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 _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR	516 THIRTEENTH STREET WELLMAN, IA 52366

(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 Correction Date: 7/18/20 A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on 6/16/20. The facility was found to not be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 52	F 000		
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 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,	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Ryan Lemmon Administrator 7/20/20

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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PARKVIEW MANOR	516 THIRTEENTH STREET WELLMAN, IA 52356

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F 880	Continued From page 1 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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to 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 for 3 of 3 sampled (Residents #1, #2, and #3) in accordance with the Centers for Disease Control and Prevention and CMS recommendations. The facility reported a census of 52. Findings: 1. During an observation on 6/16/20 at 1:40 p.m., Staff A (Nurse Aide) and Staff B (Nurse Aide) assisted Resident #1 with perineal cares and changed the resident's incontinent brief. Staff A and Staff B had surgical masks in place but no goggles or a face shield. The Iowa Department of Public Health Personal Protective Equipment Guidance dated 4/1/20 recommended healthcare workers that provide patient care in long term care facilities should use a minimum level of personal protective equipment for all patient care activities. There healthcare workers should use a face mask and eye protection for all patient encounters. 2. During an observation on 6/16/20 at 1:55 p.m., Staff A and Staff B assisted Resident #2 with perineal cares, placed a clean brief on Resident #2. Staff A and Staff B transferred Resident #2 from the wheelchair to the bed with a sit to stand lift. Staff A and Staff B had surgical masks but no goggles or a face shield. Staff B removed the sit to stand lift from Resident #2's room and placed it	F 880		

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F 880	Continued From page 3 in the hall. Staff B failed to disinfect the lift as directed per the CDC COVID-19, Preparedness Checklist for Nursing Homes and other Long Term Care Settings, dated 3/26/20, to complete frequent cleaning of high-touch surfaces and shared resident care equipment 3. During an observation on 6/16/20 at 3:00 p.m., Staff C assisted Resident #3 (who resided on the designated quarantine area) with incontinence cares and emptied Resident #3 catheter drainage bag into a graduate. After emptying the catheter, Staff C replaced the end of the tubing into the catheter bag and stated she would normally cleanse the end of the tubing with an alcohol wipe but the facility was short on wipes. While assisting the resident, Staff C had a surgical mask. Staff C failed to utilize a face shield, goggles, or gown as directed by CMS QSO-20-29-NH Memorandum Summary. The Summary directed staff to wear gloves, gown, eye protection and an N95 or higher-level respirator if able for residents with known or suspected COVID-19. During the cares, Staff C told the surveyor she did not know what PPE she was supposed to wear in the designated quarantine area. She stated she thought the residents in this wing should be treated as if they were positive for COVID-19. An undated, untitled facility list, provided to the survey team on 6/16/20, listed 7 residents on the designated quarantine area. The list stated Resident #3 had a hospital stay. The facility "Resident Matrix" documented Resident #3 admitted to the facility on 6/3/20. During an interview on 6/16/20 at 3:30 p.m., the	F 880		

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F 880	Continued From page 4 Director of Nursing (DON) provided the surveyor with a policy entitled "Novel Coronavirus COVID-19", dated 3/5/20. She pointed to the first portion of the policy entitled "Procedure" followed by the numeral "1". She stated this portion of the procedure was what the facility was using as a guideline for new admissions and readmissions. The policy directed staff to screen residents on each shift and assess for symptoms. This portion of the procedure did not direct staff to wear a gown or eye protection. The procedure did not specifically contain guidelines for taking care of residents admitted or readmitted within the last 14 days. The DON stated all of the residents in the "quarantine" wing had tested negative for COVID-19 so staff were not wearing gowns. During an interview on 6/16/20 at 5:32 p.m., the DON stated no one had directed staff to wear shields or goggles along with a mask. She stated staff would only be required to clean mechanical lifts between residents if the resident touched the lift. She stated the facility did not have a shortage of alcohol swabs and staff should cleanse catheter tubing before replacing it. She stated she did not have a policy for catheter emptying or disinfection of mechanical lifts. She stated the facility did not utilize designated staff on the "quarantine" wing and stated staff who take care of residents on that wing also work throughout the facility.	F 880		

Parkview Manor Plan of Correction for Survey ending June 16th 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 interested 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 June 16th, there were NO residents with known or suspected COVID-19 at Parkview Manor. The CDC Guidance for Healthcare professionals about Coronavirus (COVID-19) dated June 3, 2020 states, use of eye protection is recommended in areas with moderate to substantial community transmission. For areas with minimal to no community transmission, eye protection is considered optional, unless otherwise indicated as part of standard precautions.

F880 Infection Prevention and Control

Corrective Action Completed for Affected Resident:

Resident #1 was assisted with perineal cares Staff A and B had surgical masks in place but no goggles or a face shield. The Iowa Department of Public Health Personal Protective Equipment Guidance dated 4/1/20 recommended healthcare workers that provide patient care in long term care facilities should use a minimum level of personal protective equipment for all patient care activities.

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

Action/Changes to Prevent Recurrence:

Education was completed by NHA/DON, designee that all residents wear face coverings if able, all staff wear a facemask and eye protection for all patient encounters.

NHA/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 July 18th, 2020

F880 Infection Prevention and Control

Corrective Action Completed for Affected Resident:

Resident #2 was assisted with perineal cares by Staff A and B they placed a clean brief on resident #2 Staff A and Staff B Transferred resident #2 from their wheelchair to the bed with a sit to stand lift. Staff B

failed to disinfect the lift as directed per CDC COVID-19, preparedness checklist for Nursing Homes and other long term Care settings. Dated 3/26/20, to complete frequent cleaning of high-touch surfaces and shared resident care equipment.

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

Action/Changes to Prevent Recurrence:

Education was completed by DON/designee that all equipment must be wiped down with disinfecting agent after use. The disinfectant will be kept on the supply cart for employee ease of access and out of reach of residents.

DON/Designee will audit staff 3 times daily at random times for 4 weeks and 3 times Monthly thereafter.

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/DON/Designee.

Date of Compliance July 18th, 2020

F880 Infection Prevention and Control

Corrective Action Completed for Affected Resident:

Resident #3(who resided on the designated quarantine area) was assisted by staff C with incontinence cares and emptied Resident #3 catheter drainage bag into a graduate. After emptying the catheter Staff C replaced the end of the tubing into the catheter bag and stated she would normally cleanse the end of the tubing with an alcohol wipe but the facility was short on wipes. Staff C had a surgical mask. Staff C failed to utilize a face shield goggles, or gown as directed by CMS QSO-20-29NH Memorandum Summary Dated May 6, 2020. The Summary directed staff to wear gloves, gown, eye protection and an N95 or higher-level respirator if able for residents with known or suspected COVID-19. Because the resident resides on a quarantine hall does not mean they have known or suspected COVID-19.

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

Action/Changes to Prevent Recurrence:

Education was completed by NHA/DON, designee 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. Staff are to use alcohol wipes after emptying a catheter. If they are unable to locate a alcohol wipe ask nursing to get some.

NHA/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 July 18th, 2020