

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 165269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2020
NAME OF PROVIDER OF SUPPLIER CLEARVIEW HOME		STREET ADDRESS, CITY, STATE, ZIP 406 WEST WASHINGTON MOUNT AYR, IA 50854	
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	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, record review, and staff interview the facility failed to ensure staff washed their hands and changed their gloves in accordance with standard infection protocols for one of three residents observed (Resident #1). The facility census was 63 residents. According to the Minimum Data Set (MDS) assessment tool dated 6/19/20, Resident #1's had [DIAGNOSES REDACTED]. The MDS documented the resident displayed moderately impaired cognition and required assistance of one staff for bed mobility, transfers, and toilet use. The MDS revealed the resident exhibited both bowel and bladder incontinence. During an observation on 6/24/20 at 9:30 20 AM, Staff A, certified nursing assistant (C.N.A.), assisted Resident #1 to the restroom and told him to place his call light on when he was finished. When Resident #1 activated his call light, Staff A, Certified Nursing Assistant (CNA) knocked on the door, sanitized her hands, entered the room and knocked on the resident's bathroom door. Staff asked the resident if he was finished and Resident #12 replied yes. Staff A, donned gloves, assisted the resident to stand, cleansed the resident's bottom with wipes. Staff A then dispensed into the palm of their hand while still wearing a soiled glove and proceeded to rubbed the on the resident's bottom. Staff A removed their gloves, sanitized their hands, pulled up the resident's pants, assisted him back to his chair, gave resident his call light, opened his window and then washed their hands and left the room. In an interview conducted on 6/24/20 at 10:00 AM the DON verified after perineal care, staff should remove their gloves, wash their hands, and don new gloves prior to applying lotion to a resident's clean skin.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.