STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165234	A. BUILDING _____ B. WING _____	C 08/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR	516 THIRTEENTH STREET WELLMAN, IA 52356

(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 000	INITIAL COMMENTS Amended on 12/21/20 following IIDR held 12/16/20. Correction date: 8/19/20 A COVID-19 Focused Infection Control Survey and complaint #92330 was conducted by the Department of Inspection and Appeals on August 12 - 18, 2020. Complaint #92330-C was substantiated. See Federal Code of Regulations (42-CFR) Part 483, Subpart B.	F 000		
F 684 SS=D	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 record review and staff interview, the facility failed to provide treatments as ordered by the Physician for 1 of 5 sampled (Resident #1). The facility reported a census of 46. Findings include: According to the Minimum Data Set assessment dated 6/5/20, Resident #1 had a Brief Interview	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ryan Laumer | TITLE: Administrator | (X6) DATE: 09/10/2020

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 for Mental Status score of "5", indicating severe cognitive impairments. Resident #1 required limited assistance with mobility and transfers and extensive assistance with dressing, toilet use and personal hygiene needs. Resident #1 had diagnoses of cancer, congestive heart failure, renal insufficiency, diabetes mellitus and dementia. A Hospital Discharge sheet dated 7/7/20 indicated Resident #1 had excoriation and erythema to her buttock area. The sheet contained a Physician Orders to apply Dermaseptin two times a day to Resident #1's perineal and buttocks. The July 2020 Treatment Administration Record (TAR) revealed a Physician's Order to apply Dermaseptin to Resident #1's perineal and buttock area twice a day (7:00 a.m. and bedtime) for stool incontinence. The TAR revealed omissions in the morning treatment on 7/15 and 7/20 and omissions in the evening treatment on 7/7, 7/9, 7/10, 7/16, 7/17, 7/18, 7/27, 7/28, 7/29, 7/30, 7/31, 8/1 and 8/2. During an interview on 8/18/20 at 11:50 a.m., the Director of Nurses stated the facility had a supply of Dermaseptin on hand for the staff to complete Resident #1's treatments.	F 684		
F 880 SS=F	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	F 880		

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F 880	Continued From page 2 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; (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.	F 880		

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F 880	Continued From page 3 (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 observations, record review and staff interviews, the facility failed to implement infection prevention and control protocols, including an effective screening process and adhering to transmission based precautions established to mitigate the risk for the spread of COVID-19, effecting all 46 residents. The facility reported census was 46. Findings include: Observation on 8/12/20 at 11:00 a.m. revealed the facility had a designated "quarantine" hall. The hall had a census of 3 residents. The area outside the rooms failed to contain Personal Protective Equipment (PPE) supplies such as gowns and gloves. Resident #2 and Resident #3	F 880		

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F 880	Continued From page 4	F 880		

who resided on 200 hall (not quarantine hall) had a quarantine status. The door to Resident #2 and Resident #3's room failed to contain any posted sign indicating quarantine status and precautions. The area outside Resident #2 and #3's room failed to contain a PPE supplies.

During an observation on 8/12/20 at 5:09 p.m., Staff A and Staff B entered Resident #2's room and assist him with his call light and removed his meal tray. Staff A and B entered the room without donning a gown or gloves. Resident #2 recently returned from the hospital and had a quarantine status.

During an interview on 8/12/20 at 5:09 p.m., Staff A (Nurse Aide) stated residents returning from the hospital, emergency room visits and appointments outside of the facility had a quarantine status for 14 days. The residents on quarantine status had direction not to leave their rooms or commingle with other residents. Staff A stated they wear a face mask and face shield or goggles as they would with any resident, but are not required to wear a gown or gloves for residents on quarantine status.

During an interview on 8/20/20 at 11:45 a.m., the Director of Nurses (DON) stated the facility had no COVID-19 positive residents. The facility had a designated quarantine hall in which residents who return from the hospital, emergency room visits, appointments outside of the facility, and new admissions resided for 14 days. Residents on dialysis had an indefinite quarantine status. The designated quarantine hall contained private rooms and the residents on quarantine status were not allowed out of their rooms for meals or activities. The DON stated residents in

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F 880	Continued From page 5 quarantine status had no transmission based precautions other than the CDC required use of a mask and face shield. Staff are not required to wear a gown or gloves. During an interview on 8/12/20 at 12:55 p.m. Staff C (Restorative Aide) stated staff are required to wear a face shield and mask and use good hand hygiene practices when caring for all residents. Staff C stated there are some residents in quarantine, but they do not require any higher level of personal protective equipment (i.e. gowns, gloves) than any other resident. During an interview on 8/12/20 at 1:10 p.m., Staff D (Nurse Aide) stated staff are required to wear a mask and goggles or a face shield at all times and use good hand hygiene practices. Residents in quarantine do not require any additional PPE, but are required to remain in their rooms. According to the Centers for Medicare and Medicaid Services (CMS) QSO-20-29-NH dated 5/6/20, Summary COVID 19 Focused Survey for Nursing Homes protocol, residents on Contact Precautions (quarantine) require staff to wear gloves and isolation gown before contact with the resident and/or his/her environment. During an interview on 8/17/20 at 11:42 a.m., the Administrator stated on 6/13/20 stated an Agency Aide worked the overnight shift without using proper PPE (mask). The Administrator stated he was informed by the on-coming day nurse, Staff E. Out of precaution the facility had all residents placed on quarantine for 14 days. The Administrator identified the overnight aide as Staff F.	F 880		

