STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165395	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE CARE CENTER	401 S BIRCH STREET DANVILLE, IA 52623

(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	F 000		

Amended on 1/5/21 following IIDR held on 12/23/20.

Correction date: 10-5-20

The following deficiency relates to the Focused Infection Control survey conducted by the Department of Inspection and Appeals from August 20, 2020 to September 1, 2020.

See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.

F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)	F 730	

§483.35(d)(7) Regular in-service education.
The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
Based on record review the facility failed to complete annual Nurse Aide performance evaluations for 3 of 3 sampled.

Findings include:

Staff M's personnel file revealed a hire date of 10/16/17. Staff M's file contained one performance evaluation completed July 2018.

Staff P's personnel file revealed a hire date of 9/15/09. Staff P's file contained one performance evaluation completed August 2016.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marc Johnson	President	10/05/2020

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F 730	Continued From page 1 Staff Q's personnel file revealed a hire date of 11/6/14. Staff Q's file contained no performance evaluations.	F 730		
F 880 SS=L	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, 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	F 880		

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F 880	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to develop and implement a comprehensive infection control program, failed to implement an effective screening process, failed to utilize proper hand	F 880		

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F 880	Continued From page 3	F 880		

hygiene practices, and failed to utilize transmission based precautions in accordance with CDC recommendations in order to control and prevent the spread of COVID-19. The facility had an active COVID-19 outbreak affecting 14 of 25 residents with two deaths. The facility reported a census of 25.

Findings include:

Observations during the initial tour on 8/20/20 at 1:25 p.m. revealed the front door locked. The staff allowed the surveyor entry to the facility. This surveyor sanitized his hands and donned a mask and face shield, then approached the screening table. A second staff member, Staff A, checked this surveyor's temperature and recorded it. The screening form only required a temperature. The screening form lacked questions related to whether a staff or visitor had signs and symptoms common with COVID 19, exposure to COVID 19 or whether the staff or visitor sanitized their hands and donned appropriate personal protective equipment (PPE) before being allowed into the facility.

Observations on 8/20/20 at 2:05 p.m. revealed a staff member entered the facility with a mask and checked her own temperature, but failed to sanitize her hands or have someone verify her temperature.

During an interview on 8/20/20 at 3:00 p.m. Staff F (Social Worker) stated his office space is close to the front door, so when he works he is usually the one that checks the staff's temperatures in and out. Staff F stated the screening process is to check temperatures. There is no requirement to ask questions related to signs and symptoms

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F 880	Continued From page 4 or exposure to COVID 19. Staff F stated temperatures greater than 100.0 F is reported to the nurse to determine whether the employee can stay or be sent home. During an interview on 8/20/20 at 5:00 p.m., Staff D (Nurse Aide) stated she works for an agency and wasn't given much orientation prior to starting. Screening includes getting a temperature at the beginning and end of each shift. Staff are not required to answer questions related to COVID 19 symptoms or exposure outside of the facility. During an interview on 8/20/20 at 5:05 p.m., Staff G (Nurse Aide) stated she has worked at the facility about a month. Staff G stated screening is a temperature check before and after your shift. Screening does not involve answering questions related to signs and symptoms or exposure to COVID 19 outside of the facility. During an interview on 8/26/20 at 4:00 p.m., the Administrator indicated she was developing a new screening tool which would include questions related to COVID 19 symptoms and exposure. The form will require a staff member to verify the questions and temperature before allowing someone to work. Review of the new screening tool on 8/31/20, revealed on 8/26/20 Staff N (Nurse Aide) entered the facility and completed the form without a verifying initial. Staff N was afebrile, but answered affirmative to having a headache, sore throat and diarrhea. Despite answering questions related to signs and symptoms which would have restricted her from working for 10 days, Staff N not only worked her shift on 8/26/20, but also on	F 880		

