STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

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F 000	INITIAL COMMENTS Amended: 2/23/21 Correction date: 2/22/2021 The following deficiencies relate to the Focused Infection Control Survey, Complaints #93877, #94041, #94429, #94664, #94665, #94666, #94673, #94674, #94675, #94676, #94678, #94679, #94680, #94681, #94682, 94683, #94684, #94685, #94686, #94687, #94689, #94690, #94694, #94695, #94901, #94929, #94971 and Facility Reported Incident #94941 conducted November 23, 2020 to January 13, 2021. Complaint #94041-C was not substantiated. Complaints #93877-C, #94429-C, #94664-C, #94665-C, #94666-C, #94673-C, #94674-C, #94675-C, #94676-C, #94678-C, #94679-C, #94680-C, #94681-C, #94682-C, 94683-C, #94684-C, #94685-C, #94686-C, #94687-C, #94689-C, #94690-C, #94694-C, #94695-C, #94901-C, #94929-C, and #94971-C were substantiated. Facility Report Incident #94941-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 684 SS=J	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	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jimmy Obst	Administrator	02/15/2021

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 684	Continued From page 1 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 record review, and staff and provider interview the facility failed to provide treatment and care in accordance with professional standards of care for 1 of 3 sampled (Resident #12) who had an external fixator (stabilizing frame to hold fractured bones in position). The facility failed to follow physician's orders, failed to transcribe orders properly, and failed to ensure Resident #12 attended follow up appointments. The lack of treatment and care resulted in Resident #12 developing osteomyelitis (bone infection) which required hospitalization. The facility reported a census of 98. Findings include: According to the Minimum Data Set (MDS) assessment dated 12/18/20 Resident #12 admitted to the facility on 11/9/20. Resident #12 had memory problems and modified independence with decision making. Resident #12 required extensive assistance with bed mobility, transfer, locomotion on and off the unit, dressing, hygiene and toilet use. The MDS listed diagnoses of Diabetes Mellitus, metabolic encephalopathy (alteration of brain function due to failure of other organs), reduced mobility, COVID, morbid obesity and fracture of right and left lower leg. The Care Plan initiated 11/25/20 identified	F 684		

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F 684	Continued From page 2 Resident #12 admitted with pressure ulcers that require treatments. The Care Plan updated on 12/29/20 directed staff to apply treatment, creams and dressing per orders, report any new or worsening skin concerns to my nurse and/or doctor dated, and follow my treatment order as directs, weekly treatment documentation to include measurements, of each skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes. The Care Plan failed to direct staff how to care for Resident #12's external fixator and weight bearing status. The Physician Discharge Summary dated 11/9/20 revealed Resident #12 admitted to the hospital on 10/9/20 and discharged to the nursing home on 11/9/20. Resident #12 had bilateral ankle fractures in August of 2020 with right ankle external fixation. Resident #12 had a Podiatrist follow her care while hospitalized. Hospital x-rays of the right ankle showed the external fixation hardware in adequate position, and best to keep it on and follow up with x-rays to assess for healing. The Discharge Procedure Orders included the following orders: a. Change the right lower extremity dressings 3 times per week on Monday, Wednesday, and Friday) for right lower extremity. b. Apply Xeroform (non-adhering protective dressing) to pin sites, 4x4 gauze to pin sites, kerlix (gauze bandage) and light Ace (elastic) bandage. c. Weight Bearing as Tolerated on the left lower extremity and Non Weight Bearing on the right lower extremity.	F 684		

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F 684	Continued From page 3 d. Follow up after discharge with Specialist for assessment of healing of right ankle and re-evaluation of external fixation hardware. The orders specified the provider who placed the fixation hardware to follow up one week after discharge from the hospital. Review of a Progress Note dated 11/9/20 at 4:46 p.m., revealed Resident #12 admitted to the facility and had 5 pressure areas, and external fixator pin sites-two pin sites on the lateral side (further from the middle) of the right leg/foot, one pin site to the lateral side of the right fibula and one on the medial (closer to the middle of the body) side of the right tibia, one pin site on the lateral side of the right foot and one pin site on the medial side of the right foot. No treatment orders were received, pressure area treatment orders were clarified with hospital nurse. A Progress Note dated 11/27/20 at 3:20 p.m., Staff A (Licensed Practical Nurse) documented Resident #12 had serosanguinous (thin watery) drainage from right ankle near ankle metal fixator. A Progress Note dated 12/2/20 at 10:04 a.m., revealed Resident #12 had a follow up appointment for the right lower extremity fixator scheduled on 12/4/20. A Progress Note dated 12/3/20 at 11:49 a.m., documented Resident #12 tested positive for COVID. A Progress Note dated 12/4/20 at 2:30 p.m., Staff A (Licensed Practical Nurse) documented a call to discharging physician to report drainage, warmth, redness to lateral/medial right ankle. The Provider returned a call at 3:32 p.m. and no	F 684		

