| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165225 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/25/2026 |
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| Centerville Specialty Care | 1208 East Cross Street , Centerville, Iowa, 52544 |

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| F0000<br>Ok ✓ Lg | INITIAL COMMENTS<br>Correction Date: 4/2/2026<br>The following deficiencies resulted from investigation of complaint 2706489-C conducted on March 23, 2026 to March 25, 2026.<br>See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F0000 | | ✓ 4/2/2026 |
| F0880<br>SS = D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or | F0880 | F0880 Infection Prevention & Control Nursing staff failed to perform hand hygiene between glove changes.<br>Plan of correction: Ensure proper hand hygiene with resident cares and nursing treatments as well as between glove changes.<br>How residents affected & residents with potential to be affected were identified: Residents who reside in Centerville Specialty Care.<br>Corrective action taken for residents affected: Education on the facility's Infection Prevention and Control Program, audits on Resident #1 and Resident #3.<br>Measures or systemic changes made to ensure this will not recur and affect others: Education provided and audits conducted.<br>Planned monitoring of corrective actions to ensure practice is corrected and will not occur: 3 audits weekly for 3 weeks and 2 audits weekly for 2 weeks. | |

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 reverse for further 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 ✓ |
|---|---|---|
| Jean Dawn | Administrator | 04-02-26 |

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| F0880 SS = D | Continued from page 1<br>infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv) When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, clinical record review, review of facility policy, and staff interviews, the facility failed to ensure nursing staff performed hand hygiene between glove changes, and changed gloves between wounds to prevent cross contamination of wounds for 2 of 2 residents observed for wound care treatment (Resident #1 and #3). The facility reported a census of | F0880 | | |

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| F0880 SS = D | Continued from page 2<br>41 residents.<br><br>Findings include:<br>1. Review of the Minimum Data Set (MDS) assessment for Resident #1, dated 2/12/26, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 (intact cognition). The MDS documented the resident dependent on staff for Activities of Daily Living (ADLs, toileting, hygiene, bed mobility, transfers, dressing) with the exception of eating. The MDS included diagnoses congestive heart failure, diabetes, peripheral vascular disease and had 6 venous or arterial ulcers present.<br>Review of wound assessments, titled Skin and Wound, dated 3/19/26, revealed Resident #1 had open venous ulcer wounds to the right and left lateral (outer) calf.<br>Review of Clinical Physician Orders revealed the following orders:<br>An order, dated 2/3/26, LT (left) heel pain paint with Betadine (type of topical wound care solution).<br>An order, dated 3/3/26, to "cleanse ulcers to BLE (bilateral lower extremities) with Vashe Wound Cleanser. Apply Triad (type of topical wound paste) to Peri-Wound for MASD (moisture associated skin damage). Place Gelling Fiber with ATB (antibiotic) Silver Dressing to Wound Bed. Apply Super Absorbent Dressing Over, and wrap with Kerlix (type of roll gauze). May use Gelling Fiber Dressing without ATB Silver if ATB Silver not Available. (apply) every other day."<br><br>An order, dated 3/13/26, to apply Triad cream to ST (skin tear) on left shin daily with dressing change.<br><br>On 3/24/26 at 8:04 AM, Staff C, Registered Nurse (RN), entered the resident's room with her treatment cart. Staff G, Licensed Practical Nurse (LPN), entered in shortly after to assist Staff C with wound care on the resident's left and right calf venous ulcers. Staff C and Staff G, washed their hands, gowned and gloved. Staff G set up a clean field for wound care supplies on top of the treatment cart. Staff C removed the wound dressings, including the roll gauze dressing, superabsorb pads and Silver, from the right leg and then the left leg without changing gloves between legs. The dressing from the right leg wound had a large amount of bloody drainage, and both legs had open wounds. After removing the dressing from both legs, | F0880 | | |