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F 880	Continued From page 6	F 880		

During an interview on 8/17/20 at 1:12 p.m., the Director of Nursing (DON) stated on the morning of 6/13/20 she was informed of an aide not wearing her mask during her shift. The DON stated she contacted the agency and confirmed the aide had not worn her mask during the overnight shift on 6/12/20. The DON stated they requested the aide be tested for COVID 19 and placed all of their residents on quarantine for 14 days.

During an interview on 8/17/20 at 12:47 p.m., Staff F (Nurse Aide) stated she worked multiple shifts at the facility and on overnight shift it was common practice to not wear a mask and when they did it was pulled down onto their chin. Staff F stated she was told to just make sure the mask is on when day shift arrives because they are real strict. Staff F stated on the overnight shift on 6/12/20 she arrived around 10:00 p.m. and filled out the screening sheet, noting there was no witness verifying her answers or checking her temperature. Staff F stated she didn't have a mask and the facility was hiding them because staff were taking them home. Staff F stated other staff on the overnight shift was also noncompliant with wearing the mask and she had witnessed the DON not wearing a mask as well. On the morning of 6/13/20, the on-coming nurse (Staff E) questioned her about not wearing a mask and she told Staff E she hadn't worn a mask all night. Staff F stated she left and later that morning was contacted by her supervisor noting the facility was requesting she get a COVID-19 test. Staff F stated she was not a priority and didn't get the test. Staff F stated she has not worked at the facility since.

During a record review, the screening form Staff

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F 880	Continued From page 7 F filled out on 6/12/20 was examined. Staff F checked the box indicating she did not sanitize her hands and did not answer the questions related to the presence of signs and symptoms of COVID-19. Staff F did not indicate on her screening form that she has worked with individuals with COVID. Staff F indicated she was instructed to wear a mask prior to resident contact and she had been educated on social distancing and hand hygiene. The form was signed by Staff G and dated 6/12/20. During an interview on 8/17/20 at 2:35 p.m., Staff G (Administrative Assistant) was asked about her signature on Staff F's screening form dated 6/12/20. Staff G admitted it was her signature and admits she was not at the facility on 6/12/20 at 10:00 p.m. Staff G had no explanation for why she would have signed a screening form in which she had not witnessed.	F 880		

Parkview Manor Plan of Correction for Survey ending August 18th 2020

Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Executive Director, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency. At the time of the COVID-19 focused infection control survey complaint June 18th, there continued to be NO residents with known or confirmed cases of COVID-19 at Parkview Manor. Washington County continued to be considered a low risk for community COVID-19 activity in accordance to CMS QSO-20-38-NH dated August 26th 2020. Having a positivity rate under 5%.

F684 Quality of Care

Corrective Action Completed for Affected Resident:

Resident #1 affected area had no further skin breakdown since the start of Dermaseptin on 7/7/20. Education was done with staff over documentation.

The facility recognizes that All Residents have the potential to be affected.

Action/Changes to Prevent Recurrence:

Education has been given to staff on documentation, The DON has audited resident #1 documentation following up with nursing staff. DON/Designee will audit staff daily for 4 weeks weekly for 3 weeks and randomly for 3 Months.

Monitoring for Assurance of Continued Compliance:

Results of audits will be reviewed and follow up action will be taken as needed to maintain compliance via monthly review in QAPI by NHA/BOM/Designee.

Date of Compliance August 18th , 2020

F880 Infection Prevention and Control

Corrective Action Completed for Affected Resident:

Education was completed by NHA/DON/Administrative assistant, Nursing department that all residents wear face coverings if able, all staff wear a facemask and eye protection for all patient encounters. Staff are to wear gloves, gown, eye protection and an N95 or higher-level respirator if able for residents with known or suspected COVID-19. Suspected COVID-19 also includes all residents being admitted or having come back from a appointment deemed essential. The Agency CNA and Charge nurse have not and will not be scheduled shifts in the future, their Agency was notified of their actions. The charge nurse is responsible for screening done after 4:30 the administrative assistant has been educated she is to check

to see that the screening has been completed from the previous day for concerns not to sign as a witness to their completion.

Administrative assistant/ DON/Designee will audit staff daily for 4 weeks weekly for 3 weeks and randomly for 3 Months.

Monitoring for Assurance of Continued Compliance:

Results of audits will be reviewed and follow up action will be taken as needed to maintain compliance via monthly review in QAPI by NHA/BOM/Designee.

Date of Compliance August 18th , 2020