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F 684	Continued From page 4 new orders received. At 3:41 p.m., Staff A notified the facility Physician Assistant (PA) and received order for Keflex 500mg one capsule three times a day for right ankle infection for 10 days. An Order Note dated 12/11/20 at 3:20, documented Staff A notified the Physician's Assistant and received new order to discontinue previous dressing and start change dressing to right lower extremity every MWF. Apply xeroform to pin sites, 4x4 gauze to pin sites, kerlix and light ace bandage every day shift. Cleanse areas with wound cleanser prior to applying xeroform. A Progress Note initiated on 12/14/20 at 5:18 p.m., Staff B (Licensed Practical Nurse) documented Resident #12 discontinued from skilled level of care and was moved to another room. A Progress Note dated 12/15/20 at 11:54 a.m. documented Resident #12 had an appointment with the Podiatrist on 12/18/20 at 11:15 a.m. for removal of internal rotator and external fixator. Staff scheduled to go with resident and transportation set up. A Progress Note dated 12/18/20 at 4:02 p.m., Staff C (Assistant Director of Nurses) documented Resident #12 returned from an appointment with the Podiatrist with a new order to admit to the hospital for intravenous antibiotics for osteomyelitis (infection of the bone). Hardware removed from right leg. X-rays taken, resident to be admitted to the hospital when bed available. Wound care directed to be betadine soaked gauze with kling wrapped gauze twice a day until admission for foot wounds.	F 684		

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F 684	Continued From page 5 The Podiatry History and Physical dated 12/18/20 documented Resident #12 admitted to the hospital with right ankle fracture not completely healed and the external fixator left in place. Resident #12 had a 1 week follow up appointment after hospital discharge on 11/9/20. Resident #1 failed to follow up until today (12/18/20). Resident #12's partial fifth metatarsal (foot bone) amputation site was healing well at discharge from hospital. However, wound now dehisced (opened) and had signs and infection present. With the lack of follow up despite having an external fixator in place for an extended amount of time there was a concern for neglect behavior from the nursing home. The Treatment Administration Record (TAR) for December 2020 revealed an order dated 11/11/20 to the change dressing to Resident #12's right lower extremity. The order directed to apply xeroform to pin the sites, apply 4 x 4 gauze to pin sites, apply kerlix and a light ace bandage one time a day every Monday, Wednesday, Friday. The order discontinued on 12/11/20. The TAR for December 2020 revealed a new order dated 12/12/20 directed to change the dressing to the right lower extremity on every Monday, Wednesday, and Friday. Cleanse the wound with wound cleanser, apply Xerofrom to pin sites, apply 4x4 gauze to pin sites, cover with kerlix and a light ace bandage every day shift. The TAR directed the staff to complete the treatment every Monday, Wednesday, and Friday and every day shift. The TAR directed the staff to sign the treatment out as completed every day. The December 2020 TAR lacked documentation	F 684		

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F 684	Continued From page 6 to reflect the staff completed the treatment as ordered on 12/7/20, 12/14/20, and 12/18/20. During an interview on 12/29/20 at 11:40 a.m., Staff A (Licensed Practical Nurse) stated that she had routinely cared for Resident #12. Staff A contacted the Facility Provider on 11/27/20 to report serosanguinous drainage from right ankle near the metal fixator. Stated this was a change. On 12/2/20, she scheduled a follow up appointment for 12/4/20 with the foot and ankle surgeon at the direction of Staff B (Licensed Practical Nurse). Staff A further stated the appointment on 12/4/20 was cancelled by the facility because the resident tested positive for COVID on 12/3/20. On 12/4/20, she called the Hospital Provider to report had assessed increased drainage, warmth, and redness of the right lower extremity. She became aware after talking to the nurse that the Hospital Provider was no longer following the resident, confirmed she had thought she was contacting the foot and ankle surgeon. Stated she then notified the Facility Physician Assistant (PA) who ordered an antibiotic. Further stated the PA had not previously seen the resident. On 12/11/20, due to continued concerns with right lower leg, again contacted PA who ordered the treatment to the right lower leg to now be completed every day. Stated she is now aware that when she transcribed the order she failed to delete the MWF, so still read MWF, then directed every day. The TAR identified boxes for the treatment to now be signed for every day. Staff A stated the order as written was unclear. Staff A further stated she had completed the treatment and dressing on 12/11/20. Confirmed that she had dated and initialed dressings when completed. Stated if the dressing that was removed from Resident #12's	F 684		

