STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165585	A. BUILDING _____ B. WING _____	05/15/2020

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PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER	2002 CEDAR STREET MUSCATINE, IA 52761

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F 000	INITIAL COMMENTS Correction Date: 5-16-2020 The following information is related to the investigation of Complaints #90781, #91002 and #91107 conducted April 28-May 15, 2020, all three complaints were substantiated. (See Code of Federal Regulation (42CFR), Part 483, Subpart B-C):	F 000		
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations, the facility failed to notify the resident's physician and family member of a change in condition, failed to transfer a resident exhibiting fever and respiratory symptoms to the emergency room according to the physician's order for 4 of 8 open sampled residents (Resident #1, #2, #3,#4). The facility reported a census of 67 residents. Findings include: 1. According to the Quarterly Minimum Data (MDS) dated 2/22/20 Resident #1 documented with diagnoses including heart failure, renal	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kerri R Menke | TITLE: Administrator | (X6) DATE: 6-4-2020

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.

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F 684	Continued From page 1 failure, stroke, fractures of the foot, seizure disorder, depression, chronic obstructive pulmonary disease and severe morbid obesity. The resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating intact cognitive ability. The resident required extensive assistance of 2 staff for bed mobility, transfers and required extensive assistance of 1 staff for dressing, toilet use and hygiene, the resident did not walk in her room or hall and used a wheelchair to move about the facility. The MDS revealed the resident did not have a history of rejection of cares or assessments, did not experience shortness of breath and did not utilize supplemental oxygen. Review of Resident #1's Care Plan dated 2/17/20 identified the resident with chronic obstructive pulmonary disease and used an as needed (prn) inhaler and nebulizer and directed the staff to administer the inhaler as ordered and to monitor for side effects and effectiveness. The Care Plan dated 3/26/20 revealed the resident with an increased risk of potential infection related to the COVID-19 viral outbreak and directed the staff to assist with family communication related to visitor restrictions; assess the resident's temperature and assess for signs of respiratory illness and report abnormal findings to the primary care physician for further treatment and care. The Care Plan failed to indicate the resident utilized supplemental oxygen. Review of the Order Recap Report dated 3/1/20-5/4/20 revealed the resident had the following orders: a. An order for staff to perform cardio pulmonary resuscitation (CPR) per resident's request on 12/27/2018, ordered by the resident's Primary	F 684		

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F 684	Continued From page 2 Care Physician (PCP). b. An order for staff to perform a COVID-19 swab due to possible exposure ordered by the Medical Director on 4/28/20. c. An order for a catheter urine specimen for general malaise, fever and foul smelling urine on 4/28/20 by the Medical Director. d. An order for a urine culture from the urine collected previous day on 4/28/20 by PCP. e. An order given on 4/28/20 by the Medical Director directed staff to exhaust all in house options prior to transferring to the Emergency Room as long as the resident is stable as per resident and Power of Attorney wishes. f. An order on 4/29/20 given due to the current decline in the resident's health which could be COVID-19 related, please monitor for decreased oxygen saturation. If the resident's oxygen saturation goes below 90% per current 4 Liters/Nasal Cannula, transfer the resident to a local Emergency Room (ER), order given by the PCP. Review of the Physician's Orders from 3/1-4/29/20 failed to indicate the resident had an order for the administration of oxygen. Review of the April 2020 Medication Administration Record and Treatment Administration Record failed to include an order for supplemental oxygen and evidence of administration of supplemental oxygen. Observation on 4/29/20 at 12:48 a.m. revealed Staff A, Licensed Practical Nurse (LPN) at there Station 2 Nursing Station, Staff A stated Resident #1 is running a temperature of 101.2 and had a temperature all day. Surveyor inquired what the resident's oxygen saturation status, the nurse	F 684		

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F 684	Continued From page 3 stated she did not know as she has not assessed her yet. Staff A and Surveyor went into resident room to measure oxygen saturation. Resident #1 noted to be in bed, with head of bed up, oxygen running at 4 liters per nasal cannula. The resident appeared flushed and Foley catheter draining dark amber urine. Oxygen saturation noted to be 91% on 4 liters of oxygen at this time. During an interview with Staff A, LPN, the staff stated at report; which began at start of her shift at 6:00 p.m. she heard the Primary Care Physician requested the resident be sent to the ER today but indicated it is the Facility Policy to try to keep all the residents in the facility and reported staff obtained a culture for COVID-19 today. Observations at this time, the resident on Station 2 noted in her original room along with a roommate. The resident does not appear to be in any type of isolation as evidenced by no sign posted or isolation equipment noted in or outside the resident room. Staff A entered the resident's room with only a face mask and shield on. Review of Resident #1's temperature, oxygen saturation level and respiratory assessment log revealed the following: a. On 4/23/20 day shift, Resident #1 had a temperature of 99.3, oxygen saturation of 99% and rubs (abnormal sounds) in her lungs. b. On 4/23/20 evening shift, the resident had a temperature of 97.3, oxygen saturation of 89% with expiratory wheezes. c. On 4/24/20 day shift, the resident had temperature of 96.9, oxygen saturation of 84% with diminished lung sounds. d. On 4/24/20 evening shift, the resident had a temperature of 99.8, oxygen saturation of 79% with diminished lung sounds.	F 684		

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F 684	Continued From page 4 e. On 4/25/20 day shift, the resident had a temperature of 99.3, oxygen saturation of 83% with diminished lung sounds. f. On 4/25/20 evening shift, the resident had a temperature of 98.6, and oxygen saturation of 78%, the staff failed to assessed the lung sounds. g. On 4/26/20 day shift, the resident had a temperature of 97.7, oxygen saturation of 86% with diminished lung sounds. h. On 4/26/20 evening shift, the facility staff failed to assess the resident. i. On 4/27/20 day shift, the resident had a temperature of 99.5, oxygen saturation of 84% with diminished lung sounds. j. On 4/27/20 evening shift, the resident had a temperature of 96.7, oxygen saturation of 92% with diminished lung sounds. k. On 4/28/20 day shift, the resident had a temperature of 101.6, the staff failed to assess the oxygen saturation and lung sounds. l. On 4/28/20 evening shift, the resident had a temperature of 100.0, oxygen saturation of 90% and diminished lung sounds. m. On 4/29/20 day shift, the resident had a temperature of 100.2, oxygen saturation of 86% and diminished lung sounds. n. On 4/29/20 evening shift, the resident had a temperature of 103.1 and 101.7, oxygen saturation of 93% with diminished lung sounds. o. On 4/30/20 day shift, the resident had a temperature of 100.3, oxygen saturation of 83% and lung sounds not assessed. Review of the Progress Notes dated 4/23-4/28/20 revealed the facility failed to notify the physician of condition changes; oxygen saturations ranging from 78%-90% eight times and failed to report to the physician temps ranging from 99.3 -101.6 six times.	F 684		

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F 684	Continued From page 5 Review of the Progress Notes dated from 4/23-4/27/20 revealed the staff failed to document on Resident #1 on 4/24, 4/25 and 4/26/20 even though the resident utilized oxygen, had low oxygen saturation levels and elevated temperatures. Review of a Progress Note written by Staff B, LPN on 4/28/20 at 1:34 p.m., the Progress Note indicated he received a phone call from Resident #1's Primary Care Physician's (PCP) Nurse directing the staff to send the resident to a local ER due to displaying COVID-19 symptoms. The PCP's Nurse stated the resident's oxygen level 85% on 3 liters of oxygen delivered per nasal cannula and a temperature of 101.5. Staff B indicated he would relay the information to the facility Director of Nurses (DON) and Assistant Director of Nurses (ADON). Staff B charted he took all information to the ADON who stated she would take care of it. During an interview with Staff B, LPN on 5/5/20 at 1:03 p.m., the Staff Nurse stated he was not assigned to Resident #1 on Station 2 but answered the telephone on 4/28/20. Staff B stated the PCP's Nurse for Resident #1 wanted him to transfer the resident to the ER but told the PCP's Nurse he did not have the authority to do this but he will give information to the DON/ADON who does have that authority. Staff B stated there is a Facility Policy that all transfer decisions have to go through the DON and ADON. The DON/ADON will then text the Medical Director to get permission for the transfer, he will indicate if they can be transferred even if the resident is not his patient. Staff B relayed transfer info to the ADON at this time and he shared she	F 684		

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F 684	Continued From page 6 immediately said "NO" and told Staff B we are doing everything we can in the building and stated she would take care of this. During an interview with Staff C, ADON/Infection Control Nurse on 4/29/20 at 1:00 a.m., Staff C stated she tested all residents today for COVID-19, her corporation sent test kits for all residents and she obtained the orders from the Medical Director to test all residents. Staff C stated on 4/28/20 she received a message from Resident #1 PCP and the PCP's Nurse they wanted to speak to her, Staff C stated they thought I should stop doing COVID testing to speak to them. She indicated she received orders for Resident #1 to discontinue the CPAP/inhalation nebulizer due to the potential spread of the Corona Virus and initiated hand held puff inhalers in the place of nebulizer treatments. Staff C stated Staff B, LPN took a call and reported Resident #1's PCP wanted the resident sent out to the ER as she had symptoms of COVID-19 and is a full code. Staff C, ADON had Staff F, Registered Nurse (RN)/ Agency Nurse complete a COVID assessment on Resident #1 on 4/28/20. Staff C reviewed the assessment and decided Resident #1 did not meet the criteria to be transferred for COVID-19. The ADON stated she was on the phone with the facility Medical Director multiple times 4/28/20, he directed the facility to follow their policy to keep all residents in the facility and not to send out to ER if you can help it. Staff C stated she received a phone call from Resident #1's PCP inquiring why they failed to send Resident #1 to the ER as ordered earlier in the day. Staff C stated when the PCP called I would have thought if she wanted the resident sent to the Emergency Room she would have said it again, but she didn't. Staff C	F 684		