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| F0880 SS = D | Continued from page 3<br>Staff C, RN, changed her gloves without performing any type of hand hygiene (either hand washing or use of an alcohol-based hand rub). Staff G, LPN, removed her gloves, washed her hands, and donned another pair of gloves. Staff C then poured the Vashe Wound Cleanser directly over the wounds on the right leg, and used a gauze pad to wipe over the wounds after the cleanser. Staff G cleaned the left leg. The disposable pad under the resident's right leg was noted to have a large amount of bloody drainage. Staff C, RN, removed her gloves, got Triad paste out of the treatment cart and put some in a medication cup. Staff C gloved without performing hand hygiene and applied Triad paste to the right lower extremity with the gloved fingers of her left hand. Staff C, RN, and Staff G, LPN, removed their gloves, washed their hands, and donned another pair of gloves. Staff C applied the Silver dressing, superabsorb dressing and then roll gauze to the right lower leg. Staff C, RN, then picked up the medication cup with Triad paste and dropped it on the floor. Staff C picked up the medication cup off the floor with her left hand, removed the glove from her left hand, got out more Triad paste from the cart, put a new glove on her left hand without performing hand hygiene, and applied Triad paste to the left lower leg with the fingers from her left hand. Staff C then applied Betadine to the left heel. Staff C removed her gloves and donned another pair of gloves without performing hand hygiene. Staff C applied the Silver dressing, superabsorb dressing and roll gauze to left lower leg.<br>2. Review of the Minimum Data Set (MDS) assessment for Resident #3, dated 2/18/26, revealed a Brief Interview<br>for Mental Status (BIMS) score of 15 out of 15 (intact cognition). The MDS documented the resident dependent on staff for Activities of Daily Living (ADLs, toileting, hygiene, bed mobility, transfers, dressing) with the exception of eating. The MDS included diagnoses of diabetes and morbid obesity, had moisture associated skin damage (MASD) and received topical medicated treatment and nonsurgical wound dressings.<br>Review of a wound assessment, titled Skin and Wound, dated 3/19/26, revealed an open MASD wound to the right Illac crest (right front pelvic area located under the resident's abdominal fold) that measured 0.25 centimeters (cm) in length, 2.09 cm in width and 0.1 cm in depth.<br>Review of Clinical Physician Orders, dated 3/12/26, revealed an order for Triad Hydrophilic Wound Dress External Paste (wound dressings), apply to right ABD (abdominal) fold topically every day and evening shift | F0880 | | |

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| F0880 SS = D | Continued from page 4<br>for wound; and, revealed an order, dated 3/19/26, for Interdry (a fabric-like dressing used to moisture-related wounds) to abdominal folds, change on shower days and PRN (as needed) if soiled or missing.<br>On 3/24/26 at 2:00 PM, during an observation, Staff C, Registered Nurse (RN), put some Triad paste into a medication cup and took the cup to Resident #3's room. Staff D, CNA, entered into the room to assist Staff C, RN. Staff C placed the medication cup on the resident's night stand. Staff C washed her hands and gloved. Staff C then pulled down the resident's incontinent brief and pulled up the resident's stomach. The resident had two open areas, one wound on the right side of the abdominal fold and one on the left side. Both wounds had a red wound bed, and the right wound was larger than the wound on the left. Staff C got a wet wash cloth with a small amount of hand soap, wiped the wounds on the right and left side two times with the wash cloth, and then patted the area dry with a hand towel. Staff C removed her gloves and donned another pair of gloves without performing hand hygiene between glove changes. Staff C applied Triad cream to both open wounds with the same fingers of her left hand. Staff C then removed her gloves and washed her hands.<br>On 3/24/26 at 2:12 PM, during an interview, Staff C, RN, reported for wound care staff needed to wash their hands, don gloves and work from "dirty" (soiled) to clean. Staff C reported if she changed gloves during wound care, she should perform hand hygiene between glove changes. Staff C explained that if her hands were visibly soiled, then she needed to wash her hands; otherwise, she could either wash her hands or use an alcohol-based hand sanitizer. Staff C reported that if she was providing wound care to two different wounds, she didn't want to cross contaminate between the wounds, so she would change her gloves between wounds. Staff C explained that she should change her gloves and perform hand hygiene when going from dirty (removing soiled dressing) to clean (cleaning a wound and applying medication/dressing).<br>On 3/24/26 at 3:39 PM, during an interview, Staff E, RN, reported when she performed wound care on a resident with more than one wound, such as Resident #1, she did wound care to one leg at a time to prevent cross contamination between wounds. Staff E reported she changed her gloves after removing the wound dressing and after cleaning the wound. She performed hand hygiene between glove changes.<br>On 3/25/26 at 10:51 AM, during an interview, Staff G, LPN, reported when she performed wound care on Resident | F0880 | | |

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| F0880 SS = D | Continued from page 5<br>#1, she removed the soiled dressings from both legs, or "whatever the policy is". Staff G explained she changed her gloves after removing the soiled dressings and performed hand hygiene with each glove change. Staff G reported she cleaned the wounds on one leg, changed gloves, applied the treatment on that same leg, and then changed gloves before cleaning and treating the other leg.<br><br>On 3/25/26 at 2:46 PM, during an interview, the Infection Preventionist (IP) reported staff should wash their hands and don gloves prior to removing soiled wound dressings, then wash their hands and don gloves prior to cleaning wounds. After cleaning wounds, staff should wash their hands and don gloves before applying treatment. The IP reported that she would do wound treatment on one leg at a time in relation to wound care for Resident #1, and then change gloves with hand hygiene prior to moving onto the other leg.<br><br>On 3/25/26 at 3:02 PM, during an interview, the Director of Nursing (DON), reported if a nurse was changing a soiled dressing on a resident with two wounds, the nurse should get new gloves before changing the soiled dressing on the second wound. Nursing staff should perform hand hygiene between glove changes.<br><br>Review of the facility policy, titled Handwashing/Hand Hygiene, dated August 2019, revealed, in part, staff should perform hand hygiene before handling clean or soiled dressings, after contact with blood or bodily fluids, after handling used dressings and after removing gloves. | F0880 | | |