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F 684	Continued From page 7 right foot and ankle on 12/18/20 was dated 12/11/20 then it hadn't been completed in that time. The resident had moved from the skilled area to the back on 12/14/20 and she had not cared for her since that date. During an interview on 12/29/20 at 4:16 p.m., Facility Physician's Assistant confirmed that she had been contacted on 12/4/20 related to increased drainage, warmth and redness in right ankle area. Stated she had not seen resident prior to this phone contact and was not made aware the resident had an external fixator device in place. Further stated if had been made aware would have expected staff to alert the foot and ankle surgeon for further instruction given the increased risk of osteomyelitis. Would additionally have expected routine follow up by the foot and ankle surgeon and was unaware this was not occurring. Further confirmed she had ordered an increase in the frequency of treatment and dressing change to 7 days a week from 3 days of week when contacted due to continued concerns. During an interview on 12/30/20 at 9:45 a.m., the Hospital Provider's Nurse stated she had been contacted on 12/4/20 related to increased drainage, warmth, and redness in the right ankle. She directed facility staff to call Podiatry or have the Facility Provider see the resident. Reviewed the discharge summary and reported directed one week follow up with the Podiatrist. Stated would not be able to verify that the hospital summary was sent to the facility, but would expect the facility to call and enquire if had questions regarding the external hardware device. During an interview on 1/4/20 at 2:27 p.m., the	F 684		

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F 684	Continued From page 8 Podiatrist stated that he would have expected to see the resident as a follow up for external fixator one week after discharge from the hospital and weekly thereafter. Further confirmed resident had not attended any appointments after discharge on 11/9/20 until 12/18/20 when required hospitalization. Stated clinic would not have cancelled any appointments and are seeing COVID positive residents in the clinic. Further stated the facility nurse attending resident stated the facility is not letting residents leave because of COVID. Stated when the Resident #12 presented on 12/18/20 the dressing in place on the right foot/ankle was dated as last changed on 12/11/20 and the fixator was loose with increased drainage. Stated the dressing had been ordered by him to be changed three times a week. He was unaware the treatment had been changed to daily or that the resident had presented with signs and symptoms of infection on 12/4/20 and would have expected to have been notified. The Podiatrist stated it was his medical opinion that poor follow-up, not attending appointments, failure to complete treatment as ordered, and not notifying with changes such as: signs and symptoms of infection, and loose hardware are the cause of hospitalization. During an interview on 1/5/20 at 11:04 p.m., the Podiatrist Office Nurse stated she was present for the 12/18/20 appointment. She removed the dressing on the right foot/ankle which was dated as last changed on 12/11/20. Further stated she had removed the ace wrap bandage and noted the gauze was stuck to wounds, and had an obvious odor. Stated she said to the facility nurse attending that the dressing was dated 12/11/20 and is supposed to be changed three times a week. The Podiatrist Office Nurse further	F 684		

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F 684	Continued From page 9 stated the resident had missed multiple appointments. Scheduled for regular intervals with external hardware. Further stated would be considered a no call/no show after 30 minutes and their office would not have cancelled any appointments. Clarified needs to be monitored closely when external hardware in place. During an interview on 12/29/20 at 11:15 a.m., Staff C (Assistant Director of Nurses) confirmed she had attended the 12/18/20 appointment with Resident #12. Stated the Podiatrist was concerned with the right foot and wanted Resident #12 to go directly to the hospital for hardware removal. Stated earlier appointment had been canceled due to COVID positive, but wasn't sure if the facility or the clinic had cancelled. Stated dates and initials dressing when completes dressing change. Further stated if dressing was dated 12/11/20 then that would be the date the dressing was last changed. She would expect the dressing and treatment to be completed daily if ordered daily. During an interview on 12/28/20 at 4:00 p.m., the Facility Wound Nurse stated Resident #12 admitted with pressure ulcers and wounds to the right foot for external fixator. Confirmed she completed weekly assessments but floor nurses would be responsible to complete treatments. Stated she dates and initials dressing when completes dressing change, and would expect to be completed as ordered. Further stated she would not be responsible to schedule follow up appointments for external fixator, would be the responsibility of the Director of Nursing and the Assistant Director of Nursing. During an interview on 12/28/20 at 4:17 p.m.,	F 684		

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F 684	Continued From page 10 Staff B (Assistant Director of Nurses) stated could not provide any documentation of appointments made with the Podiatrist prior to the 12/4/20 appointment that was cancelled. She stated the appointment was cancelled by the clinic due to the resident testing positive for COVID the day before. Stated she had not scheduled any appointments prior to 12/4/20 as there had been no direction to do so. Staff B stated an expectation of staff to change the dressing as ordered and to date and initial the dressing with change. Confirmed the date on a dressing would be the last time the dressing was changed. Further interview on 12/29/20 the ADON reviewed the treatment that had been changed on 12/11/20 to be completed daily. Stated the order as written was confusing. The MWF was not deleted and remained in bold print, and was followed in small print to complete every day. Confirmed treatment was not completed as ordered 12/11/20-12/18/20. During an interview on 1/4/20 at 10:50 a.m., the Administrator confirmed that treatment had not been completed daily as ordered on 12/11/20-12/18/20. Stated the order was confusing, and could find no documentation of triple check of new orders as expected. On 12/30/20 at 2:00 p.m. the State Agency informed the facility of the Immediate Jeopardy. The facility removed the Immediate Jeopardy on 12/30/20 reviewing all wound orders for accuracy, reviewing all care plans for residents with wounds for accuracy, educating nursing staff on the proper procedure for completion of treatments for physician's orders, reviewed all scheduled physician appointments to ensure appointments are attended, implemented weekly skin	F 684		

