#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/24/2020 **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED C 165260 B. WING 09/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 STATE STREET **DONNELLSON HEALTH CENTER DONNELLSON, IA 52625** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ľD PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 Amended 11/24/20 following IDR. Correction date: 9//0/2020 The following deficiency relates to the Focused Infection Control Survey and Complaint #92958. Complaint # 92958 was not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. F 880 Infection Prevention & Control F 880 SS=K 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,

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

accepted national standards:

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

Hamistrator

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NHX

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		165260	B. WING			C 09/09/2020	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, Z 901 STATE STREET DONNELLSON, IA 52625	IP CODE	00/00/2020	
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F 880	§483.80(a)(2) Writte procedures for the but are not limited to (i) A system of surve possible communical infections before the persons in the facility. When and to who communicable disereported; (iii) Standard and trop to be followed to provide to provide the followed to provide the involved, and (B) A requirement to least restrictive postircumstances. (v) The circumstances. (v) The circumstances. (v) The circumstances or infected contact with resider contact will transmit (vi) The hand hygier by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must har	en standards, policies, and program, which must include, oc: eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a out not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  Stem for recording incidents facility's IPCP and the aken by the facility.  Indle, store, process, and as to prevent the spread of	F8	380			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C		
		165260	B. WING			1	) 09/2020
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F 880	IPCP and update the This REQUIREMENT by: Based on observation interviews, the facilic comprehensive inferogram and an efficient and visitors in CDC guidance. The Staff A to work with Staff A tested position reported a census of Findings include: The CDC's Preparit Homes Infection Concessed in the CDC in the CDC's Preparit Homes Infection Concessed in the Infection Concessed in the Infection Concessed in the Infection of Concessed in the Inventory in the Inventory to denon-essential and virtual inventory to denon-essential and virtual inventory in the Inventory	duct an annual review of its heir program, as necessary. NT is not met as evidenced tion, record review, and staff ity failed to implement a ection prevention and control fective screening process for accordance with CMS and he facility knowingly allowed symptoms of COVID-19. The facility for COVID-19. The facility of 49.  In for COVID-19 in Nursing fontrol for Nursing Homes he 25, 2020, directed the leand Manage Healthcare  In the facility of all volunteers and wide care in the facility. Use the stermine which personnel are whose services can be delayed are necessary to prevent or in.  In actice, ask HCP (including hel and ancillary staff such as	F	380			
		dietary services) to regularly s for fever and symptoms					