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F 684	Continued From page 7 told the PCP they had 3 nurses assess Resident #1 for COVID and they all felt she did not meet the criteria to transfer to the ER. Staff C again stated the facility Medical Director directed her to treat the resident in the facility. Staff C, ADON said they do not have any COVID-19 in the building and we want to keep it that way and would isolate the residents immediately if they suspected anyone had COVID-19. Staff C did state they have had 2 staff members that recently tested positive for COVID-19 virus. During an interview on 5/3/10 at 8:41 a.m. with the facilities' Medical Director, the Medical Director stated he does not remember getting a phone call from the facility on 4/28/20 regarding Resident #1. The Medical Director stated Resident #1 is not my patient and I would never give an order to contradict another Physician's Order. Review of an order dated 4/28/20 at 5:15 p.m., the order written stated to exhaust all in house options prior to transferring as long as resident is stable as per the resident's wishes. The Medical Director stated this was a general policy they developed as result of the COVID-19, but it did not indicate not to transfer a resident, especially a resident of another physician Review of the hand written COVID-19 Assessment Form dated 4/28/20 (the form did not include the time of assessment). Staff F, Agency RN indicated the resident requested CPR, had temperatures of 101.6 and 101.5, oxygen saturation level 92% on 3 liters of oxygen, had diminished lung sounds with wheezing, and both yes/no boxes related to shortness of breath checked. The 2nd page of the COVID-19 Assessment Information Form indicated the resident had a temperature with an onset date of	F 684		

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F 684	Continued From page 8 4/27/20 but no other symptoms noted. During an interview with Staff G, DON on 5/4/20 at 9:12 a.m., Staff G stated when she came to work on 4/28/20 she was told they had to place supplemental oxygen on Resident #1 because her oxygen saturation level is low at 88%. Around noon on 4/28/20 the DON spoke to Resident #1, she denied all complaints of shortness of breath, cough, sore throat but her urine had a strong odor. The Agency Nurse working with Resident #1 called earlier in shift to obtain order for an urinalysis (UA) and change in the resident's nebulizer orders. At approximately 1:00 p.m. the DON spoke to the resident again to inquire how she was feeling. The DON assessed the resident her lungs were clear, oxygen saturation at 90%. The DON stated the resident refused to go to the ER on that day and time. The DON stated the nurse working with Resident #1 that day shift stated she felt the symptoms the resident experienced not respiratory related. The DON stated she spoke to the Medical Director on 4/28/20 between 4:30-5:00 PM, told him resident refusing to go to ER because she didn't feel ill. The DON stated she did not receive any information regarding the PCP contacting the facility to inquire why the resident didn't' go to the ER. The DON stated if the nurses had an order to transfer the resident to the ER they should have transferred her. The DON stated on 4/28/20 they tested all residents for COVID-19 and at this time they had at least 20 positive cases of COVID-19 and still more results coming in. The DON stated Resident #1 transferred to a local ER on 4/30/20 and then transferred to a larger hospital that same day due to oxygen needs. Review of Resident #1's Progress Notes revealed	F 684		

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a note entered by Staff G, DON on 4/29/20 (late entry) the note stated Resident #1 refused to go to the ER on 4/28.20.

During an interview with Resident #1 on 5/4/20 at 1:53 p.m., the resident stated she is feeling better. Asked the resident if she told the facility staff that she didn't' want to go to the hospital, the resident stated she could not remember but stated she doubts she said that because she wants all measures done to save her life.

During an interview with Staff F, RN/Agency Nurse on 5/7/20 at 7:39 a.m., Staff F stated she worked on 4/27/20 and 4/28/20- day shift. On 4/28/20 the staff completed COVID-19 swabs on all the residents. Resident #1 had a temperature the day before but didn't complain of a cough on 4/28/20. Staff F stated she received a phone call from the PCP's nurse on 4/28/20 directing her to place Resident #1 in droplet isolation and to move her away from the roommate. Staff F stated she relayed these orders to the ADON who informed her they were only taking orders from the Medical Director. Staff F stated sometime later in the shift she received a phone call from Resident #1's PCP, the PCP was angry because they had give specific orders for Resident #1 to be transferred to the ER. Staff F stated the order came in while she was off grounds for her lunch time and didn't know about it. Staff F spoke to the ADON regarding the phone call from the PCP, the ADON informed Staff F they are not sending anyone out. Staff F stated she charted 3 times in Resident #1's clinical record on 4/28/20 day shift: a focused assessment, a conversation with Resident #1 regarding her code status with the resident's response and the phone call from the PCP questioning why the resident not transferred

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to the ER. Staff F informed upon review of those notes, the entries spoken of were not found in the progress notes dated 4/28/20, she stated again I wrote those three things in the progress notes, I don't know what happened to them.

Review of the Progress Notes on 4/28/20 day shift did not contain any progress notes written by Staff F, RN Agency nurse.

During an interview with Staff D, LPN on 5/5/20 at 1:22 p.m., Staff D stated she worked with Resident #1 on 4/29/20, the resident had a temperature of 100.2 and required 4 liters of oxygen to keep her oxygen saturation at 93%. Staff D stated the resident did not utilize oxygen prior to running the abnormal temperatures. The nurse stated later in her shift she received orders for a repeat urinalysis, an antibiotic and the PCP stated the resident could possibly be COVID positive and to send to a local ER if the resident's oxygen saturation level goes below 90% on 4 liters of oxygen.

Review of a Progress Note dated 4/30/20 at 5:44 a.m., Staff E, LPN sent a fax to the PCP informing them Resident #1 with a temperature of 101.7 and administered medication to lower the temperature.

Review of a Progress Note dated 4/30/20 at 10:08 a.m. Staff D, LPN indicated Resident #1 with a temperature of 100.3 and an oxygen saturation level of 83% on 4 liters of oxygen and unable to raise the resident's oxygen saturation level. The nurse notified the PCP to inform and transferred the resident to a local Emergency Room.

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F 684	Continued From page 11 Review of a SARS-C0V-2 (COVID-19) test results revealed the staff collected the specimen on 4/28/20 and the lab reported back on 4/29/20 that Resident #1 tested positive for COVID-19. Review of a fax to Resident #1's PCP dated 4/30/20 at 7:00 a.m. revealed the resident tested positive for COVID-19 and they gave the resident medication to treat a temperature of 101.7. Review of a typed Condition Report dated 4/28/20 from Resident #1's PCP. The notes revealed the office's Physician's Assistance (PA)became aware of Resident #1's change of condition on this day, the resident had oxygen saturation of 85 % on 3 liters of oxygen, has a temperature over 101 and is requiring increased oxygen. The PA informed the PCP the resident began showing signs of illness since 4/23/20 but the record lacked documentation from 4/23-4/27/20. The PA gave an order to transfer the resident to a local ER on 4/28/20 but the staff failed to transfer the resident per order given. The PCP stated as of 5:00 p.m. on 4/28/20 the staff had not transferred the resident to the ER per orders. The PCP contacted the resident's nurse, the nurse reported the resident is stable and that the ADON and DON did not feel it appropriate to transfer the resident as they felt the resident was stable. The PCP again contacted the facility at 7:30 p.m., another nurse working reported the resident is now on 4 liters of oxygen, temperature 100.0 and oxygen saturation 92%. and 6 other residents are exhibiting increased temperatures. PCP spoke to the ADON who reported the entire building was swabbed for COVID-19 but only 1 resident had a temperature. The ADON reported to PCP the Medical Director has put into place protocols and does not want patients to leave the	F 684		

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facility for fear of contracting COVID from an outside exposure and respiratory protocol states only symptoms of shortness of breath, then the patient can leave the facility to go to the ER but only if using accessory muscles for breathing or if low oxygen saturations cannot be corrected with the application of oxygen. The ADON reported to the doctor the DON was responsible for not sending the Resident #1 to the ER as they are following the protocols as outlined by their medical director and felt the resident was stable in the facility and didn't need transferred to the ER. The PCP indicated she reviewed her concerns and feels they have multiple cases of COVID-19 in their building already.

During an interview with Resident #1's PCP on 4/29/20 at 8:50 a.m., the PCP stated her Physician's Assistant contacted the facility regarding 5 residents she was going to do telehealth visits on, the nurse working on the floor asked the PA if she was going to also see three other residents who were ill. The 3 ill residents included Resident #1. The PA and her nurse had the ability to read the resident's electronic Progress Notes and stated Resident #1 had symptoms of COVID 19. The PA called the facility and ordered Resident #1 to be sent to a local emergency room due to low oxygen saturations. The PCP stated she outlined the details of the incident in the Condition Update dated 4/28/20. The PCP stated she gave a directive to place Resident #1 into droplet isolation, send to the ER and swab for COVID-19 virus on 4/28/20, she said they did not follow thru on this order.