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F 684	Continued From page 11 assessments and documented in the record, wound referrals as needed, conducted audits to ensure all medications and treatments were completed per physician's orders, and implemented a plan to review all orders prior at the morning quality assurance meeting. At the time of the exit the scope and severity was lowered from a "J" to "D" as we need to see if the facily is implementing proper procedure for treatments.	F 684		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review and resident and staff interviews, the facility failed to ensure that residents are free of any significant medication errors for 1 of 3 sampled (Resident #3). The facility failed to properly transcribe an order for Novolog (fast acting insulin), which resulted in the Resident #3 receiving 10 units at 4:00 a.m. and 10 units at 5:30 a.m. Resident #3 became unresponsive and confused and had a critically low blood glucose level of 34 requiring transfer to the Emergency Department. The facility reported a census of 98. Findings Include: 1. Minimum Data Set (MDS) assessment dated 12/4/20 revealed Resident #3 had diagnoses that included heart failure, renal failure, Diabetes	F 760		

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F 760	Continued From page 12	F 760		

Mellitus, anxiety, fractures, hypertension (high blood pressure), required extensive assistance by 2 or more staff members for bed mobility dressing and personal hygiene, and complete dependence for transfers to and from bed and chair, locomotion on and off the unit, and toileting. Resident #3 scored 15 on the Brief Interview for Mental Status (BIMS). A score of 15 identified intact cognition. The MDS further documented the resident received insulin injections.

The Care Plan identified Resident #3 had Type 2 Diabetes Mellitus with neuropathy and retinopathy and directed the staff to complete accu-checks and administer insulin as ordered by the Physician, and monitor/document/report as needed signs and symptoms of hypoglycemia (sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, and staggering gait).

Review of the December 2020 Medication Administration Record (MAR) revealed the following:

a. An order dated 12/7/20 at 4:30 p.m., to administer Novolog 100 unit/ml inject 10 units subcutaneously before meals every Monday, Wednesday, Friday and Sunday for Type 2 Diabetes Mellitus.

b. An order dated 12/8/20 at 4:00 a.m., to administer Novolog 100 unit/ml Inject 10 units subcutaneously before meals every Tuesday, Thursday, Saturday, and Sunday for Type 2 Diabetes Mellitus.

c. On 12/13/20 at 4:14 a.m., Staff D (Registered

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F 760	Continued From page 13 Nurse) administered 10 units of Novolog insulin subcutaneously to the right lower quadrant of Resident #3's abdomen. d. On 12/13/20 at 4:51 a.m., Staff D, administered another 10 units of Novolog insulin administered subcutaneously to the left lower quadrant of Resident #3's abdomen. An Order Entry sheet dated 12/15/20 revealed on 12/7/20 at 3:50 p.m. Staff C (Assistant Director of Nursing) entered the Novolog order and entered a dose of 10 units before meals at 4:00 a.m., 12:00 p.m. and 4:30 p.m. on Tuesday, Thursday, Saturday and Sunday and 10 units before meals at 5:30 a.m., 12:30 p.m. and 4:30 p.m. on every Monday, Wednesday, Friday and Sunday. The sheet revealed two 10 unit doses on Sunday. During an interview on 12/6/20 at 1:30 p.m., Staff C (Assistant Director of Nurses) reviewed the above order sheet and admitted she transcribed the order wrong when Resident #3 had the insulin order changed due COVID and a change in dialysis time on 11/30/20. Staff C entered the order to change the time to 4:00 a.m. on dialysis days (Tuesday, Thursday and Saturday) and 5:30 a.m. on non-dialysis days (Monday, Wednesday, Friday and Sunday). Staff C realized now that she had entered Sunday incorrectly which directed staff to administer 10 units of insulin at 4:00 a.m. and 5:30 a.m. on Sundays. Staff C further stated the time change order should have been double and triple checked for accuracy, however she could not provide documentation that this had occurred. Staff C explained the process after an order is received is a triple check form is attached and the next nurse should double check the order for accuracy and place in	F 760		

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her box for the triple check. Since she had initiated the order, another nurse would need to complete the triple check, however it should have been returned to her box, but it had not.

During an interview on 12/16/20 at 9:35 a.m., Staff D (Agency Registered Nurse) confirmed she worked the overnight shift from 6:00 p.m. on 12/12/20 (Saturday) to 6:00 a.m. on 12/13/20 (Sunday) morning. Staff D never worked at the facility prior to this. Staff D confirmed she administered Resident #3's insulin at 4:00 a.m. and again at 5:30 a.m. Resident #3 informed Staff D that he normally hadn't receive insulin at that time, so she double checked the MAR prior to administering. She was aware that he was a dialysis patient, but not familiar with his care needs. Stated she gave the resident the 4:00 a.m. injection, then returned to room at 5:30 and gave the second ordered injection. Staff D reported Resident #3 alert and she recalled no other interaction with Resident #3.

