STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165524	A. BUILDING _____ B. WING _____	12/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY LUTHERAN HOME	SEVEN ELLIOTT STREET COUNCIL BLUFFS, IA 51503

(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 OK JAG Correction Date: 1-8-2021 A Focused COVID-19 Infection Control Survey was conducted 11/24-12/1/2020 by the Department of Inspections and Appeals. The facility was found to not be in compliance with CMS and Centers Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. (See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C). Total residents: 77	F 000		
F 880 SS=D	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;	F 880	Videos watched — staff — 1-8-21 2 staff left completed — 1-11-21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	RN/CAO	1-8-2021

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 880	Continued From page 1 §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 infection.	F 880		

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F 880	Continued From page 2 §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, staff interviews, and facility staff education the facility staff failed to wear the appropriate Personal Protective Equipment (PPE) while cleaning 1 of 3 resident rooms (Resident #1) that were located on the presumptive unit, Skyline Yellow. At the time of the Focused COVID-19 Infection Control Survey, the facility reported 18 positive cases on 11/24/2020. The facility reported a census of 77 residents. Findings include: Observation on 11/24/2020 at 9:54 a.m., revealed 6 rooms on the Skyline Yellow with signs on the doorframes that stated N95. Observations revealed storage drawers with blue disposable gowns stored in the hallway. Observation on 11/24/2020 at 9:55 a.m., revealed Staff C, Housekeeping entered Resident #1's room with a surgical mask and goggles on. Staff C cleaned her room while Resident #1 sat in her recliner. There was not a N95 mask sign on the doorframe of Resident #1's room. Staff C failed to don a gown before entering Resident #1's room which was located on Skyline Yellow. Observation on 11/24/2020 at 10:02 a.m., revealed Staff C was in the hallway and had put on a blue disposable gown, N95, and goggles and went into Resident #2 and #3's room to clean. There was a sign that read N95 on the	F 880		

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F 880	Continued From page 3 doorframe of their room. Observation on 11/24/2020 at 10:11 a.m., Staff C exited Resident #2 and #3's room, doffed her gown and gloves. Staff D, Certified Nursing Assistant (CNA) donned a blue disposable gown, gloves and already had her goggles, N95 with surgical mask on. Record review revealed the following Progress Notes dated 11/15/2020 at 11:01 a.m.: Resident #1 complained of sore throat and ear pain. A rapid COVID test was performed and was negative. Her family was notified of the room change and negative COVID swab. Another Progress Note on 11/15/2020 10:33 p.m.: Resident #1 transferred to room 233 on Skyline Yellow. Record review revealed the following Progress Note dated 11/24/2020 at 4:52 a.m.: negative COVID-19 test and an order to lift droplet precautions on 11/29/2020. Record review revealed the following Progress Notes dated 11/22/2020 at 11:29 a.m.: Resident #2 remained on droplet precautions, no roommate and no signs and symptoms of COVID-19. 11/23/2020 at 1:31 p.m.: remained on droplet precaution. 11/24/2020 at 1:23 a.m.: remained in droplet isolation, no complaints voiced, no cough or shortness of breath noted. 11/27/2020 10:19 a.m. COVID test came back positive, asymptomatic at that time, moved to Skyline Red. Record review revealed the following Progress Notes dated 11/8/2020 at 3:26 p.m.: Resident #3 was moved to room 230 A for infection control purposes. Progress note dated 11/12/2020 at 11:15 a.m.: COVID test obtained with a negative	F 880		