Review of COVID-19 Testing Conversation dated 4/29/20 written by the PCP's Office Nurse

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F 684	Continued From page 13 revealed on 4/28/20 at 11:40 a.m., she received a report from Staff F, Agency RN at this time, the facility RN reported Resident #1 is running a temperature of 100.2 and had low oxygen saturations since yesterday which required her to be placed on supplemental oxygen. The PCP's Nurse gave orders to the ADON to test for the COVID-19 virus, place the resident in droplet isolation, start Albuterol multi dose inhaler four times daily and discuss the code status and there patient's preference for intubation. At 1:39 p.m. the PCP's Nurse received an update report, the resident's temperature is 101.6, oxygen saturation is 75% on 2 liters of oxygen, when oxygen increased to 3 liters the oxygen saturation went to 85%. The PCP gave an order to transfer the resident to the ER to be evaluate due to Resident #1's high temperature and low oxygen levels. The order to transfer given to Staff B and he read back the order to her, which indicated he understood the order. The PCP directed staff to utilize an ambulance for the transfer and inform the ambulance staff the resident has symptoms of COVID-19. The PCP called the local ER to make them aware of the resident coming to the ER and COVID status. Review of the Conversation Notes revealed the PCP's Nurse called multiple times yesterday (4/28/20) to see why the patient not sent out to the ER, but did not receive a response. At 5:30 p.m. the Staff C, ADON replied to the PCP's Nurse that is was out of her hands and that this is for the DON. During an interview with the PCP's Nurse on 4/29/20 at 10:09 a.m., revealed she called the facility to only get vitals on the 5 residents she would be seeing for telehealth on 4/28/20. She was asked if she was going to see the additional 3 ill residents which included Resident #1. She	F 684		

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F 684	Continued From page 14 stated she could electronically view the vitals and Progress Notes and discovered the resident began to have symptoms on 4/24/20 but the staff failed to document anymore until 4/27/20. The staff informed the PCP's Nurse Resident #1 had an elevated temperature, oxygen saturation of 75% on 4 liters of oxygen, and the resident did not utilize supplemental oxygen prior to this illness. The PCP's Nurse ordered the resident to be tested for COVID-19 and to place the resident in droplet isolation as she has symptoms of COVID- 19. The PCP's Nurse stated she called the facility throughout the day to inquire why the staff did not send the resident to the ER. The PCP's Nurse gave orders for the resident to be placed in droplet isolation and to have a COVID swab completed at a local lab. These orders were not followed. Review of the Emergency Room records for Resident #1 on 4/30/20 revealed the staff transferred the resident to the ER for COVID-19 symptoms and low oxygen levels. The resident tested positive for COVID and she is a resident at a local nursing home facility where there is a concern for a COVID outbreak. The resident complained of difficulty breathing and reports having a cough when arriving to the ER. An x-ray report dated 4/30/20 revealed patchy airspace opacities at the left base, which may represent atelectasis or developing pneumonia and lab reports consistent with a viral infection. The resident required 5 liters of oxygen and had to be transferred to a larger hospital with a diagnosis of acute respiratory failure with hypoxia (low oxygen levels). Review of a Progress Note dated 5/5/20 revealed the resident returned to the facility.	F 684		

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F 684	Continued From page 15 Review of a COVID-19 Policy and Procedure dated 4/7/20 indicated the purpose of the policy is to identify and isolate symptomatic residents and prevent the potential contamination of facility population with Novel Coronaviris. The Policy directs the staff to assess the residents every shift for abnormal vital signs and noted respiratory symptoms. Should residents exhibit any of the following symptoms the facility shall initiate droplet isolation precautions for symptomatic residents and roommates if applicable. For symptoms which included: 1. A fever greater than 100.4. 2. A sore throat. 3. A cough. 4. Decreased oxygen saturation levels. 5. Difficulty breathing or painful respirations. 6. Fatigue, body aches, headache or any other flu-like symptoms. The Policy also directed nursing staff on th following: a. The facility shall notify the primary medical provider or their designee of symptoms. b. Residents will be placed into droplet isolation along with their roommate. c. Follow up testing shall occur per the order of the primary care physician. d. Residents and room mate will remain in droplet isolation precautions until tests are return with definitive diagnosis. e. Should the resident require transfer to hospital and is hospitalized the roommate will continue droplet isolation requisitions until tests are confirmed or 14 day isolation period has been completed with no noted symptoms of illness.	F 684		

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Review of an undated Physician Notification Policy directed the staff to respond in an appropriate and timely manner to acute changes in a resident's condition as indicated by the nursing staff and to ensure continuity of care. The Policy identified the types of conditions to notify the physician; altered mental status, chest pain, diarrhea, shortness of breath and vital sign changes. The policy described emergency situations as: chest pain, shortness of breath, vital signs as temperature over 101 and oxygen saturation below 90%.

2. According to the Minimum Data Set (MDS) dated 4/10/20 Resident #2 documented with diagnoses including renal failure, pneumonia, viral hepatitis, seizure disorder, anxiety, depression, chronic obstructive pulmonary disorder and respiratory failure. The MDS revealed the resident had a Brief Interview for Mental Status (MDS) score of 11 which meant the resident had intact cognitive ability. Resident #2 required limited assistance of 1 staff for transfers, walking in room, and needed extensive assistance of 1 staff for dressing, toilet use and personal hygiene. The resident noted to be continent of bowel and bladder, had shortness of breath with exertion and laying flat and received supplemental oxygen therapy.

Review of the undated Care Plan revealed the resident with a risk for falls due to non compliance with requesting assistance with transfers and not wearing oxygen as ordered. The Care Plan failed to inform staff how oxygen is administered and the amount prescribed.

Review of Resident #2's Progress Notes revealed

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F 684	Continued From page 17 the following: a. On 4/23/20 at 1:22 p.m., the staff noted a bruise on the resident's left shin and contacted the resident's physician. Oxygen saturation level noted as 91% on room air. b. On 4/24/20 at 6:09 a.m., the staff documented Resident #2 did not feel well, had a temperature of 99.2, oxygen saturation 90% on 1 liter of oxygen via nasal cannula and incontinent of urine. The staff contacted the Primary Care Physician (PCP) regarding the urinary incontinence and increased weakness. The PCP ordered an urinalysis and an antibiotic. c. On 4/25/20 at 2:00 a.m., there resident had a temperature of 100.2. d. On 4/25/.20 at 6:00 a.m., the nurse documented the resident utilized oxygen all night via face mask due to mouth breathing. e. On 4/25/20 at 12:25 p.m., noted upon entering the resident's room, the resident sat at side of bed, shaking, covered in a blanket. The resident's temperature 102.5, oxygen saturation level 82% on 3 liters of oxygen, unable to obtain a blood pressure due to the resident's constant involuntary movement. The resident reports chest discomfort which just started. The floor nurse notified Staff C, ADON per new facility policy. The ADON advised the staff nurse to await a call back, as she would authorize and obtain an order for an Emergency Room (ER) visit. f. On 4/25/20 at 12:40 p.m., Staff C, ADON received orders from the Medical Director for there resident to have IV fluids, Rocephin (antibiotic) IV, medication to lower the temperature and to insert a Foley catheter, give oxygen as needed to maintain oxygen saturations greater than 88% and to check oxygen saturations every shift. g. On 4/25/20 at 1:20 p.m., Staff C, ADON at	F 684		

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resident bedside, informed the resident of the new orders. The residents temperature at this time 99.4 and oxygen saturation 88% on 3 liters of oxygen per nasal cannula. Staff C reported gave Medical Director an update and he directed Staff C to continue with prior plan and try to avoid sending the resident to the ER and continue to treat the resident in house. Staff C notified the Charge Nurse of interventions in place and completed orders.

h. On 4/25/20 at 4:00 p.m., the resident had a temperature of 103.6 and oxygen saturation of 80% on 2 liters of oxygen per nasal cannula. The staff nurse made the Director of Nurses aware.

i. On 4/25/20 at 5:37 p.m., the resident remains restless, removing his oxygen, temperature 102.9 and oxygen saturation 86% on 3 liters of oxygen.

j. On 4/25/20 at 7:50 p.m., the resident had a temperature of 104.5, oxygen saturation 86% on 2/3 liters of oxygen, stated he cannot breath and a cough noted. Staff provided 1:1 with resident as he attempted to pull out Foley catheter and frequently removed his oxygen. The Staff Nurse contacted the management, the management advised the nurse to apply resident's BiPAP and to monitor. Staff C, ADON will notify the Medical Director and family.

k. On 4/25/20 at 8:05 p.m., the nurse notifies the family, family refused to allow transfer to the Emergency Room, family indicated resident only has urinary tract infection does not need to go to the ER.

l. On 4/25/20 at 11:51 p.m., the resident has a temperature of 104.5.

m. On 4/26/20 at 2:04 a.m., Staff C, ADON obtained an order for the resident to have Zofran every 6 hours as needed for nausea.

n. On 4/26/20 at 2:10 a.m., the resident had a green, bile emesis and Staff Nurse administered

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F 684	Continued From page 19 Zofran. The resident's oxygen saturation level 75-76% on 3 liters of oxygen and temperature 102.5. n. On 4/26/20 at 3:56 p.m., the resident has a temperature of 104.5. o. On 4/27/20, the resident has temperature of 100.3 at 3:30 a.m. and at 3:01 p.m. a temperature of 99.0. p. On 4/28/20, the staff obtained a nasal swab for COVID-19 ordered by the Medical Director due to heavy virus activity in the community. The DON documented at 5:05 p.m., the resident is asymptomatic and will monitor vital signs and respiratory assessments twice daily as a proactive measure. q. On 4/29/20, the resident had a temperature of 99.6 at 6:52 a.m. and at 9:43 a.m. temperature of 100.5. r. On 4/30/20, the resident appeared more confused at 1:43 a.m. and at 5:00 a.m. the nurse documented the resident ran a low grade fever all night, confusion continues and the resident had complaints of body aches and pains. s. On 4/30/20, the staff reported to the PCP the resident had a temperature of 101.0 and oxygen saturation level of 85% on 4 liters of oxygen. At 10:48 a.m. the staff received an order from the PCP to transfer the resident to the ER for COVID-19 and low oxygen saturation levels. Observation on 4/30/20 at 11:28 a.m., Resident #2 in bed, the Staff Nurse called 911 to transfer the resident to a local the ER. The resident is observed in bed, oxygen on via a non-re-breather mask, the Foley catheter is draining dark colored urine. The nurse gave a verbal report to Emergency Medical Staff (EMS) personnel, the resident is COVID-19 positive, oxygen saturation is 85% on 4 liters of oxygen and unable to be	F 684		

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stabilized. The resident has been running temperatures. The resident left the facility via ambulance at 11:32 a.m.