The Progress Notes dated 12/13/20 revealed the following:

a. At 8:30 a.m., Staff A (Licensed Practical Nurse) documented Resident #3 had a blood glucose level of 34, lethargic, diaphoretic, and unable to arouse. The staff rubbed sugar on Resident #3's gums.

b. At 8:35 a.m., Staff A administered a Glucagon injection.

c. At 9:00 a.m., Staff A Resident #3 still lethargic and not responding and had a blood glucose level of 57.

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F 760	Continued From page 15 d. At 9:45 a.m., Staff E (Registered Nurse asked to assist, blood glucose level 69, lethargic and difficult to arouse. Aroused with vigorous tactile stimuli and loud verbalization of his name, and confused when normally oriented. Resident #3 tachypneic (rapid respirations) at 28 breaths per minute. Oxygen saturation 73% on room air. Placed on 2 liters of oxygen per nasal cannula. Staff called 911, Medics arrived quickly and report given. e. At 3:00 p.m. Staff F (Registered Nurse) talked to the nurse and physician at the hospital and learned Resident #3 admitted for a collapsed left lung with mucus plug, determined an acute event. According to a Medication Error Report sheet dated 12/13/20 revealed Resident #3 received Novolin 10 units at 4:00 a.m. and 5:30 a.m. Resident #3 had an outcome of dropped blood glucose level. The staff provided an intervention of juice and glucagon to raise the blood glucose level. The sheet included a summary of the error and documented the type of error as duplicate order and the reason for the error as transcription error. Review of a History and Physical dated 12/13/20 revealed Resident #3 presented to the Emergency Department with altered mental status after receiving a double dose of insulin. Resident #3 had a blood glucose level of 34 and received glucagon. He had an oxygen saturation in the mid-70s on room air upon arrival. Assessment included hypoglycemic episode due to double insulin dosing. On 12/21/20 at 1:30 p.m. the Administrator provided a blank form titled Triple Check. The	F 760		

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F 760	Continued From page 16 Administrator explained the staff complete the form with all new orders. The form directs first check to be completed by the receiving nurse, the second and third check are to be completed by the charge or shift nurse. The Administrator confirmed the facility was unable to find a completed triple check form for the insulin order entered on 12/7/20. The Administrator stated an expectation of staff to complete the triple check from for all new orders. During an interview on 12/15/20 at 12:40 p.m., Staff A (Licensed Practical Nurse) stated she entered Resident #3's room to deliver room tray and take vital signs and was unable to wake Resident #3 up. Resident #3 had a blood glucose level of 34. Staff A placed sugar on a toothette and placed it inside Resident #3's cheek. Staff A sent another staff to obtain the Emergency Kit for glucagon. She had another emergency so asked Staff E (Registered Nurse) to assist. Staff A confirmed that she had knowledge of the triple check system to assure orders are correct. During an interview on 12/16/20 at 1:00 p.m., Staff E (Registered Nurse) stated at 9:30 a.m., Staff A (Licensed Practical Nurse asked for assistance with Resident #3. Staff A informed Resident #3 had a low blood glucose level that wasn't raising. Staff E obtained a blood glucose level of 69. Resident #3 had an altered mental status, required vigorous tactile stimulation, confused and usually made own decisions, and had audible congestion. Staff E reported Resident #3 critically ill, a full code, and needed to be transferred out. Staff E called 911 and Medics arrived quickly. Staff E had knowledge of the triple check system for new orders. Staff E	F 760		

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F 760	Continued From page 17 reported the facility did not require a double check prior to administering insulin. On 12/17/20 at 4:40 p.m. the State Agency informed the facility of the Immediate Jeopardy. The facility removed the Immediate Jeopardy on 12/17/20 by educating staff on the procedure for transcribing physician's orders, insulin administration, time changes, double check system implemented for insulin, complete bi-weekly audits of the MARS, and education provided to agency staff. After the corrective actions the scope and severity lowered from "J" to "D".	F 760		
F 880 SS=E	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	F 880		

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F 880	Continued From page 18 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; (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	F 880		

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F 880	Continued From page 19 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 observations, staff and resident interviews, record review, facility policy and procedures the facility failed to implement an effective infection control program in accordance with CDC recommended infection control practices to control and prevent the spread of COVID, failed to ensure proper hand hygiene, failed to properly don and doff Personal Protective Equipment (PPE), failed to notify the Iowa Department of Public Health, and failed to create an individual plan to cohort residents during and outbreak. The facility had 30 positive COVID residents on 11/20/20. 10 COVID negative residents resided in a rooms with COVID positive residents. The facility reported a census of 98. Findings include: 1. Record review of residents on A Hall revealed Room 39-A tested positive on 11/16/20 with roommate in room 39-B testing positive on 11/20/20. Record review of residents on A Hall revealed Room 40-B tested positive on 11/16/20 with roommate in room 40-A testing positive on 11/20/20. Record review of residents on B Hall revealed Room 50-B tested positive on 11/16/20 with roommate in room 50-A testing positive on	F 880		

