day shift for wound. Start date 6/20/24. <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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 10:25 AM, Staff M, NP removed isolation gown and gloves and washed hands before exiting the room.</p> <p>At 10:26 AM, Staff B, RN and Staff L, CNA removed isolation gowns and gloves and washed their hands before exiting the room.</p> <p>During an interview on 7/23/24 at 10:31 AM, Staff B, RN stated she should not have worn the isolation gown out to the hallway. She felt she did change her gloves appropriately between wounds.</p> <p>During an interview on 7/24/24 at 7:23 AM in an interview with Staff E, Licensed Practical Nurse (LPN) stated when completing wound care, she would change her gloves anytime they became soiled. Staff E stated after she entered a room to start wound care, and needed something from the medication cart in the hall, she would need to remove the isolation gown, gloves and wash her hands before leaving the room.</p> <p>During an interview on 7/24/24 at 9:34 AM, Staff G, RN stated when completing wound care, he would change his gloves anytime they became soiled. Staff G stated after entering a residents room to start wound care, and needed something from the medication cart in the hall, he would need to remove the isolation gown, gloves and wash his hands before leaving the room.</p> <p>During an interview on 7/24/24 at 1:23 PM, the Director of Nursing (DON) stated when completing wound care, she would expect the nurse to change her gloves anytime they became soiled. She added after a nurse entered a room to start wound care, and needed something from the medication cart in the hall, she would expect the nurse to remove the isolation gown, gloves and wash hands before leaving the room.</p> <p>A review of the facility policy titled: Dressing Change, dated as last revised November 2023 indicated the nurse should change gloves any time they become soiled, perform hand hygiene and don new gloves. After the dressing change is completed, the nurse should remove gloves and wash their hands.</p> <p>A review of the facility policy titled: Enhanced Barrier Precautions, dated as last revised March 2024 directed staff use Enhanced Barrier Precautions (gown and gloves) when providing care to residents with wound or indwelling medical device without secretions or excretions that are unable to be covered or contained are not known to be infected or colonized with any MDRO (Multi-Drug Resistant Organism).</p>		