Review of local the ER notes dated 4/30/20 at 12:30 p.m., revealed Resident #2 arrived to the ER from a local nursing home for ongoing shortness of breath. The resident tested positive today for COVID-19. Today experienced low oxygen saturations into the 70% range and transferred to the ER. The resident stated he had difficulty breathing and has a cough. Upon arrival he had oxygen saturation of 78% on room air and placed on 6 liters of oxygen per nasal cannula then placed on 15 liters with non re-breather mask.

Review of SARS-CoV-2 (COVID-19) test result revealed the specimen obtained on 4/28/29 returned positive on 4/29/20.

During an interview with the Primary Care Physician (PCP) on 5/12/20 at 9:44 a.m., the PCP stated she was called by the facility on 4/23/20 and informed the resident began to experience increased urinary incontinence and staff requested a urine culture. On 4/24/20 the PCP got a text message from the facility wanting to know if she had time to review the results, the PCP started the resident on an antibiotic for a urinary tract infection and Staff C, ADON reported the resident is much better. The PCP stated she was not informed the resident had increased temperatures, low oxygen saturation levels stating if she would have known this information on 4/24/20 she would have ordered the resident to be placed in droplet isolation and transferred to the ER. The PCP stated she was on call the weekend of 4/25/20 and 4/26/20 and would have

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received the call from the facility. The PCP does not know why the facility called the Medical Director about her patient as she was available. The PCP stated she gave a directive to place Resident #2 into droplet isolation and to swab for COVID-19 virus on 4/28/20, she said they did not follow thru on this order.

During an interview with the PCP's Nurse on 5/12/20 at 8:13 a.m., the Nurse stated in regards to Resident #2, she was not aware the resident was ill until 4/28/20 when a Floor Nurse asked if the PCP planned to see Resident #2 that day as he was running a high temperature with low oxygen saturation levels. The PCP's Nurse stated the staff only informed their office of the urinary symptoms in earlier conversations on 4/23/20 and failed to mention the other symptoms. The PCP's nurse asked Staff C, ADON why they contacted the Medical Director instead of PCP, she indicated because it was a new policy to call there Medical Director on the weekend and after hours for all residents in the facility, even residents that are not on his case load. The PCP became first aware of the IV fluids and IV antibiotics ordered by the Medical Director after review of Resident #2's clinical record. .

During an interview with Staff G, Director of Nurses on 5/4/20 at 9:12 a.m., the DON stated Staff C, ADON directed Staff F, RN/Agency Nurse to complete the COVID-19 assessment. Review of the 4/28/20 COVID assessment, without a time on the form, indicated the resident had a oxygen saturation of 86% on 3 liters of oxygen via mask and expiratory wheezes and shortness of breath with temperatures 99.4 and 98.4 and the resident is a full code. The DON indicated the newly formulated COVID-19 policy

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F 684	Continued From page 22 directed the staff to complete vitals and respiratory status on each resident every shift. If a resident experiences adverse symptoms the Staff Nurse is required to contact administration prior to contacting the PCP. The administration will review the reason the staff feel they should call the PCP, the administration will then decide if the PCP can be called. During an interview with Staff E, LPN on 5/5/20 at 2:50 p.m., revealed on the evening of 4/25/20, she contacted the Nurse on call and gave an update on Resident #2's condition including increased temperatures and low oxygen saturation levels. The ADON informed her about the orders given by the Medical Director. Staff E stated she does not know why the ADON contacted the Medical Director as the Medical Director is not the resident's primary physician. Staff E sent a text to the ADON several times during her shift on 4/25/20 asking what do we do, he needs to go to the ER. Staff E stated she did not directly contact the resident's PCP because the ADON said she will take care of it. Staff E stated on 4/30/20 the resident remained in the same room with his roommate and no droplet isolation precautions in place. Review of a Conversation: COVID-19 Testing Form revealed a note dated 4/28/20 at 11:28 a.m., the PA-C's Nurse gave a verbal order to a Staff Nurse to place Resident #2 in droplet isolation, remove CPAP for the time being, discontinue nebulizer's and inhalers and start a Combivent inhaler, start Symbicort inhaler, test for COVID-19 and re-educate/discuss code status with patient as he is a full code. A note dated 4/28/20 at 9:39 p.m. revealed PA-C discussed the residents condition with the	F 684		

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F 684	Continued From page 23 supervising PCP and felt the resident had COVID dating back to 4/24/20. The PA-C stated on 4/24/20 the nursing home requested only a urinalysis and failed to mention any other symptoms and did not contact the PCP after 4/24/20. They did not have any further communication with the facility until 4/28/20 when the PCP's nurse called to get vitals on another resident and was asked by the floor nurse if the PCP would see Resident #2 as he is running a temperature. It is noted the resident continued to use the BiPAP on multiple occasions and Resident #2 had a room mate which is a concern for aerosolizing the virus. The Conversation Form dated 4/29/20 at 9:40 a.m. revealed the PCP did not get a call back regarding the resident's code status and attempted to reach out multiple times and never received an answer. Review of an undated Physician Notification Policy directed the staff to respond in an appropriate and timely manner to acute changes in a resident's condition as indicated by the nursing staff and to ensure continuity of care. The Policy identified the types of conditions to notify the physician such as; altered mental status, chest pain, diarrhea, shortness of breath and vital sign changes. The policy described emergency situations as: chest pain, shortness of breath, vital signs as temperature over 101 and oxygen saturation below 90%. Review of a COVID-19 Policy and Procedure dated 4/2/20 indicated the purpose of this Policy is to identity and isolate symptomatic residents and prevent the potential contamination of facility population with Novel Coronavirus. The Policy directed the staff to initiate droplet isolation precautions for symptomatic residents and	F 684		

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F 684	Continued From page 24 roommates. The Policy provided criteria to guide evaluation of persons under investigation for COVID-19 which included: for any patient meeting criteria for evaluation of COVID-19, clinicians are encouraged to contact and collaborate with their facility Medical Director and/or State and Local Health Departments. 3. According to the Minimum Data Set (MDS) dated 3/31/20 Resident #3 documented with diagnoses including heart failure, peripheral vascular disease, inflammatory bowel disease, renal failure, diabetes, anxiety and depression. The resident had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident had intact cognitive ability. The resident required limited assistance 2 staff for bed mobility and extensive assistance of 2 staff for transfers and extensive assistance of 1 staff for moving about the facility, dressing, toilet use and personal hygiene. The resident utilized a wheelchair for mobility and did not utilize supplemental oxygen therapy. Review of the undated Care Plan revealed a focus area that stated the resident is at risk for COVID-19 viral outbreak and directed staff to assist the resident with communication with family, assess the resident's temperature, monitor for signs of respiratory illness and report abnormal findings to the primary care provider for further treatment and care. Review of the Progress Notes revealed the following: a. On 4/28/20 at 4:42 p.m., the staff completed a nasal swab for COVID-19 per order of the Medical Director due to the heavy virus activity in	F 684		

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the community. The notes revealed the resident only symptom on this day is a fever.
b. On 4/28/20 at 11:59 p.m., a nurse obtained a sterile urine specimen and sent it to a local lab.
c. On 4/29/20 at 1:21 a.m., Staff C, ADON contacted the PCP to report preliminary urine results, at 1:19 p.m. the staff noted a cough.
d. On 4/30/20, facility received a call from the PCP with orders to re-swab the resident for COVID-19, to titrate oxygen to keep oxygen saturations over 94% and to let the PCP know how many liters the resident required to keep the oxygen levels stable at 94%.

Review of a hand written COVID-19 Assessment Form dated 4/28/20, noted the resident had temperatures of 101.4 and 101, oxygen saturation level of 93% on room air and complaining of a sore throat. The documenting nurse indicated the resident had oxygen levels below 90% until she repositioned the resident, the lungs sounds are course sounding.

During an interview with the PCP's Nurse on 4/29/20 at 10:09 a.m., the Nurse stated the staff told her Resident #3 has a high temperature, low oxygen saturations and a cough. The PCP ordered the resident to be placed in droplet isolation as he shown signs of COVID-19. The staff failed to follow this order.

Review of the April Medication/Treatment Administration record failed to indicate the resident utilized oxygen in April 2020.

Review of a Conversation COVID-19 Testing Form (Communication Form) dated 4/28/20, at 11:47 a.m., the PCP ordered the resident to be tested for COVID-19 and to place the resident in

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droplet isolation. At 1:12 p.m., the PCP's Nurse attempted multiple times to have a virtual visit with Resident #3 but staff failed to respond to this request. The resident had a temperature of 101.4, and oxygen saturation of 88% on room air. The PCP directed the nurse to administer oxygen at 1 liter per nasal cannula and to titrate to keep resident's oxygen saturation level over 94%. On 4/29/20 at 12:31 p.m., the PCP's Nurse called to get an update on the resident and notified of the negative COVID-19 test. The resident current with a temperature of 102, a non-productive cough, shortness of breath and a new order to retest the resident for COVID-19. A note in the Conversation Form dated 5/1/20 at 6:59 p.m. indicated the PCP spoke with Staff H, Nurse Consultant and gave orders to stop using the resident's CPAP for the time being, to utilize oxygen at 3 liters to maintain the residents oxygen saturation at 92% or above and to transfer to the ER if unable to keep oxygen saturations maintained at 92%.

