

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Creekside		STREET ADDRESS, CITY, STATE, ZIP CODE 503 Wical Way Grundy Center, IA 50638	
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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff and resident interviews, policy review, and guidance from the Centers for Disease Control and Prevention (CDC), the facility failed to implement Enhanced Barrier Precautions (EBP) for 2 of 2 residents reviewed for infection control (Resident #2 and #40). Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated he received hemodialysis (mechanical process to remove wastes from the body, due to poor functioning kidneys) while a resident and upon admission. The Electronic Health Record (EHR) indicated Resident #40 had diagnoses of unspecified kidney failure and Stage 5 kidney disease. In addition, she had a surgical wound to her right anterior neck from a right jugular dialysis catheter (used for getting dialysis). The Care Plan initiated 7/27/20 indicated that Resident #40 refused EBP due to not wanting the extra clutter. The Electronic Treatment Administration Record (ETAR) indicated to maintain EBP for line cite and wounds every shift. The ETAR included documentation staff completed the task for all 3 shifts on 12/16/25. The Physician's Orders indicated that EBP for line site and wounds every shift was discontinued on 12/17/25. The Progress Notes indicated on 12/16/25 at 8:26 AM Staff C, Household Coordinator, documented Resident #40 requested to be removed from EBP. Staff C removed the precaution materials from the room. During an observation on 12/17/25 at 8:00 AM observed Resident #40 with an external catheter to right upper chest for hemodialysis. The room lacked a sign for EBP, or Personal Protective Equipment (PPE) supplies noted in their room. In an interview on 12/17/25 at 9:48 AM Staff D, Certified Nurse Assistant (CNA), stated Resident #40 is not in EBP but was last year sometime. She is independent in her room, so staff don't go in often to help her. In an interview on 12/17/25 at 10:10 AM Staff E, Licensed Practical Nurse (LPN), stated Resident #40 is not in EBP anymore as she signed a waiver not to have it anymore. She added Resident #40 would have the dialysis shunt for the rest of her life. (continued on next page)		

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/17/25 at 12:29 PM Staff F, Infection Preventionist (IP), stated EBP is not used for Resident #40 as her port is covered and they don't mess with it. Staff F added Resident #40 said she didn't want EBP and she signed something to not have EBP. Staff F added another resident, Resident #2, with a urinary catheter also declined EBP. In an interview on 12/18/25 at 9:09 AM Resident #40 stated the staff didn't use gowns when helping her. She added she recently signed something for the supplies to be removed from her room as they didn't wear them anyway. She denied that she did not like the clutter. In an interview on 12/17/25 at 1:30 PM the Director of Nursing (DON) stated that Resident #40 is not in EBP as they didn't want the precautions. The DON felt they had a right to refuse the precautions as they were to protect them and she had them sign a waiver. In a policy titled Transmission Based Precautions Isolation and PPE Use effective April 2019, lacked documentation about resident refusing EBP and signing a waiver. The Centers for Disease Control and Prevention (CDC) indicated document dated June 2021 titled Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities that skilled nursing facilities should consider EBP for residents with wounds or indwelling medical devices, regardless of Multi Drug Resistant Organisms (MDRO) colonization status or infection or colonization with an MDRO. In Quality and Safety Oversight (QSO)-22-08-NH, dated 3/20/24, the Centers for Medicare and Medicaid Services (CMS) indicated that in July 2022, the CDC released EBP recommendations and CMS is updating its infection prevention and control guidance accordingly. The new guidance related to EBP was being incorporated in F880 Infection Prevention and Control to assist LTC surveyors when evaluating the use of enhanced barrier precautions in nursing homes. Indwelling medical devices and wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. The expansion of EBP for all residents with wounds or indwelling medical devices is intended to protect these high-risk individuals both from acquisition and from serving as a source of transmission if they have already become colonized. 2. Resident #2's (MDS) dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS documented Resident #2 had an indwelling catheter (a thin flexible tube left inside the bladder to drain urine into a bag). Resident #2's Care Plan revised 10/16/25 documented the indwelling catheter with intervention of Resident #2 declining EBP and has signed a negotiated risk agreement. On 12/17/25 at 11:00 AM watched Staff B, CNA, emptied Resident #2's indwelling catheter. Staff B didn't wear a gown per EBP policy. In addition, Resident #2's room didn't have a EBP sign outside the door. On 12/17/25 at 11:10 AM Nurse A, LPN, verbalized EBP was not used per Resident #2's request for dignity and he signed a negotiated risk. On 12/18/25 at 9:15 AM Resident #2 verbalized he signed a form so staff wouldn't wear the gown.		