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F 880	Continued From page 5 8/27, 8/28 and 8/29. During an observation on 8/20/20 at 1:25 p.m. a staff member is standing by the front entrance with her face mask pulled down below her chin and as this surveyor proceeded into the facility, Staff B (Dietary Aide) exited the kitchen into the dining room without wearing a mask, goggles or face shield. At 1:36 p.m., a Dietary Aide entered the facility without a mask or sanitizing her hands, had her temperature checked and proceeded to the kitchen. Observation on 8/20/20 at 2:00 p.m., revealed East South Hall had a partition and Personal Protective Equipment in the hallway. The floor contained several brown bags with staff names. The bags contained used PPE. Room 2 unoccupied. Room 3 occupied by Resident #1. Room 4 occupied by Resident #2 and #3. Room 5 occupied by Resident #4 and #5. During an interview on 8/20/20 at 2:15 p.m., the Administrator stated they had a designated isolation hall on East South for newly admitted residents, returning from hospital or emergency room or who have appointments outside of the facility. The unit contained 4 rooms (Room 2, 3, 4, & 5) with a total of 8 beds. Residents are placed on a 14 day isolation status and staff are to wear full PPE (mask, goggles, gown, gloves) when caring for these residents. The Administrator stated to preserve PPE supply, staff are permitted to re-use PPE (gowns, masks, goggles) without changing from room to room. Staff are to keep their gowns, masks and goggles in a paper sack. The Administrator stated the facility currently has no residents with COVID 19, although mentioned a therapy staff who had	F 880		

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F 880	Continued From page 6 recently tested positive for COVID 19. Observation on 8/20/20 at 2:45 p.m. Staff C (Licensed Practical Nurse) exited Room 5 on the isolation hall without wearing a gown or goggles and not sanitizing her hands. At 2:50 p.m., Staff D (Nurse Aide) entered Room 4 on the isolation hall without wearing a gown. And at 5:00 p.m., a Dietary Aide prepared plates of food at the steam table with her face mask pulled below her chin. Later the Dietary Aide delivered the plated food to the residents. During an interview on 8/20/20 at 4:00 p.m., the Administrator indicated the Director of Nurses was out ill and she was functioning as the facilities Infection Preventionist. The Administrator was asked to provide the facilities, infection control policies related to their surveillance plan, source control protocols, screening process, isolation protocols and emergency staffing plan. The Administrator stated she had gathered multiple documents from the CDC and public health departments but has not formally put the information into policy form. During an interview on 8/20/20 at 5:00 p.m., Staff D (Nurse Aide) stated she worked for an agency and did not receive much orientation prior to working. Staff D stated on the isolation hall, she changes her gown after each resident contact. Staff D stated other aides re-use their gowns indefinitely with all residents on isolation. During an interview on 8/20/20 at 5:05 p.m., Staff G (Nurse Aide) stated she worked at the facility about a month. Staff G stated on the isolation hall they wear full PPE. Gowns are re-used and placed in a brown paper sack with the staffs	F 880		

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F 880	Continued From page 7 name on the sack. One gown is used for all of the residents in isolation and not exchanged after each contact. During an interview on 8/24/20 at 11:55 a.m., the Administrator stated the facility had a status of COVID-19 outbreak and explained the progression of events to date. Four residents on the isolation hall had confirmed positive for COVID-19 and one died from COVID-19. Five other residents developed symptoms and moved to the designated Symptomatic Hall (East North). Initially three staff had confirmed positive COVID 19, and several others are now having symptoms. Staff J reported to work on 8/23/20 not feeling well with body aches and a cough, but no temperature. She was allowed to work, but went home ill at 12:00 p.m. The Administrator stated all residents and staff are tested if having symptoms and they have initiated twice a week testing for all staff and once a week for all residents. The Administrator stated staff are now wearing full PPE, gowns, face shield, N95 masks, shoe coverings and gloves on the now designated COVID hall (East South) and symptomatic hall (East North). During an interview on 8/24/20 at 5:31 p.m., Staff H (Occupational Therapist Assistant) stated she first started feeling ill late on 8/11/20. She had been in contact with Residents #1, #2 and #4 that day. Staff H stated she had a temperature the next day and did not report to work. She is tested on 8/12/20 and had confirmed positive for COVID-19 on 8/13/20. During an observation on 8/25/20 at 6:00 p.m., on the COVID hall revealed no supply of N95 masks, but instead dust masks. The floor of the COVID	F 880		

