DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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: 1-21-21 A Focused COVID-19 Infection Control Survey was conducted in conjunction with an investigation of complaint 93997-C, 94017-C, 94082-C, 94098-C, 94103-I, and 94190-C from October 13 - November 12, 2020. 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. Total residents: 48 Complaints 93997-C, 94082-C, 94098-C and facility reported incident 94103-I were substantiated. Complaints 94017-C and 94190-C were not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to ensure staff provided medications according to physician orders for 2 of 3 residents reviewed (Resident #5	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/26/2021

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 658	Continued From page 1 and #9). The facility reported a census of 48 residents. Findings include: 1. The annual Minimum Data Set (MDS) assessment tool dated 9/24/20 revealed Resident #5 diagnoses that included dementia, high blood pressure, edema, major depression, anxiety, and osteoarthritis. The MDS revealed the resident displayed severe cognitive impairment and behaviors, and required extensive assist of 2 staff for transfers and ambulation (walking). The Care Plan with a revision date of 10/7/20 documented Resident #5 took antipsychotic medication for major depressive disorder and had moments of anxiety and crying. The Medication Administration Record (MAR) dated September 2020 revealed an order for Lorazepam 0.25 to 0.5 milliliters orally every 2 hours as needed for anxiety. The Progress Notes dated 9/19/20 documented the resident wandered up and down the hallways throughout the day, crying and grabbing for staff as they walked by. The nurse attempted to administer lorazepam but none was available. Staff attempted other interventions at the time, but the record lacked documentation to show whether or not they were effective. 2. An admission MDS dated 10/28/20 revealed Resident #9 admitted to the facility on 10/22/20 with diagnoses that included dementia, hypertension, and atrial fibrillation. The MDS documented the resident scored 4/15 on the Brief Interview of Mental Status Test, which meant the	F 658		

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F 658	Continued From page 2 resident demonstrated severe cognitive impairment. The MDS also documented the resident required extensive assist of one staff for transfers and ambulation. The MAR dated October 2020 for Resident #9 failed to contain information that showed the resident received their routine medications on 10/22/20. Review of the Progress Notes for Resident #9 revealed the following: 10/22/20 at 2:27 PM The resident arrived to the facility per ambulance, family and physician aware. 10/23/20 at 2:27 PM Medication not available from the pharmacy, so staff sent to the physician to notify him and ask if the facility can give them when they arrive. Famility notified and they were upset. 10/23/20 at 5:21 PM Medications arrived and given per orders. During an interview with the Nurse Consultant on 10/27/20 at 11:20 PM, she stated when orders are received for medications the nurse is supposed to have the orders faxed to the pharmacy in time to have them delivered for evening or bed time med pass the same day the order is received. She added this procedure is usually always followed except when a resident admitted late in the day last week and the nurse forgot to fax them to pharmacy in time.	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 3 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 observations, clinical record review, and family and staff interviews the facility failed to notify the resident's physician and family member of a change in condition and failed to transfer a resident exhibiting shortness of breath, cough, fatigue, and oxygen saturations as low as 74 percent to the emergency room according to physician orders for 1 of 1 residents reviewed (Resident #2). The resident was later admitted to the hospital and passed away from Covid-19 complications. Due to these findings, an Immediate Jeopardy (IJ) was identified to resident health and safety. The facility reported a census of 48 residents. Findings include: According to the annual Minimum Data Set (MDS) assessment tool dated 10/2/20, Resident #2 had diagnoses that included dementia, epilepsy, diabetes, hypertension, sleep apnea, and chronic obstructive disease (COPD). The MDS documented the resident scored 5/15 on the Brief Interview of Mental Status (BIMS) test which meant he demonstrated severe cognitive impairment. The MDS also documented he was independent with transfers, ambulation (walking), dressing, and eating with set up help. The MDS revealed Resident #2 did not use oxygen and did not experience shortness of breath.	F 684		