Review of the Physician's Order Sheet dated 5/5/20, the physician directed staff to complete O2 saturation levels every shift, to keep O2 to maintain saturation levels equal to or greater than 92%, and if O2 requirements are greater than 3 liters via nasal cannula to maintain oxygen saturations above or equal to 92% call the PCP and notify resident is to be transferred due to Full Code status. Staff H, Nurse Consultant failed to write the order she received on 5/1/20 from the PCP until 5/5/20.

Review of the Station 2 Temperature Logs for Resident #3 revealed the following abnormal findings:
a. On 4/28/20 day shift, the resident had a

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F 684	Continued From page 27 temperature of 101.4 and oxygen saturations of 88%, failed to identify the amount of oxygen needed, 4/28/20 evening shift (6 p.m. to next am at 6 a.m.), the resident had a temperature of 99.5 and oxygen saturations of 90%. b. On 4/29/20 day shift, the resident had a temperature of 100.8 with a dry cough. c. On 4/30/20 day shift, the resident had a temperature of 102.0, oxygen saturation of 83-86%, staff indicted they increased the oxygen to 4 liters at 2:00 p.m. and the oxygen saturation rose to 93% on 4 liters of oxygen. d. On 5/1/20 evening shift, the resident had an oxygen saturation of 85% and blood pressure of 90/57. e. On 5/2/20, the resident had an oxygen saturation of 98% on 3.5 liters of oxygen. Review of the Progress Notes revealed the staff failed to follow the orders of 5/1/20 and failed to contact the resident's physician with the use of oxygen over 4 liters to maintain oxygen saturation on 5/1 and 5/2/20. Observation of Resident #3 on 4/30/20 at 11:45 a.m. revealed the resident in the same room. Staff D, LPN reported the resident continues to have an increased temperature and is a full code. Review of Resident #3's Temperature Logs indicated the resident had increased temperatures and low oxygen saturations from 4/28-5/2/20, the facility failed to notify the PCP. Review of the Progress Notes dated 5/7/20 at 4:33 a.m. Resident #3 transferred via ambulance to a local ER for low oxygen saturation and high temperature. The resident is COVID-19 positive.	F 684		

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Review of an undated Physician Notification Policy directed the staff to respond in an appropriate and timely manner to acute changes in a resident's condition as indicated by the nursing staff and to ensure continuity of care. The Policy identified the types of conditions to notify the physician such as; altered mental status, chest pain, diarrhea, shortness of breath and vital sign changes. The Policy described emergency situations as: chest pain, shortness of breath, vital signs as temperature over 101 and oxygen saturation below 90%.

4. According to the Minimum Data Set (MDS) dated 2/12/20 Resident #4 documented with diagnoses including cancer, Alzheimer's Disease, Non-Alzheimer's Dementia, anxiety and depression. The resident had a Brief Interview for Mental Status score of 5 which indicated severe cognitive ability. The resident required limited assistance of 1 staff for dressing, toilet use and personal hygiene. The resident had occasional urinary incontinence and frequent bowel incontinence. The resident did not experience shortness of breath and did not utilize supplemental oxygen therapy.

Review of the Care Plan dated 3/26/20 identified the resident with an increased risk for infection related to the COVID-19 viral outbreak. The Care Plan directed the staff to assess temperature and signs of respiratory illness and report abnormal findings to the primary care physician for further treatment and care.

Review of a Progress Note dated 5/7/20 at 2:28 p.m., Staff B, LPN informed by a Certified Nurse Aide (CNA) the resident's blood sugar was

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dropping. Staff B went into the resident's room where the ADON noted to be standing by the resident's bed. The ADON informed him the resident's oxygen saturation level was 64% on 3 liters of oxygen. Staff B noted this is a change from his normal.

Review of a Progress Note dated 5/7/20 at 5:23 p.m., Staff B, LPN back into the resident's room, the resident's head is at the foot of the bed, his skin is gray in color. The resident removed his supplemental oxygen cannula. His oxygen saturation level currently measured 89% without his oxygen.

Review of a Progress Note dated 5/8/20 at 4:47 a.m., the Night Nurse document the resident's skin is cool to the touch and resident is lethargic, he refuses to drink fluids even with assistance. The resident's respirations rate is 16 per minute but shallow, oxygen saturation level is 92%, oxygen is on.

Review of a Progress Note dated 5/8/20 written at 9:52 a.m., revealed the Day and Night Nurse entered the resident's room at 6:15 a.m. and found the resident without a pulse and unresponsive. The staff noted the resident recently tested positive for COVID-19 and had a significant decline in his physical status. The notes revealed they contacted the Medical Examiner, DON and the family.

During an interview with a family member of Resident #4 on 5/14/20 at 3:28 p.m., the family member stated they spoke to Staff B, LPN on 5/7/20 evening and told the family the resident is having a good night and did not mention any respiratory issues.

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The family member stated they received a phone call on 5/8/20 at approximately 10:00 a.m., Resident #4 passed away. The family stated if they knew he was not well they would have asked to have him sent to the ER or at least been given this option.

During an interview with Resident #4's Primary Care Physicians' Nurse on 5/14/20 at 3:45 p.m., the nurse indicated they did not have any idea the resident was having oxygen saturation issues. The last communication with the facility regarding his status was on 4/30/20 when they were made aware the resident tested positive for COVID-19. The PCP received a fax on 5/8/20 informing them the resident passed away. The physician did not get notification of low oxygen saturations or a change in the resident's condition. The nurse indicated the physician was upset over the lack of notification regarding his patient's condition and would have directed the staff to send him to the ER if agreeable with the family.

During an interview with Staff B, LPN, the staff worked the evening shift when the resident exhibited low oxygen saturations. Staff B stated he has absolutely no recollection of anything with Resident #4.

During an interview with Staff N, LPN on 5/14/20 at 4:50 p.m., Staff N arrived to work at 6:00 a.m. for her shift on 5/8/20, she stated shortly after being there an aide reported they think Resident #4 has passed away, they found the resident without breaths. Staff N notified the Funeral Home and the Medical Examiner but admitted she did not contact the resident's family until later in the morning. She stated she completed her

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F 684	Continued From page 31 nursing tasks so she would remain timely and admitted she should have called the resident's family right away. During an interview with Staff C, ADON on 5/14/20 at 4:40 p.m., Staff C stated she completed the resident's oxygen saturations the night of 5/7/20 and aware they were low. She alerted the resident's nurse. Staff C reviewed the resident's Progress Notes from the evening of 5/7/20 and verified the lack of physician and family notification. During an interview with Staff G, DON on 5/15/20 at 6:00 a.m. , the DON stated she was contacted between 6:30 a.m. and 7:00 a.m. with the death of Resident #4. She directed the staff to call the appropriate people and was not aware the nurse did not call the family right away. Staff G stated they should have called the resident's physician and contacted the family with the prior evenings low oxygen saturation levels to allow them to make appropriate decisions in regards to the resident's care. Review of a Family/Guardian Notification Policy dated 11/2019, the purpose of the Policy is to direct staff to notify the family or legal representative of changes in condition, injury and death in a timely manner to ensure transparency of communication. The Policy directed the staff to notify the resident representative of a change of condition injury or death. On May 5, 2020, the facility abated the Immediate Jeopardy. The facility provided education to the Nursing Staff on a new policy entitled Nursing Assessment of Residents During Respiratory Illness Outbreak/Pandemic dated 5/5/20. The	F 684		

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F 684	Continued From page 32 policy directed the Nursing Staff on appropriate documentation, surveillance of resident vitals, respiratory status and change in condition. The policy also instructed the Nursing Staff on notification and documentation requirements for all changes of a resident's condition to the Primary Care Physician (PCP), family and facility staff. At the time of exit, the scope and severity was lowered to an E after verification of staff's implementation of their policies.	F 684		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility failed to obtain orders for the use of non-rebreather oxygen masks for 4 of 8 open sampled residents (Resident #2, #3, #7, #8). The facility reported a census of 67 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 4/10/20 Resident #2 documented with diagnoses including renal failure, pneumonia, viral hepatitis, seizure disorder, anxiety, depression, chronic obstructive pulmonary	F 695		

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disorder and respiratory failure. The MDS revealed the resident had a Brief Interview for Mental Status (MDS) score of 11 which meant the resident with intact cognitive ability. Resident #2 required limited assistance of 1 staff for transfers, walking in room, and needed extensive assistance of 1 staff for dressing, toilet use and personal hygiene. The resident noted to be continent of bowel and bladder, had shortness of breath with exertion and laying flat and received supplemental oxygen therapy.

Review of the undated Care Plan revealed the resident had a risk for falls due to non compliance with requesting assistance with transfers and not wearing oxygen as ordered. The Care Plan failed to inform staff how oxygen is administered and the amount prescribed.

Observation on 4/30/20 at 11:28 a.m., Resident #2 in bed, the staff nurse called 911 to transfer the resident to a local Emergency Room (ER). The resident observed in bed, oxygen administered via a non-re-breather mask, the Foley catheter is draining dark colored urine. The nurse gave a verbal report to the Emergency Medical Staff (EMS) personnel, the resident is COVID-19 positive, oxygen saturation is 85% on 4 liters of oxygen, unable to be stabilized and running elevate temperatures. The resident left the facility via ambulance at 11:32 a.m.

Review of the the Physician's Orders from 4/8-4/30/20 failed to reveal an order for the use of a non-rebreather oxygen mask.