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	CON	MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880		age 3 o stay home when they are ill.	F 8	80			
	- If HCP develop than 100.0 F) or sy COVID-19 while at supervisor and leave for how to respond worked while ill (e.grisk assessment for co-workers).	o fever (T greater to or less amptoms consistent with work they should inform their ve the workplace. Have a plan to HCP with COVID-19 who g., identifying and performing a per exposed residents and sected COVID-19 should be ag. Screen all HCP at the					
	beginning of their s COVID-19.  - Actively take th document absence COVID-19. If they	shift for fever and symptoms of neir temperature* and e of symptoms consistent with are ill, have them keep their or facemask on and leave the					
	>100.0 F or subject be intermittent or m individuals, such as immunosuppressed medications (e.g., N	r measured temperature tive fever. Note that fever may nay not be present in some s those who are elderly, d, or taking certain NSAIDs). Clinical judgement to guide testing of individuals					
	higher risk and sho facilities if they have	in multiple locations may pose puld be encouraged to tell te had exposure to other inized COVID-19 cases.					
		enters for Disease Control navirus document dated May					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	CON	TE SURVEY MPLETED
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F 880	range of symptoms symptoms to sever appear 2-14 days a	ge 4 th COVID-19 have had a wide reported, ranging from mild e illness. Symptoms may fter exposure to the virus. owing symptoms may have	F 8	30		
	- Cough.	eath or difficulty breathing.				
	- Fatigue, Muscle	e or body aches.				
	- Headache.					
	<ul><li>New loss of tas</li><li>Sore throat.</li></ul>	te or smell.				
	- Congestion or r	runny nose.				
	- Nausea or vom	iting.				
	- Diarrhea.					
	Staff Å (Nurse Aide) body aches from he temperature. Staff her low grade tempher. Staff A reporte degrees Fahrenheit she called the facilit grade temperature Administrator who co Director of Nurses (	on 8/26/20 at 10:15 a.m., reported on 8/18/19 she had ead to toe and low grade A called the facility to report erature which was unusual for d a baseline temperature 97.6 (F). The next day (8/19/20) by and reported she had a low all morning. She talked to the directed her to talk to the (DON). Staff A explained to oms she had. The DON				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		165260	B. WING				) 09/2020
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CO 901 STATE STREET DONNELLSON, IA 52625	DDE		J912020
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F 880	directed her to repowork she had her to She had a fourth te neck of 98.9 degree avoid the residents worse and had bod (Agency Licensed Ftemperature and it told her she did not home. Staff A text her of her symptom to finish her shift an believed they had have enough staff. someone else to woon 8/20/20 and the The RPiD Report re COVID-19 tested on Report on 8/24/20 a had COVID-19.  Review of the time following:  1) Have you left the days?  2) Do you have cold 3) Have you been e Covid-19? If yes, le supervisor.  Review of the Time Staff A clocked in at 10:03 p.m.	ort to work. Upon arrival to emperature taken 3 times. Imperature obtained on her es F. She was not told to a Around 9:00 p.m. she felt y aches and sweating. Staff B Practical Nurse) took her was 100.1 degrees F. Staff B have the authority to send her the Administrator and informed is. The Administrator told her ad then go home. Staff A er work because they did not Staff A attempted to find ork. Staff A had a COVID test results returned on 8/24/20.  Evealed Staff A had a collected on 8/20/20. The Final at 6:44 p.m. revealed Staff A clock questions revealed the	F8	180			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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F 880	Date, Shift, Temper Temperature upon cough, cold, sore the Hands hygiene perhand washing, and the log directed to a sheet for tracking part of the "Employee sig 8/19/20 revealed Shave symptoms of shortness of breath of 98.8 degrees Fahou.1 degrees Fahou.1 degrees Fahou.1 degrees Fahougust 18, 20, two 2020, and two outg Cell phone records between Staff A and number from August 20, 2020 at August 19, 20 at 12 text message, "Standard and she won't and call to get my truck" August 19, 20 at 12 text message, "Hopnope she is not cor August 19, 20 at 1:	document Employee Name, rature upon clock in, clock out, Symptoms of proat, shortness of breath, facility protocol, Observer for PPE utilized. The bottom of attach copy to daily schedule surposes.  In in tracking sheet" log dated taff A indicated she did not cough, cold, sore throat, or an Staff A had a temperature threnheit upon clock in and renheit upon clock out.  Cell phone log revealed the connellson Heath Center at; and one incoming call to on outgoing calls on August 19, oing calls on August 20, 20.  Teveal text messages of the DON's cell phone st 19, 20 at 12:17 p.m. and 4:55 p.m.  C:17 p.m., Staff A stated in a ff C said no. I messaged Staff swer me. Still waiting on the consist as sick as I am. So	F8	80				