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F 684	Continued From page 4 The resident's Diagnosis Report with an onset date of 10/6/20 documented a diagnosis of Covid-19. Review of the Progress Notes for Resident #2 revealed the following: a. On 10/6/20 at 2:49 PM, staff documented they received an order for Zyrtec and the family was notified that the resident tested positive for Covid-19. b. On 10/7/20 at 11:47 AM, Staff found resident's brother assisting him to stand because his gait was unsteady. c. On 10/9/20 at 5:16 PM, Resident #2 complained of fatigue with a temperature (T) of 99.2 (F) and an oxygen saturation (O2 Sat) of 85% on room air (RA). d. On 10/13/20 at 8:43 AM, the resident's O2 sat was 91% on RA and T 98.2. e. On 10/13/20 at 9:34 AM staff requested an oxygen order from the physician to keep O2 sats above 94%. f. On 10/13/20 at 11:30 AM, therapy staff reported resident became short of breath with an O2 sat of 74% on RA. Oxygen (O2) started at 3 liters per nasal cannula with O2 sats of 89-90%. Staff updated the physician regarding the resident's condition. During an observation on 10/13/20 at 11:45 AM, Staff A talked on the telephone at the nurses station by the dining room and told the caller	F 684		

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F 684	Continued From page 5 Resident #2 had oxygen saturations in the "70's" (%). Review of the resident's Progress Notes revealed the following: a. On 10/13/20 at 12:42 PM, staff received an order for oxygen and med pass supplement. b. On 10/13/20 at 1:38 PM, a hospital emergency room (ER) called the facility to report the resident's daughter had called them and wanted him to be seen. c. On 10/13/20 at 1:43 PM, the resident's physician called back with an order to send the resident to the emergency room per family request. Staff notified the resident's daughter. d. On 10/13/20 at 1:50 PM, Staff notified the resident's daughter that "Medivac" had been unable to transport the resident at that time. Staff documented the daughter directed staff to leave the resident at the facility, then. During an interview on 10/13/20 at 12:43, PM Staff B stated Resident #2 had tested positive for Covid-19 and was requiring more assistance with all of his cares. Review of the resident's Progress Notes revealed the following: a. On 10/13/20 at 9:01 PM, Staff documented the resident's O2 sats were 87% and the resident required assist of one staff to stand and use the restroom due to fatigue. b. On 10/14/20 at 12:41 AM, Staff documented the resident's face was flushed and his lungs were clear. The resident presented with a cough but no distress and although his lungs remained	F 684		

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F 684	Continued From page 6 clear, the resident's O2 Sats were variable on 5 liters of oxygen. c. On 10/15/20 at 7:10 AM, Therapy staff alerted the nurse consultant resident had O2 sats of 79% on 5 liters of oxygen, CPAP on, and heart rate 104. Staff applied an oxygen mask and notified the family and physician. The physician ordered staff to send the resident to the ER. d. On 10/15/20 at 7:56 AM, Staff sent the resident to the hospital via ambulance and notified the resident's family contact. e. On 10/15/20 at 11:46 AM Daughter called and reported concern with Staff A. f. On 10/20/20 at 9:20 PM, The hospital called to report the resident passed away at 7:45 PM. During an interview on 10/15/20 at 9:20 AM, Resident #2's daughter was tearful and sounded distraught. She stated when they wanted her father seen by the physician at the ER, Staff A told her on 10/13/20 that her Dad's condition wasn't an emergent situation and therefore she would call "Medivac" instead of the rescue squad. She added when the Medivac didn't have any openings, Staff A called her back told her that if family wanted him to be seen, they could take him to the hospital themselves. The resident's daughter reported Staff A told her they should bring two strong men to help transfer him into the car. The daughter reported she told Staff A that they weren't going to be able to do that, so he would have to stay there then. During an interview on 10/15/20 at 9:40 AM with another daughter of Resident #2 she stated that	F 684		