Review of a local ambulance run report dated 4/30/20 at 11:35 a.m., the report indicated EMS responded to a 911 call regarding the resident,

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F 695	Continued From page 34 upon arriving they were escorted to the residents' room, EMS noted upon arrival the staff placed a non rebreather mask with oxygen running at 15 liters on the resident. 2. According to the Minimum Data Set (MDS) dated 3/31/20 Resident #3 documented with diagnoses including heart failure, peripheral vascular disease, inflammatory bowel disease, renal failure, diabetes, anxiety and depression. The resident had a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident with intact cognitive ability. The resident required limited assistance 2 staff for bed mobility and extensive assistance of 2 staff for transfers and extensive assistance of 1 staff for moving about the facility, dressing, toilet use and personal hygiene. The resident utilized a wheelchair for mobility and did not utilize supplemental oxygen therapy. Review of the undated Care Plan revealed a focus area that stated the resident is at risk for COVID-19 viral outbreak and directed staff to assist the resident with communication with family, assess the resident's temperature, monitor for signs of respiratory illness and report abnormal findings to the primary care provider for further treatment and care. Review of the April Medication/Treatment Administration record failed to indicate the resident utilized oxygen in April 2020. Review of the Physician's Order sheet dated 5/5/20 the staff are directed to complete O2 saturation levels every shift, to use O2 to	F 695		

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F 695	Continued From page 35 maintain saturation levels equal to or greater than 92%, and if O2 requirements are greater than 3 liters via nasal cannula to maintain oxygen saturations above or equal to 92% call the Primary Care Physician (PCP) and notify as the resident is to be transferred due to Full Code status. Staff H, Nurse Consultant failed to write the order she received on 5/1/20 from the PCP until 5/5/20. Review of the Station 2 temperature logs for Resident #3 revealed the following abnormal findings: a. On 4/28/20 day shift, the resident had a temperature of 101.4 and oxygen saturations of 88%, failed to identify the amount of oxygen needed, 4/28/20 evening shift, (6 p.m. to the next am at 6 a.m.) the resident had a temperature of 99.5 and oxygen saturations of 90%. b. On 4/29/20 day shift, the resident had a temperature of 100.8 with a dry cough. c. On 4/30/20 day shift, the resident had a temperature of 102.0, oxygen saturation of 83-86%, staff indicted they increased the oxygen to 4 liters at 2:00 p.m. and the oxygen saturation rose to 93% on 4 liters of oxygen. d. On 5/1/20 evening shift, the resident had an oxygen saturation of 85% and blood pressure of 90/57. e. On 5/2/20 the resident had an oxygen saturation of 98% on 3.5 liters of oxygen. Review of the Progress Notes revealed the staff failed to follow the orders of 5/1/20 and failed to contact the resident's physician with the use of oxygen over 4 liters to maintain oxygen saturation on 5/1/20 and 5/2/20. Review of Physician's Orders from 4/21-5/15/20	F 695		

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F 695	Continued From page 36 the orders failed to include an order for a non-rebreather oxygen mask. Review of a local ambulance run report dated 5/7/20 at 5:22 a.m., the run report revealed when EMS arrived to the facility the staff escorted them to Resident #3's room. EMS found the resident in bed with a non re-breather mask on, oxygen administered at 4 liters. EMS increased the resident's oxygen to 10 liters with the non rebreather mask and the resident's oxygen saturation level rose to 96%. 3. According to the Minimum Data Set (MDS) dated 4/1/20 Resident #7 documented with diagnosis including Alzheimer's Disease. The resident had a BIMS score of 4 which indicated severe cognitive ability, and required extensive help of 2 staff for transfers, bed mobility, dressing, toilet use and personal hygiene. Review of the Care Plan failed to reveal the resident used supplemental oxygen therapy. Review of a Progress Note dated 4/28/20 indicated the staff completed a COVID-19 nasal swab and noted the resident does not have symptoms. The notes revealed the staff will monitor vital signs and respiratory status twice daily. On 5/6/20 at 2:02 p.m., the nurse noted a drop in the resident's oxygen saturation level to 78%, the supplemental oxygen increased to 4 liters, the staff place a non rebreather mask on the resident at this time. On 5/6/20 at 1:53 p.m., staff called 911 for continued low oxygen saturation levels and unresponsiveness. EMS took the resident to a local hospital then subsequently transferred to a larger hospital and	F 695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 37 placed on a ventilator. Review of a local ambulance run report dated 5/6/20 at 2:26 p.m., EMS indicated the staff reported placing a non-rebreather mask on the resident then bumped the oxygen up to 4 liters. Resident currently had an oxygen saturation level of 72%. Review of the Order Recap Sheet dated 4/28-5/5/20 revealed the resident did not have an order for a non rebreather mask. 4. According to the Minimum Data Set (MDS) dated 4/22/20 Resident #8 documented with diagnoses including heart arrhythmia, renal failure, pneumonia, diabetes, cerebral palsy, stoke, seizure and psychotic disorders. The staff required limited assistance of 1 staff for transfers, walking, dressing and extensive assistance of 1 staff for toilet use and personal hygiene. The MDS revealed the resident had a BIMS score of 12 which indicated intact cognitive ability. Review of the Care Plan failed to indicate the resident used supplemental oxygen therapy. Review of a local ambulance run report dated 5/4/20 at 9:36 p.m., the EMS stated when they arrived to the facility, the resident had on a non rebreather oxygen mask with 1 liter of oxygen running. Review of the Order Recap Summary dated 4/7-5/31/20 failed to include an order for the staff placed a non-rebreather mask on the resident. During an interview with Staff H, Nurse Consultant on 5/14/20 at 3:00 p.m., the staff	F 695		

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F 695	Continued From page 38	F 695		

stated they currently do not have any non-rebreather mask available in the building and do not have any residents with an order to use one. Staff H stated we do have an order into our supplier for more but they are on backorder. Staff H along with the Administrator stated there were only 2 residents that utilized the non-rebreather mask because they both developed a low oxygen saturation level and needed a high level of oxygen.

During an interview with Staff C, Assistant Director of Nursing (ADON) on 5/14/20 at 3:07 p.m., the staff stated they recently had 2 residents who used the non-rebreather masks. Staff C indicated the staff should have an order before applying the masks and said the amount of oxygen you would us with the non-rebreather is according to the Physician's Orders.

During an interview with Staff N, LPN on 5/15/20 at 11:35 a.m., Staff N stated she has not used a non-rebreather mask at the facility and does not know if you have to have a Physician's Order to use, she stated she has not had any training on the use of these types of masks.

During an interview with Staff A, LPN on 5/15/20 at 2:05 p.m., Staff A stated she has used a non-rebreather on residents at the facility, she didn't know if it required a Physician's Order and hasn't been trained on their use.

Review of an Administration of Oxygen Therapy Policy dated 5/12/19 and an Oxygen Use During COVID-19 Activity Period Policy dated 4/2/20 failed to address the use of a non-rebreather mask.

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F 880	Continued From page 39	F 880		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 40 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility failed to implement effective infection control measures in attempts to mitigate the transmission of the COVID-19 virus amongst their residents and failed to follow Physician's Orders to place 3 of 3 COVID-19 symptomatic residents into droplet isolation (Residents #1, #2, #3). The facility reported a census of 67.	F 880		

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F 880	Continued From page 41 Findings include: 1. According to the Quarterly Minimum Data (MDS) dated 2/22/20 Resident #1 documented with diagnoses including heart failure, renal failure, stroke, fractures of the foot, seizure disorder, depression, chronic obstructive pulmonary disease and severe morbid obesity. The resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated intact cognitive ability. Review of Resident #1's Care Plan dated 3/26/20 revealed the resident with an increased risk of potential infection related to the COVID-19 viral outbreak and directed the staff to assist with family communication related to visitor restrictions; assess the resident's temperature and assess for signs of respiratory illness and report abnormal findings to my primary care physician for further treatment and care. Review of the Order Recap Report dated 3/1/20-5/4/20 revealed the resident had the following orders: a. An order for staff to perform a COVID-19 swab due to possible exposure, ordered by the Medical Director on 4/28/20. b. On order on 4/29/20 due to the current decline in the resident's health which could be COVID-19 related, please monitor for decreased oxygen saturation. If the resident's oxygen saturation goes below 90% per current 4 Liters/nasal cannula transfer the resident to a local Emergency Room (ER), order given by the Primary Care Physician (PCP). Observation on 4/29/20 at 12:48 a.m. revealed	F 880		

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F 880	Continued From page 42 Staff A, Registered Nurse (RN), at Station 2 Nursing Station, Staff A stated Resident #1 is running a temperature of 101.2 and had a temperature all day. Surveyor inquired what the resident's oxygen saturation status, the nurse stated she did not know as she has not assessed her yet. Staff A and Surveyor went into resident room to measure oxygen saturation. The resident in bed next to window. Staff A reported Resident #1 tested for COVID-19 today. Observations at this time, the resident on Station 2 in her original room along with a roommate. The resident does not appear to be in any type of isolation as evidenced by no sign or isolation equipment noted in or outside the resident room. Staff A entered the resident's room with only a face mask and shield on. Review of Resident #1's temperature, oxygen saturation level and respiratory assessment log revealed the following: a. On 4/23/20 day shift, Resident #1 had a temperature of 99.3, oxygen saturation of 99% and rubs in her lungs. b. On 4/23/20 evening shift, the resident had a temperature of 97.3, oxygen saturation of 89% with expiratory wheezes. c. On 4/24/20 day shift, the resident had temperature of 96.9, oxygen saturation of 84% with diminished lung sounds. d. On 4/24/20 evening shift, the resident had a temperature of 99.8, oxygen saturation of 79% with diminished lung sounds. e. On 4/25/20 day shift, the resident had a temperature of 99.3, oxygen saturation of 83% with diminished lung sounds. f. On 4/25/20 evening shift, the resident had a temperature of 98.6, and oxygen saturation of 78%, the staff failed to assessed the lung sounds.	F 880		