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		165260	B. WING		<u> </u>	1	09/2020
	PROVIDER OR SUPPLIER	ER		g	STREET ADDRESS, CITY, STATE, ZIP CODE 801 STATE STREET DONNELLSON, IA 52625		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 7	F8	80			
		16 p.m., text message sent one stated, "Okay great. How					
		16 p.m., Staff A stated in a text ly only 30mintues but will be ure"					
		16 p.m., text message sent one stated, "Okay, I'll hold you					
	message, "Lol, oka	16 p.m., Staff A stated in a text y. I promise I am on my way to or not I am coming in"					
		26 p.m., text message sent one stated, "We are all sick."					
	message, "DON it's	55 p.m. Staff A stated in a text s Staff A and I need a covid u meet me at the nursing the test"					
		55 p.m. text message sent one stated, "How far out are					
		29 p.m. text message sent one stated, "It is protocol."					
	message, "LOL ma still feel like death to "And the guy I am s and he has several	29 p.m. Staff A stated in a text kes sense" "I just know that I oday and still getting fevers" seeing is sick the same way people at his work place out So they made him get tested					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		165260	B. WING			1	09/2020
	PROVIDER OR SUPPLIER	ER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 901 STATE STREET DONNELLSON, IA 52625		03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	, , , , , , , , , , , , , , , , , , ,	ge 8 p.m. Staff A stated in a text	F8	380			
	message, "I am her	e"					
		reveal text messages d the Administrator's cell d/19/20.					
	message, "Okay so about running eleva and with them going temper at 9pm beca	p.m. Staff A stated in a text I have been open and honest ated temperature all week long g up to 100. Now as I took my ause I stopped sweating and body aches again it is back up					
		50 p.m. text message sent s cell phone stated, "I'm sorry					
	August 19, 20 at 9:5 message, "Sorry thi	50 p.m. Staff A stated in a text is is Staff A"					
	from Administrator's	50 p.m. text message sent s cell phone stated, "What was e nurse temped you today at					
	August 19, 20 at 9:5 message, "99"	50 p.m. Staff A stated in a text					
		50 p.m. text message sent s cell phone stated, "ok. Are ght?"					
	August 19, 20 at 9:5 message, "yes"	50 p.m. Staff A stated in a text					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION BING		COM	E SURVEY PLETED
		165260	B. WING				C <b>09/2020</b>
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F 880	August 19, 20 at 9: from Administrator's home and rest and tomorrow"  August 19, 20 at 9: message, "Okay ar doctor to make sur infection"  August 19, 20 at 9: from Administrator's us updated."  During an interview Director of Nursing screening process temperature inside had symptoms, the stated that she thou is the temperature home. The DON stakes the temperature home. The DON stakes the temperature in the sobserving. The DON stated the em temperature in the observing. The DOS sure what symptom or the screening to not heard from Statemessage prior to he The DON stated the when she showed is following day at 5 pdid not know if the statemest and the statemest and the statemest and the showed is following day at 5 pdid not know if the statemest and the statemes	50 p.m. text message sent is cell phone stated, "ok. Go we'll check in with you come it can be a stated in a text in a state in a text	F8	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(		E SURVEY IPLETED
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F 880	Continued From particles of the policy and the stated Staff A's symexhaustion, and act was not sure if she stated she told Staff that Staff A finished Review of the screek August 11 - 26, 20 rentries.  According to Covid-www.coronavirus.io 18.1% positivity rate September 1, 2020 Review of the policy Preparedness Plan Emergency Procedemployees should be symptoms and experience.	age 10  or on 8/26/20 at 4:15 p.m. Staff d Practical Nurse) stated if an feeling well, I would take their ssess their symptoms. Staff B nptoms were fever, thy. Staff B stated that she could make the decision, but ff A to leave. Staff B stated if her shift on August 19, 2020.  ening sign in sheets from revealed several incomplete  1-19 in Iowa Dashboard at the county had be (past 14 day average) on the county had be (past 14 day average) on the county had be instructed to self-report	F 8	DEFICIENCY)			
	On 9/2/20, the facili Jeopardy. The facili and time clock to in symptoms and edus screening process in the facility of the fac						

Plan of Correction

Donnellson Health Care Center Focused Infection Control Survey August 26th, 2020 September 9th, 2020

The statements made in the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with state and federal regulators the facility has or will take the following actions set forth in the plan of correction.

#### **F880 Infection Prevention & Control**

This facility does and will continue to implement a comprehensive infection prevention and control program and an effective screening process for staff and visitors in accordance with CMS and CDC guidelines. On September 1st, 2020, the facility provided education to staff on the new employee COVID-19 screening questions prior to entrance into the facility for each scheduled shift. The education included a revised question programmed into the electronic time clock, a listing of COVID symptoms next to the time clock and education on staff temperatures to determine if staff is able to work their scheduled shift. The facility will ensure that staff follow the updated screening process and that any employee with a temperature over 99.0 degrees will be directed to go home for follow up direction from their supervisor. The human resource department will continue to monitor how staff answer the questions in the electronic time clock system on a daily basis. The administrator or designee will continue to monitor the daily staff screen in forms and staff temperatures to ensure that staff are not working while feeling ill or have a temperature above 99.0. All results will be shared with the QA team monthly for 3 months.