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F 880	Continued From page 20 11/20/20. Record review of residents on C Hall revealed Room 47-A tested positive on 11/12/20 with roommate in room 47-B testing positive on 11/20/20. During an interview on 11/23/20 at 2:11 p.m., the Administrator and the Director of Nursing stated they did not have a written plan in place prior to 11/12/20, when the first resident tested positive for COVID, to directing staff how to handle an outbreak for 1 resident testing positive and the other negative. They reported they had the first 3 residents test positive with an antigen testing and quarantine all residents on the hall and shut the wing down. They contacted the National Health Safety Network electronically and no response received. They made phone contact with the Iowa Department of Public Health and followed their guidelines and the guidelines of the CDC and CMS guidelines to direct the staff how to care for COVID positive and negative residents. 2. During an observation on 12/7/20 at 11:20 a.m., Staff G (Nurse Aide) entered a COVID Positive room N6, outside the room was located signage that stated droplet precautions, and to wear N95 mask, shield, gown and gloves. The door to the room was sealed with a plastic barrier with a zipped entrance. A fan was observed to be placed in the window to provide negative pressure. Staff G, had a KN95 mask, goggles, disposable gown. Prior to entering the room Staff G donned a second gown and gloves. Staff G entered the room and provided care to resident. Staff G then exited the room with a red bag of soiled items. Under constant observation Staff G set the red bag directly on the floor, then	F 880		

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F 880	Continued From page 21 proceeded to remove her gloves and both gowns, the tie to one of the gowns fell onto the floor. Staff G carried the soiled gowns and gloves, and red bag of soiled items up and down the hall looking for a red receptor, which when located placed the soiled items in. Staff G walked to a clean isolation cart down the hall to obtain a new first layer gown. Staff G donned a new gown, sanitized her hands at a wall sanitizer dispenser. Staff G touched multiple surfaces after leaving the COVID positive isolation room which included the clean isolation cart, prior to sanitizing her hands. Staff B (Assistant Director of Nurses) present for the entire observation, reported she would not expect staff to go up and down the hall with soiled items, should have a red receptacle outside of the COVID positive rooms to place soiled item. Staff B stated an expectation of staff to sanitize hands immediately after removing gown and gloves. Confirmed this had not occurred even though sanitizer was readily available outside of the room on the wall. Staff B alerted maintenance to now place red bins outside of each COVID positive room. 3. During an observation on 12/7/20 at 11:45 a.m., Staff F (Registered Nurse) prepared medications as she stood at the medication cart to take into room 30. Staff F had a green disposable gown, KN95 mask and goggles on while setting up medications. Staff F donned gloves and a second gown and proceeded to enter the room labeled as droplet isolation and sealed with a plastic barrier with zipped entrance. Staff F carried a glucometer and test supplies, a disposable glass of water and medications in a disposable cup. Under constant observation Staff F obtained a blood glucose reading resident's blood sugar and administer oral medications.	F 880		

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F 880	Continued From page 22 Staff F exited the room and removed her gloves. Staff F used one of the soiled gloves as a barrier and placed the glucometer on the soiled glove and placed the glucometer on it, on the surface of the medication cart. Staff F failed to sanitize hands, was then observed as she obtained the medication cart key from her pocket and unlocked the medication cart. With soiled hands unlocked the bottom drawer and obtained a disinfecting wipe from container and wrapped around the blood glucose machine. At this time Staff F removed her top gown which she had donned to prior to entering the COVID positive room and placed on a hook outside the room for re-use. Under continued observation Staff F, RN then sanitized hands. 4. During a meal observation on 12/9/20 at 11:45 a.m., Staff H (Dietary Aide) had a gown, KN95 mask, shield and gloves as she pushed a beverage cart down the hall for lunch meal. Staff H exited room W30 (COVID positive) positive by signage and zippered plastic barrier at entrance. Staff H failed to wear a second gown and failed to remove gloves and sanitize hands. Under constant observation with same gloved hands and gown returned to the beverage cart and poured drinks into disposable cups. With soiled gloved hands Staff H observed to touch the handle of the cart, disposable glasses, milk container and red juice container. Staff H was then observed to enter room W32, no signage for positive COVID precautions with poured drinks. Staff H then returned to the cart and prepared beverages and delivered to room W29 labeled as Covid-19 positive precautions. Staff H then observed to enter and exit room W-29 and continued to wear the same gown and gloves. Staff H, then returned to the cart and prepared	F 880		