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F 880	Continued From page 43 g. On 4/26/20 day shift, the resident had a temperature of 97.7, oxygen saturation of 86% with diminished lung sounds. h. On 2/26/20 evening shift, the facility staff failed to assess the resident. i. On 4/27/20 day shift, the resident had a temperature of 99.5, oxygen saturation of 84% with diminished lung sounds. j. On 4/27/20 evening shift, the resident had a temperature of 96.7, oxygen saturation of 92% with diminished lung sounds. k. On 4/28/20 day shift, the resident had a temperature of 101.6, the staff failed to assess the oxygen saturation and lung sounds. l. On 4/28/20 evening shift, the resident had a temperature of 100.0, oxygen saturation of 90% and diminished lung sounds. m. On 4/29/20 day shift, the resident had a temperature of 100.2, oxygen saturation of 86% and diminished lung sounds. n. On 4/29/20 evening shift, the resident had a temperature of 103.1 and 101.7, oxygen saturation of 93% with diminished lung sounds. o. On 4/30/20 day shift, the resident had a temperature of 100.3, oxygen saturation of 83% and lung sounds not assessed. During an interview with Staff C, Assistant Director Of Nursing (ADON)/Infection Control Nurse on 4/29/20 at 1:00 a.m., Staff C stated she tested all residents yesterday for COVID-19, her corporation sent test kits for all residents and she obtained the orders from the Medical Director to test all residents. Staff C stated Staff B, Licensed Practical Nurse took a call and reported Resident #1's PCP ordered the resident sent out to the ER as she had symptoms of COVID-19 and is a full code. Staff C, ADON had Staff F, RN/ Agency Nurse complete a COVID assessment on	F 880		

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F 880	Continued From page 44	F 880		

4/28/20. Staff C reviewed and decided Resident #1 did not meet the criteria to be transferred to the ER for COVID-19. The ADON stated she was on the phone with the facility Medical Director on 4/28/20, he directed the facility to follow their policy to keep all residents in the facility and not to send out to the ER if you can help it. Staff C told the PCP they had 3 nurses assess Resident #1 for COVID and they all felt she did not meet the criteria to transfer to the ER. Staff C again stated the facility Medical Director directed her to treat the resident in the facility. Staff C, ADON said they do not have any COVID-19 in the building and we want to keep it that way and if we did we would isolate the residents immediately if they suspected anyone had COVID-19. Staff C did state they have had 2 staff members that recently tested positive for COVID-19 virus.

During an interview with Staff G, Director Of Nursing (DON) on 5/4/20 at 9:12 a.m., Staff G stated when she came to work on 4/28/20 she was told they had to place supplemental oxygen on Resident #1 because her oxygen saturation level is low at 88%. DON stated the nurse working with Resident #1 that day shift 4/28/20 stated she felt the symptoms the resident experienced is not respiratory related. DON stated on 4/28/20 they tested all residents for COVID-19 and at this time they had at least 20 positive cases of COVID-19 and still more results coming in. The DON stated Resident #1 transferred to a local ER on 4/30/20 and then transferred to a larger hospital that same day due to oxygen needs.

During an interview with Staff F, RN/Agency Nurse on 5/7/20 at 7:39 a.m., Staff F stated she worked on 4/27/20 and 4/28/20 day shift. On

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F 880	Continued From page 45 4/28/20 the staff completed COVID-19 swabs on all the residents. Resident #1 had a temperature the day before but didn't complain of a cough on 4/28/20. Staff F stated she received a phone call on 4/28/20 from the PCP's Nurse directing her to place Resident #1 in droplet isolation and to move her away from the roommate. Staff F stated she relayed these orders to the ADON who informed her they were only taking orders from the Medical Director. Review of a SARS-C0V-2 (COVID-19) test results revealed the staff collected the specimen on 4/28/20 and the lab reported back on 4/29/20 that Resident #1 tested positive for COVID-19. During an interview with Resident #1's PCP on 4/29/20 at 8:50 a.m., the PCP stated her Physician's Assistant (PA) contacted the facility regarding 5 residents she was going to do telehealth visit on, the nurse working on the floor asked the PA if she was going to also see three other residents who were ill. The 3 ill residents included Resident #1. The PA and her Nurse had the ability to read the resident's Progress Notes electronically and stated Resident #1 had symptoms of COVID-19. The PA called the facility and ordered Resident #1 to be sent to a local ER due to low oxygen saturations. The PCP stated she outlined the details of the incident in the Condition Update dated 4/28/20. The PCP stated she gave a directive to place Resident #1 into droplet isolation and to swab for COVID-19 virus on 4/28/20, she said they did not follow thru on this order. 2. According to the Minimum Data Set (MDS)	F 880		

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F 880	Continued From page 46 dated 4/10/20 Resident #2 documented with diagnoses including renal failure, pneumonia, viral hepatitis, seizure disorder, anxiety, depression, chronic obstructive pulmonary disorder and respiratory failure. The MDS revealed the resident had a Brief Interview for Mental Status (MDS) score of 11 which meant the resident had intact cognitive ability. Review of Resident #2's Care Plan failed to include the resident had an increased risk for potential infections related to the COVID-19 viral outbreak. Review of the Progress Notes revealed the following: a. On 4/25/20 at 12:25 p.m., noted upon entering the resident's room, the resident sat at the side of bed, shaking, covered in a blanket. The resident's temperature 102.5, oxygen saturation level 82% on 3 liters of oxygen, unable to obtain a blood pressure due to the resident's constant involuntary movement. The resident reports chest discomfort which just started. The Floor Nurse notified Staff C, ADON per new facility policy. The ADON advised the Staff Nurse to await a call back, as she would authorize and obtain an order for an ER visit. b. On 4/28/20, the staff obtained a nasal swab for COVID-19 ordered by the Medical Director due to heavy virus activity in the community. The DON documented at 5:05 p.m., the resident is asymptomatic and will monitor vital signs and respiratory assessments twice daily as a proactive measure. c On 4/30/20, the resident appeared more confused at 1:43 a.m. and at 5:00 a.m. the nurse documented the resident ran a low grade fever all night, confusion continues and the resident had	F 880		

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F 880	Continued From page 47 complaints of body aches and pains. d. On 4/30/20, the staff reported to the PCP the resident had a temperature of 101.0 and oxygen saturation level of 85% on 4 liters of oxygen. At 10:48 a.m. the staff received an order from the PCP to transfer the resident to the ER for COVID-19 and low oxygen saturation levels. Observation on 4/30/20 at 11:28 a.m., Resident #2 in bed, the Staff Nurse called 911 to transfer the resident to a local ER. The resident is observed in bed, oxygen on at 4 liters via a non-rebreather mask, the Foley catheter is draining dark colored urine. The nurse gave a verbal report to the Emergency Medical Staff (EMS) personnel, the resident is COVID-19 positive, oxygen saturation is 85% on 4 liters of oxygen and unable to be stabilize. The resident has been running temperatures. The resident left the facility via ambulance at 11:32 a.m. Review of SARS-CoV-2 (COVID-19) test result revealed the specimen obtained on 4/28/29 returned positive on 4/29/20. During an interview with Staff F-RN/Agency nurse on 5/7/20 at 7:39 a.m. Staff F stated she worked on 4/27/20 and 4/28/20 day shift. On 4/28/20 the staff completed COVID-19 swabs on all the residents. Staff F stated she received a phone call from the PCP's Nurse directing her to place Resident #2 in droplet isolation and to move him away from the roommate. Staff F stated she relayed these orders to the ADON who informed her they were only taking orders from the Medical Director. 3. According to the Minimum Data Set (MDS)	F 880		

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F 880	Continued From page 48 dated 3/31/20 Resident #3 documented with diagnoses including heart failure, peripheral vascular disease, inflammatory bowel disease, renal failure, diabetes, anxiety and depression. The resident had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident had intact cognitive ability. Review of Resident #3's undated Care Plan revealed a focus area that stated the resident is at risk for COVID-19 viral outbreak and directed staff to assist the resident with communication with family, assess the resident's temperature, monitor for signs of respiratory illness and report abnormal findings to the primary care provider for further treatment and care. During an interview with the PCP's Nurse on 4/29/20 at 10:09 a.m., the nurse stated the staff told her Resident #3 has a high temperature, low oxygen saturations and a cough. The PCP ordered the resident to be placed in droplet isolation on 4/28/20 as he is showing signs of COVID-19. During an interview with Staff F-RN/Agency Nurse on 5/7/20 at 7:39 a.m. Staff F stated she worked on 4/27/20 and 4/28/20 day shift. On 4/28/20 the staff completed COVID-19 swabs on all the residents. Staff F stated she received a phone call from the PCP's Nurse directing her to place Resident #3 in droplet isolation and to move him away from the roommate. Staff F stated she relayed these orders to the ADON who informed her they were only taking orders from the Medical Director. During an interview on 4/29/20 at 1:00 a.m. with Staff C, ADON/Infection Control Nurse stated we	F 880		

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F 880	Continued From page 49	F 880		

currently do not have any COVID-19 positive residents. The staff indicated the facility has strict guidelines on transferring a resident out to the ER from the Medical Director. The Medical Director said we can do as much in the facility as they can do at the hospital like managing temperatures and giving fluids. Staff C stated if she suspected a resident had COVID-19 she would place them immediately in droplet isolation. We have designated the 100 Hall as our COVID Unit if needed. Staff C stated they currently did not have any residents with COVID symptoms and does not have any residents in droplet isolation. Staff C stated yesterday on 4/28/20 they completed COVID-19 swab test on all their residents per order of the Medical Director.

During an interview with Staff A, Licensed Practical Nurse (LPN) on 4/28/20 at 10:50 p.m. the staff stated the DON and ADON tested all residents for COVID-19 but we currently do not have any symptomatic residents in the building. We have 3 residents who are ill with temperatures but the temperatures are from a urinary tract infection.