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F 880	Continued From page 8 Hall and the Symptomatic Hall contained several brown bags containing gowns, surgical masks and hair coverings. The COVID Hall and the Symptomatic Hall failed to contain signage on entry doors identifying precaution status, PPE requirements, donning and doffing protocols, etc. During an interview on 8/25/20 at 6:20 p.m., Staff L (Nurse Aide) stated her assignment included the COVID Hall and the Symptomatic Hall. Staff L stated the brown bags contained PPE for re-use. Each staff had a bag. Staff L stated she worked for an agency and is uncomfortable with the way the facility uses PPE. During an observation on 8/26/20 at 12:07 p.m., Staff K (Maintenance) entered the COVID Hall with gown and mask, had no contact with residents, and then left the hall without doffing PPE or hand hygiene. Staff K returned to the COVID Hall minutes later in a gown and surgical mask and proceeded to place screws in the wall to allow face shields to be hung. Staff K again left the COVID hall without doffing PPE or performing hand hygiene. During an observation on 8/26/20 at 2:12 p.m. Staff M (Nurse Aide) removed her PPE while on the COVID Hall and carried trash to the dumpster outside through the back door. The facility failed to utilize biohazard bags. Staff M stated she is told to dispose of trash in this manner. During an observation on 8/26/20 at 2:14 p.m., Staff L (Nurse Aide) exited the COVID Hall and entered the Symptomatic Hall without removing PPE and performing hand hygiene. Staff L stated she was told she could wear the same gown for residents on the Symptomatic Hall, but is	F 880		

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F 880	Continued From page 9 uncertain about the COVID Hall. During an observation on 8/26/20 at 3:15 p.m. Staff L (Nurse Aide assigned to the COVID Hall and Symptomatic Halls) commingled with staff in close proximity, less than 6 feet, who worked on the Asymptomatic Halls. During observations on 8/29/20 at 7:45 p.m. revealed Staff N (Nurse Aide) and Staff O (Nurse Aide) standing in the lobby area near the designated entrance to the facility. The surveyor entered and waited momentarily, then proceeded with answering the screening questions and checking his temperature. The surveyor again waited momentarily to see if staff offered to verify answers or the temperature check. The surveyor entered the facility. Staff N and Staff O indicated they worked for an agency and were assigned to work the Asymptomatic Halls. Staff N indicated the nurse and another aide working up front on the COVID and Symptomatic halls. Both staff are asked if they have watched the PPE video prior to their shifts. Staff O stated she has and Staff N stated she has not. This surveyor entered the COVID Hall and Symptomatic Hall. The DON exited the COVID hall wearing full PPE, doffing gloves and hand sanitizing before approaching the medication cart. The DON stated 11 residents currently had confirmed COVID-19. The COVID Hall had a census of 10. The Symptomatic Hall had a census of 1. The DON continued to work at the medication cart, then entered the COVID Hall in full PPE. Moments later the DON exited the COVID Hall doffing all PPE, then sanitizing her hands and donning PPE before proceeding to the Symptomatic Hall. The Facility Matrix Identified the facility had 14	F 880		

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F 880	Continued From page 10 residents positive for COVID, 10 residents with COVID symptoms and 2 residents positive for COIVD who passed away on 8/22/20 and 8/26/20. During an observation on 8/29/20 at 8:14 p.m. Staff L (Nurse Aide) the COVID hall. Staff L removed her gloves, mask and gown and performed hand hygiene. Staff L donned a new gown, mask and face shield and entered the Symptomatic Hall in which one resident had a positive COVID status. Staff L answered the call light of the positive resident, exited the room and removed the trash. Staff L removed PPE and sanitized her hands before exiting the hall. Staff L stated she has not watched the PPE training video prior to her shift and was planned to do so afterwards. On 8/26/20 at 3:00 p.m. the State Agency notified the facility of the Immediate Jeopardy. On 8/31/20 the facility abated the Immediate Jeopardy by implementing a new staff and visitor surveillance form, implemented a designated staff to screen, educated staff on proper utilization of Personal Protective Equipment, designated staff to the symptomatic unit and the COVID unit, educated staff on how to properly handle contaminated laundry, implemented red tape to alert staff of the isolation wing, educated staff on proper hand hygiene, and educated staff on the expectations and policies related to the spread of COVID-19. After the corrective actions the scope and severity lowered from "L" to "F".	F 880		
F 885 SS=C	Reporting-Residents,Representatives&Families	F 885		