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F 880	Continued From page 4 results. Progress Note dated 11/27/2020 at 10:57 a.m.: COVID test obtained with positive results. Resident #3 was asymptomatic and placed on droplet precautions in Skyline Red unit. Review of the Isolation Precautions List the facility provided revealed Resident #1 was moved to Skyline Yellow on 11/16/2020 because she exhibited signs and symptoms of COVID-19, Resident #2 was moved to Skyline Yellow on 11/19/2020 because she had been exposed to COVID-19, and Resident #3 was moved to Skyline Yellow on 11/1/2020 because she had off ground appointments. Review of the facility's education related to working on the Skyline Yellow unit revealed staff were instructed to enter the facility the back dock and go through the normal screening process. Staff will then enter Skyline Yellow through the temporary door on Sunrise. Staff are to never enter Skyline Red. Staff must wear a surgical mask and eye protection at all times. If working with a resident that was symptomatic and has a pending COVID 19 test, staff must wear a N95 with a surgical mask over and a disposable gown. The surgical mask and gown must be changed when exiting the resident room. During the Entrance Conference on 11/24/2020 at 8:35 a.m., the Director of Nursing (DON) and Assistance Director of Nursing (ADON) stated the facility had 18 resident with positive COVID-19 tests. They stated Skyline Yellow was the quarantine area and Skyline Red the area residents that were positive resided. When asked what PPE needed to be worn when entering Skyline Yellow they stated gown, N95 (if desired), otherwise a surgical mask, gloves and goggles.	F 880		

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F 880	Continued From page 5 Before entering Skyline Red PPE need to be changed. They stated some of their staff will wear a N95 with a surgical mask over the N95 for added protection. During staff interview on 11/24/2020 at 10:00 a.m., Staff B, Licensed Practical Nurse (LPN) and Staff C, Certified Medication Aide (CMA) were asked why the current residents resided on Skyline Yellow, they stated some had symptoms of COVID and others were exposed to COVID. When asked what PPE needed to be worn when going in to a room that had a sign that stated N95, they indicated staff need to wear a blue disposable gown, gloves, N95 with a surgical mask over it, and goggles. When asked what PPE needed to be worn when going in a room without a N95 sign they stated the same thing but did not have to wear a N95 unless the staff wanted to. They could just wear a surgical mask. Staff B and C were asked if non nursing staff had to wear PPE they stated they wear the same PPE as nursing. When asked if Housekeeping Staff wear the same PPE as nursing they stated yes. During a staff interview on 11/25/2020 at 3:42 p.m., the DON, ADON, Administrator, and Nurse Educator filling in for the Infection Preventionist (IP) while the IP completing COVID-19 tests. The staff members were asked why Resident #1, #2 and #3 were on Skyline Yellow. They stated Resident #1 had signs of symptoms of COVID-19, Resident #2's roommate had a positive test while they shared a room and Resident #3 had an off ground appointment. When asked what PPE staff were expected to wear while they worked on Skyline Yellow they stated all staff were to wear disposable gowns, N95 (if they chose to) otherwise a surgical mask,	F 880		

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F 880	Continued From page 6 eye protection and gloves. During a staff interview on 11/30/2020 at 10:55 a.m., Staff D, CNA stated she worked on Skyline Yellow. Staff D was asked what PPE needed to be worn when caring for residents on Skyline Yellow, she stated full PPE: gown, surgical mask unless they needed a N95, gown, goggles, and gloves. She stated they did not have to wear face shields and could wear surgical masks over their N95 masks if they wanted to. Staff D stated all staff that work on that hall have to wear the full PPE. She stated dietary is not allowed back there; only nursing staff and one housekeeper. She stated that Housekeeping Staff start in Skyline Yellow then goes to Red before she leaves and she has to be in full PPE just like the nursing staff.	F 880		

Amended POC Date

Bethany Lutheran Home

Plan of Correction

Infection Control Survey November 24, 2020 – December 01, 2020

To correct this deficiency as it relates to residents #1, #2, #3, Infection Preventionist and Interim Director of Nursing provided education to staff member C on 12/09/2020.

To protect other residents in similar situations, all staff will complete POC education (PPE lesson, Sparkling Surfaces, Clean Hands, Keep COVID OUT) by January 08, 2021.

To ensure the problem does not recur, the head of housekeeping or designee, will perform weekly PPE audits. Audit forms will be kept by the head of housekeeping. If further education from audit is needed, the head of housekeeping will collaborate with the Infection Preventionist or designee to provide the further education needed.

To monitor performance and ensure solutions are permanent, PPE audits will be reported to QAPI committee for 3 months. The QAPI committee will then determine if further reporting and/or monitoring is to continue.