Observation on 4/30/30 at 9:00 a.m., revealed staff walking about Station 1 and Station 2 with only shields and masks on, the staff did not have on gloves or gowns at this time. Staff I, Certified Nurse Aide (CNA) working on Station 2 asked should I have more than my mask and shield on we are getting a lot of COVID positive residents and most of them are down here. Staff I asked what the nurse directed her to do, she stated nothing different than before.

Observation on 4/30/20 at 9:30 a.m., on Station 2 revealed a yellow isolation gown hanging on the

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	165585	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER	2002 CEDAR STREET MUSCATINE, IA 52761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 50	F 880		

cloth room divider and a red isolation tag on the door. Staff I stated she has to walk into the room without a gown on, only mask and face shield to put on the isolation gown. The staff stated the resident in Bed A is positive for COVID-19 and Bed B is negative for COVID-19.

During an interview on 4/30/20 at 10:30 a.m., Staff J, CNA and Staff K, CNA noted at the end of Station 1 south exit door. The staff were asked what re-education they received this morning regarding the wearing of Personal Protection Equipment (PPE) and precautions for residents now that they have COVID positive residents. Both Staff J and K indicated they have not received any education on what to do now that they have residents positive for COVID-19. Both staff said so far today they have only been wearing their shields and masks.

During an interview with Staff H, Nurse Consultant on 4/30/20 at 12:30 p.m., Staff H did not respond to the question why the staff did not have on gowns at Station 2 this am with know COVID-19 positive residents, she stated we have plenty of PPE.

During an interview with Staff H, Nurse Consultant on 4/30/20 at 2:00 p.m., Staff H stated we will make Station 2 the designated COVID-19 unit, they have 44 or 45 beds on that wing and the fire doors will be shut with a separate entrance from the rest of the facility. Staff H stated we will have designated staff to work exclusively on that unit.

Observation on 4/30/20 at 2:07 p.m., Staff H conducting a staffing education for the oncoming evening staff. Staff H said to the staff in the

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F 880	Continued From page 51 huddle, we brought this (COVID-19) to them (residents) by not wearing our Personal Protective Equipment (PPE). During an interview with Staff G, DON on 4/30/20 at 2:23 p.m., the DON stated at this time we have 20 COVID positive residents and reports they still have pending test results and indicated those residents do not have any COVID symptoms. During an interview on 5/5/20 at 2:50 p.m. with Staff E, LPN, indicated she worked the night of 4/29/20 into morning of 4/30/20. Shortly after midnight on 4/30/20 the COVID-19 test results started to come in via fax. Staff E stated she did not have access to isolation gowns but did eventually find a few packs, stating I did the best I could. Staff E stated she put a gown in each room of the residents who results indicated they were positive for COVID-19. If the person was a 1 assist she put in 1 gown if required 2 staff put in 2 gowns. She stated there were residents who cohabited in rooms with a roommate who was negative so she hung the gown closer to the positive residents. The staff had to wear their same mask and shield into each room, negative or positive. She placed as many red isolation signs as many she could find on the positive rooms and had to photo copy some for the doors as she ran out. She indicated she started the positive residents on droplet isolation precautions. Staff E worked on 5/4/20 and 5/5/20 on Station 2 and reported the staff wore the same hazmat suit all day, in and out of resident rooms. She indicated there were a few residents on Station 2 who were negative for COVID- 19 on these days. During an interview with Staff M, CNA on 5/5/20	F 880		

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F 880	Continued From page 52 at 6:00 p.m., Staff M stated she worked day shift on 4/30/20 on Station 2. The staff knew we had COVID-19 positive residents but didn't direct us to wear anything but our face shields and masks. During an interview with Staff L, CNA on 5/6/20 at 12:52 p.m., Staff L stated she worked on 5/2/20 on Station 2. Staff directed her to wear the same white hazmat suit, goggles and masks into every room on Station 2. She voiced a concern with this but was told all the residents on Station 2 are positive for COVID-19. During an interview with Staff A, LPN on 5/7/20 at 5:30 a.m., Staff A stated she worked the night shift on 5/6/20 into the morning of 5/7/20. Staff A stated they have been having her work on Station 2 but tonight they assigned me to Station 1 because Station 2 is such a hard unit to work on with all the COVID-19 residents. Staff A stated when she worked on Station 2 she would wear the same white hazmat suit, mask and face shield the entire shift. Staff A stated they do not change into a different suit or put on a gown, she stated everyone has been exposed already. Staff A stated they re-test more residents on Station 2 who first returned with negative results because they were showing COVID-19 symptoms. Review of a COVID-19 Resident Log dated 4/29/20 revealed the following: a. Station 2 had 2 residents testing positive b. Station 3 had 11 residents testing positive, 3 inconclusive and 6 residents testing negative. Review of a COVID-19 Resident Log dated 5/14/20 revealed the following: a. 61 residents testing positive b. 4 residents testing negative; 1 on Station 2	F 880		

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F 880	Continued From page 53 and 3 on Station 1 c. 2 inconclusive (both residents refused to be retested). d. 9 deaths Review of the COVID- 19 Policy and Procedure dated 4/2/20 directs the staff to assess the residents every shift for abnormal vital signs and noted respiratory symptoms. Should residents exhibit any of the following symptoms the facility shall initiate droplet isolation precautions for symptomatic residents and roommates if applicable for symptoms which included: 1. Fever greater than 100.4. 2. Sore throat. 3. Cough. 4. Decreased oxygen saturation levels. 5. Difficulty breathing or painful respirations. 6. Fatigue, body aches, headache or any other flu-like symptoms. The Policy further directed: a. The facility shall notify primary medical provider or their designee of symptoms. b. Residents will be placed into droplet isolation along with their roommate. c. Follow up testing shall occur per the order of the Primary Care Physician. d. Residents and room mate will remain in droplet isolation precautions until tests are return with definitive diagnosis. e. Should the resident require transfer to a hospital and is hospitalized, the roommate will continue droplet isolation requisitions until tests are confirmed or 14 day isolation period has been completed with no noted symptoms of illness. On April 30, 2020, the facility abated the Immediate Jeopardy. The facility provided	F 880		

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F 880	Continued From page 54 education to the Nursing Staff and provided proper Personal Protective Equipment (PPE) for all staff. The facility also created a dedicated Area/Unit for the COVID-10 positive residents be moved to with assigned dedicated staff to care for those residents. At the time of exit, the scope and severity was lowered to an E after verification of staff's implementation of their policies and Infection Control procedures.	F 880		

Pearl Valley Rehab - Muscatine
2002 Cedar Street
Muscatine, IA 52761
Phone: 563-264-2023

Facility ID #165585

Provider's Plan of Correction
Date Survey Completed: May 15, 2020

F 000: Initial Comments:

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies by Pearl Valley Rehab - Muscatine. To remain in compliance with State and Federal regulations, the facility has taken or will take the following actions set forth in this plan of correction.

F684 Quality of Care

The facility does and will continue to ensure nursing staff properly notify physicians and family members of change of conditions and follow physician's orders regarding transferring residents to the emergency room as ordered for any resident, including resident #1, #2, #3 and #4.

All residents have the potential to be affected by the deficient practice.

All licensed nursing staff were educated on May 5, 2020 regarding the Policy and Procedure for Assessment and Documentation and the documentation requirements for pandemic assessments during a pandemic outbreak. The DON and ADON were educated on May 5, 2020 regarding following physician orders and auditing of resident assessments and documentation per the facility policy and procedure for pandemic outbreaks.

The DON and ADON will continue to perform daily audits of all resident assessment logs and documentation completed by the nurses to make sure physicians and family members were notified if a resident had any change of condition during the pandemic outbreak.

All findings will be submitted through the quarterly QA and QAPI process for further system improvement implementation.

Date of Compliance: May 16, 2020.

F695 Respiratory/Tracheostomy Care and Suctioning

The facility does and will continue to ensure nursing staff obtain orders for the use of non-rebreather oxygen masks for any resident, including resident #2, #3, #7 and #8.

All residents have the potential to be affected by the deficient practice.

All licensed nursing staff were interviewed and educated on the difference between regular oxygen masks and non-rebreather oxygen masks and the need to have an order if and when a non-rebreather oxygen mask was to be used. As we don't have non-rebreather oxygen masks in the facility, they were educated as to how to go about getting an order and the non-rebreather mask.

The DON and ADON will continue to perform daily audits on all resident O2 stats and documentation regarding the use of oxygen and how it was being received, i.e. nasal cannula, regular oxygen mask or non-rebreather oxygen mask.

All findings will be submitted through the quarterly QA and QAPI process for further system improvement implementation.

Date of Compliance: May 16, 2020.

F880 Infection Prevention and Control

The facility does and will continue to implement effective infection control measures to mitigate the transmission of the COVID-19 virus amongst their residents and to follow physician orders regarding placing symptomatic residents into droplet isolation for any resident, including resident #1, #2, and #3.

All residents have the potential to be affected by the deficient practice.

All staff, including nursing staff, were wearing appropriate PPE per the Iowa Department of Public Health and CDC/CMS Guidelines on April 30, 2020. The facility had a designated PPE room with gloves, gowns, coveralls, face shields, face masks, N95 masks, etc that was available to all staff in the facility as well as PPE supplies at each nurses station in the med rooms. The facility also had a designated COVID-19 Unit where all positive residents were moved to with dedicated staff working only in that Unit once we started receiving positive test results from the facility wide testing initiated on April 28, 2020.

The Administrator ordered 20 Sterilite 3-drawer wide carts to put PPE supplies in the halls throughout the facility and does and will continue to do daily/weekly rounds to make sure PPE is fully stocked in said carts. The Administrator also does complete inventory counts of PPE in the building twice weekly to make sure we have enough supplies for all staff in the facility.

All findings will be submitted through the quarterly QA and QAPI process for further system improvement implementation.

Date of Compliance: May 16, 2020.