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F 885	Continued From page 11 CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review and family interview, the facility failed to inform a resident's Responsible Party of a positive COVID-19 test result for 1 of 5 sampled (Resident #3). The facility reported census of 25. Findings include: According to the Analytical Final Report dated 8/24/20 at 1:23 p.m. Resident #3 had positive	F 885		

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F 885	Continued From page 12 COVID-19 test. The Clinical Record failed to reflect the facility notify Resident #3's Responsible Party of the positive COVID-19 test result. During an interview on 8/25/20 at 3:43 p.m., Resident #3's Daughter indicated that her mother reported she was positive with COVID, but no one from the facility had notified her.	F 885		
F 947 SS=C	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure Nurse Aides received 12 hours of continuing competency for 2 of 7 Nurse	F 947		

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DANVILLE CARE CENTER	401 S BIRCH STREET DANVILLE, IA 52623

(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 947	Continued From page 13 Aide (Staff P and Staff Q) records reviewed. The facility reported a census of 25. Findings include: During an interview on 9/1/20 at 11:15 a.m., the Administrator stated the facility provides periodic inservices and monthly on-line training, but notes since COVID training has been more sporadic and not closely monitored. The Administrator provided on-line (Relias) and inservice documentation and sign in sheets. Review of 7 Nurse Aide training records, noted 2 aides, with over a year of service, failed to receive the the minimum 12 hours of in-service training required per year.	F 947		

Danville Care Center – Plan of Correction for Focused Infection Control Survey Ending 9-1-20 Page 1

F730

This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law require it.

Without waiving the foregoing statement, it is the policy of Danville Care Center to complete a performance review of every nurse aide at least once every 12 months.

Supervisory Staff (DON, Administrator), and Administrative staff have been re-educated regarding completing Nurse Aide Performance Review evaluations at least once every 12 months. Date of Hire starts the calendar of the 12-month period.

Compliance will be monitored by DON, Administrator, and Corporate Office.

Correction Date: October 05, 2020

F880

This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law require it.

Without waiving the foregoing statement, Danville Care Center maintains it has an infection control program. Danville Care Center has developed a much more comprehensive infection control program. The facility will investigate, control, and prevent infections. The facility will take standard precautions. An example is respiratory hygiene. The elements in standard precautions include education of healthcare facility staff, patients, visitors. Post signs, mandate source control measures (cough etiquette) (face masks). Transmission-based precautions will be used. Those precautions include Contact Precautions, Droplet Precautions, and Airborne Precautions. Isolation of resident will occur for virus-positive residents. Symptomatic residents will be isolated. Asymptomatic residents will be isolated. A new screening process is in place for employees & visitors. (note-visitors are limited or restricted). Proper donning and doping will be reinforced as all staff employees have watched and signed off on in-service records. Proper hand hygiene is mandated to reduce the transmission of infectious agents. Personal Protective Equipment are mandated for source control measures. Visual signs have been placed at the entrance and other strategic places.

All Staff have been re-educated at an in-service meeting on October 5th regarding the prevention infection survey held from 8-20-20 to 9-1-20. All staff will be viewing youtube videos of PPE lessons, Clean Hands, and Keep Covid Out.
RCA (Root Cause Analysis) training was completed by corporate staff on 10-1-20, and a team of employees will be selected and trained on RCA. This is a companion learning tool to our QAPI. RCA will facilitate lasting systemic changes within facilities to drive sustained compliance.

Compliance will be monitored by DON, Administrator, supervisory staff and the Corporate Office.

Abated on 8-31-20
Correction date 9-25-20.

F885

This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law require it.

It is the policy of Danville Care Center to inform residents and their responsible parties of healthcare concerns such as emergencies and non-emergencies and new diagnosis. With respect to resident #3 and other residents, Danville Care Center maintains it will notify all responsible parties by 5:00 pm the next day. In most cases, the resident and the responsible party will have been notified more immediate.

Correction Date 10-5-20

F947

This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law require it.

It is the policy of Danville Care Center to provide in-service training for all employees. Danville Care Center recognizes that certified nurse assistants must have no less than 12 hours of training per year.

Compliance will be monitored by DON, Administrator, and supervisory staff.

Correction Date 10-5-20