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F 880	Continued From page 23 beverages and entered and exited room W34, no COVID precautions posted, continued to wear the same gloves and gown. Staff H continued to wear the same gloves and gown as prepared and delivered beverages to room 31 before exited the unit and entered the kitchenette in the back area still wore the same gloves and gown. During an interview on 12/9/20 at 2:15 p.m., Staff B (Assistant Director of Nurses) stated she would expect dietary staff to follow the same precautions as nursing staff. Would expect to deliver beverages to the COVID negative rooms' first wearing gown, KN95 mask, and eye protection and sanitize hands immediately upon exiting the room. Then would expect to deliver beverages to the COVID positive rooms and would need to don a second gown and gloves prior to entering. The second gown and gloves would be doffed as exits and hands sanitized immediately. 5. In an interview on 12/9/20 at 2:30 p.m., Staff I (Nurse Aide) reported Staff J (Registered Nurse) would often pull down her mask and leave under her chin when in the hallways and front common area of the nursing home. Staff I reported that was commonly known that Staff J reported respiratory problems and difficulty breathing with mask on. During an interview on 12/15/20 at 2:45 p.m., Staff K (Prior Director of Nursing) confirmed Staff J failed to wear mask at all times, had witnessed herself. Reported she had provided education and had verbally counselled, but should have formally written up for not following the standard COVID precautions of wearing a KN95 mask, gown and eye protection at all times. Stated all	F 880		

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F 880	Continued From page 24	F 880		

staff had been educated and confirmed had been an expectation of all staff to follow the standard COVID precautions. Stated not following precautions put the residents and fellow staff at risk. Staff K, RN further stated current expectations for PPE included the following: KN95 mask at all times when in the facility, eye protection (goggles or face shield), gown at all times when in the facility, when enter a COVID positive room, identified by signage and a plastic zipped barrier would expect a second gown over the top of gown worn at all times, and gloves, and second gown and gloves should be discarded immediately upon exiting the COVID positive room and hands sanitized immediately.

Review of an undated document titled Altoona Nursing and Rehabilitation Center, Plan for outbreak when facility is at capacity revealed the policy of the facility to follow the CDC and IDPH guidelines and adhere to current CDC infection prevention and control recommendations. Procedures identified included the following:

Facilities will establish a COVID care unit which is physically separate from other rooms or units housing residents with COVID such as a separate floor, wing, or cluster of rooms.
All recommended Covid-19 PPE (personal protective equipment) will be worn during care of residents which included use of an N95 or higher level respirator, eye protection (goggles or disposable face shield), gloves and gown.

The Handwashing/Hand Hygiene policy and procedure dated 10/2009 stated that the purpose was to provide guidelines for effective hand washing and hygiene techniques that aid in the prevention of the transmission of infections.

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F 880	Continued From page 25 General guidelines included the following: 1. Appropriate ten to fifteen second handwashing with soup and water must be performed: a. Before and after contact with residents. b. When hands are visible dirty or soiled with blood or other body fluids. c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin. d. After removing gloves. 1. The use of gloves does not replace handwashing. 1. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub included the following situations: a. Before and after direct contact with residents. b. Before donning sterile gloves. c. After contact with resident's intact skin. d. After contact with inanimate objects (e.g., medical equipment) in the immediate vicinity of the resident. e. After removing gloves. 4. Hand hygiene is always the final step after removing and disposing of PPE.	F 880		

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	165162	A. BUILDING _____ B. WING _____	C 01/13/2021

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F 880	Continued From page 26 https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html: The Centers for Disease Control and Prevention updated 11/4/20, for The Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronarvirus Disease 2019 (COVID-19) Pandemic: Personal Protective Equipment Health Care Provider (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring Airborne Precautions (e.g., tuberculosis, measles, varicella). Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19. Hand Hygiene HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and	F 880		

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F 880	Continued From page 27 after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHS with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location. Personal Protective Equipment Training Employers should select appropriate PPE and provide it to HCP in accordance with OSHA PPE standards (29 CFR 1910 Subpart I) external icon. HCP must receive training on and demonstrate an understanding of: when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE, the limitations of PPE. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Respirator or Facemask (Cloth masks are NOT	F 880		

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F 880	Continued From page 28 PPE and should not be worn for the care of patients with suspected or confirmed COVID-19 or other situations where use of a respirator or facemask is recommended.) Put on an N95 respirator (or equivalent or higher-level respirator) or facemask (if a respirator is not available) before entry into the patient room or care area, if not already wearing one as part of extended use strategies to optimize PPE supply. Other respirators include other disposable filtering face piece respirators, powered air purifying respirators (PAPRs), or elastomeric respirators. N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol generating procedure. See appendix for respirator definition. Disposable respirators and facemasks should be removed and discarded after exiting the patient ' s room or care area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or facemask. If reusable respirators (e.g., powered air-purifying respirators [PAPRs] or elastomeric respirators) are used, they should also be removed after exiting the patient ' s room or care area. They must be cleaned and disinfected according to manufacturer ' s reprocessing instructions prior to re-use. When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with suspected or confirmed SARS-CoV-2 infection. Those that do not currently have a respiratory protection	F 880		

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F 880	Continued From page 29 program, but care for patients with pathogens for which a respirator is recommended, should implement a respiratory protection program. Eye Protection Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays. Ensure that eye protection is compatible with the respirator so there is not interference with proper positioning of the eye protection or with the fit or seal of the respirator. Remove eye protection after leaving the patient room or care area, unless implementing extended use. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse. Gloves Put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily	F 880		

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F 880	Continued From page 30 contaminated. Remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene. Gowns Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Reusable (i.e., washable or cloth) gowns should be laundered after each use. Additional information is available at Personal Protective Equipment: Questions and Answers. Facilities should work with their health department and healthcare coalition external icon to address shortages of PPE.	F 880		

Altoona Nursing and Rehabilitation Plan of correction for survey ending 1/13/2021

This serves as the credible allegation of compliance for Altoona Nursing and Rehabilitation Center. We assert that all correctives described in this plan of correction have been implemented. Regarding the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of Altoona Nursing and Rehabilitation Center is committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Altoona Nursing and Rehabilitation Center is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon re-survey.

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Altoona Nursing and Rehabilitation Center has completed the following interventions as a result of the findings from survey exiting 1/13/2021. The facility will be in substantial compliance with F 684 and F 760 by February 15, 2021. The facility will be in substantial compliance with F 880 by February 22, 2021.

F684 SS=J (Abated to D) QUALITY OF CARE: Altoona Nursing and Rehabilitation Center will ensure that based on a comprehensive assessment of a resident, each resident will receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident choices. All nurses were re-educated by the Director of Nursing and/or Assistant Director of Nursing on 12/30/2020 regarding the importance of transcribing orders correctly, following physician's orders, and ensuring residents appointments are made and attended to timely. Effectively immediately, the DON/ADON and/or designee on the weekends will complete a "triple check" process whereas orders are reviewed for accuracy and completion prior to the morning quality assurance meeting. Orders from the previous 24-hour period will be pulled from PCC (Point click Care-the facilities EMR system) for review. Any corrections required will be completed immediately at time of review. Resident appointments will be documented on an appointment calendar and transportation arrangements made. This calendar will be reviewed during the morning quality assurance meeting to ensure appointments are kept and attended too. Should a resident be unable to attend a scheduled appointment the resident's provider, attending physician, and resident representative will be notified and documented in the resident's medical record. Nursing staff were re-educated by the Director of nursing and Director of Clinical Services on 12/30/2020 instructing them to run a "missing entry" report in PCC to ensure all treatments have been completed prior to the end of his/her shift and documented. The DON/ADON and/or designee will additionally run a missing entry report every 24 hours with immediate corrections as needed. Weekly skin assessments are completed and will continue on a weekly basis. Those residents with wounds have documented measurements, and description of wounds completed weekly by the

wound nurse and reviewed by the Director of Nursing.

Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting with additional intervention as indicated.

F 760 SS=J (Abated to D) RESIDENTS ARE FREE FROM SIGNIFICANT MEDICATION ERRORS: Altoona Nursing and Rehabilitation Center will ensure that residents are free from medication errors. Nurses were re-educated by the DON, ADON, and Director of Clinical services on 12/21/2021 as to the proper procedure for transcription of physician orders and insulin administration. Education included that medication "time changes" must also be approved by the physician and a physician's order written for clarification. Reviewed proper transcription and documentation of insulin, and the five rights of medication pass. The facility immediately implemented a system where a nurse administering insulin will verify with another nurse that it is the right drug, the right dose, the right route, and the right time prior to insulin administration. Effective immediately, the DON/ADON/Designee will review the 24-hour progress notes for any changes in resident's status, and any new physician's orders prior to the morning quality assurance meeting to ensure accuracy. Blood sugars and insulin orders were audited by the Director of Nursing for accuracy in transcription and administration on 12/16/20. Orders are now reviewed in a "triple check" process prior to the morning quality assurance meeting to ensure ongoing compliance. Since error in insulin administration Altoona Nursing and Rehabilitation has not employed any agency staff. In the event agency staff would be utilized, the nurse will require a competency/proficiency test on insulin administration and medication pass prior to working. Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.

F 880 SS=E INFECTION PREVENTION AND CONTROL: Altoona Nursing and Rehabilitation Center will ensure infection prevention and control practices are followed in order to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility will ensure that staff adhere to proper hand hygiene, doning and doffing of PPE (Personal Protective Equipment) and cohorting of residents appropriately during a COVID outbreak. The facility administratorwill ensure ongoing communication and contact the Iowa Department of Public Health Department in the event of an outbreak within the facility. Altoona Nursing and Rehabilitation Center currently has no active COVID-19 cases in the facility. Staff were re-educated by the Director of Nursing, facility administrator and Director of Clinical Services on 1/25/2021 regarding infection control practices, hand hygiene, and donning and doffing of PPE correctly. Hand washing and

donning and doffing proficiencies completed with staff by the DON, ADON and licensed nurses to ensure compliance. Random audits of PPE usage, donning and doffing will be completed by the DON/ADON to ensure ongoing compliance. The administrator contacted Telligen (QIO) as directed on 2/16/2021 to schedule root cause, analysis of infection control practice. Upon receipt of the facilities statement of deficiencies, staff began watching directed you tube videos of PPE lessons, Sparkling surfaces, Clean hands, and Keep Covid out. All staff will have completed these videos by compliance date of February 22, 2021. Staff will not be allowed to work after February 22, 2021 until video observation has been completed. Newly hired employees will be required to watch these videos as part of their new employee orientation. Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.