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F 684	Continued From page 7 the family was very upset because the facility did not send the resident to the ER on 10/13/20 as the doctor had ordered. She added that on Monday 10/12/20 her dad was very weak and needed 2 staff to even dangle his legs. She reported they (the family) were very concerned with the low oxygen saturations because their dad had pneumonia recently. She added that she lived out of the state and felt like she had to fight for her dad's life from a long distance. During an interview with the nurse consultant on 10/19/20 at 12:45 PM, she reported she expected the facility nurses to transfer any resident with an O2 sat below 90% to the hospital. When asked, she verified that O2 sats in the 70's and 80's were definitely an emergency. During an interview on 10/19/20 at 3:15 PM, Staff F reported when she administered Resident #2's medications on 10/13 and 10/14, she noted he had become more unsteady, needed more cues, exhibited increased lethargy, and needed more assist to sit up and eat. During an interview on 10/19/20 at 3:35 PM, Staff G stated that on 10/14/20 Resident #2 was more sleepy than usual but when she assessed him she did not notice any signs of distress. She added she was not aware the physician had given an order to send the resident to the ER on 10/13/20 and reported had she known, she would have followed up on it. When asked, she replied that if her assessment of the resident had been abnormal assessment (shortness of breath, distress, or oxygen saturation below 90%) she would have called the family and sent him to the hospital.	F 684		

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F 684	Continued From page 8 During an interview on 10/19/20 at 6:20 PM, Staff H stated that on the evening and overnight shift on 10/13/20 to 10/14/20, the resident had a cough and his oxygen saturations were running in the high 80's, so she kept him on oxygen at 5 liters per nasal cannula. She stated the resident was not in any distress and was resting comfortably, so she monitored him and reported it to the day shift nurse. She commented the local hospital had denied admissions recently due to being full and that is where he would have been sent if she had transferred him to the hospital that night. During an interview on 10/20/20 at 11:40 AM Staff A stated that she didn't feel it was an emergency to send Resident #2 to the emergency room via ambulance on 10/13/20 because she was able to get his oxygen saturation back up at that time. She stated that is why she called Medivac instead of the rescue squad and when Medivac wasn't able to provide transportation she called the resident's daughter so they could make other transportation arrangements. She added that she knew they had strong young nephews so she recommended that the daughter call them to help lift and transfer the resident into a car. She stated that is when the daughter said the family would not be able to do that and would have to keep him at the facility. Staff A acknowledged she should have called the physician back at that time to let him know Medivac could not transport the resident. With regard to the nurse's documentation on 10/9/20 at 5:16 PM, Staff A said she probably should have notified the family and doctor of Resident #2's oxygen saturations dropping into the 80's, but doesn't recall doing either one.	F 684		

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F 684	Continued From page 9 During an interview with Resident #2's physician on 10/20/20 at 12:40 PM, he stated that if he gives staff an order to send a resident to the ER he wanted them sent via ambulance. He added the local EMS is very responsive and the Medivac should have never been called for the resident on 10/13/20. He reported he was actually very upset the facility even called him because he had given the facility strict instructions if any of the residents with Covid-19 had their O2 sats drop below 90% they should call the family and if the family wants them seen, then they are to call 911 and send them to the ER immediately. He stated on 10/9/20 when the resident's oxygen saturation dropped to 85 percent he should have at the very least been notified or the family called and given the option of hospitalizing him then. During a second interview on 10/20/20 at 2:15 PM, Staff A verified another nurse had mentioned those standing orders from the physician to send residents to the ER per family request with any O2 sats below 90%, but she said she could not find that order in writing anywhere or in the resident's orders so she elected not to follow that protocol. The facility was notified of the Immediate Jeopardy determination on 10/21/20 and subsequently submitted an acceptable abatement plan. The scope and severity of the deficiencies was lowered to a "D." The IJ was abated by the facility on 10/21/20 when they implemented the following actions: 1. Education was provided to all staff on 10/21/20; staff that had not acknowledged and/or received education were provided education prior to their next	F 684		

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F 684	Continued From page 10 scheduled shift. 2. An audit of current resident conditions was completed on 10/21/20. Residents with change(s) in condition were assessed and documentation was entered in the resident's medical record. In addition, staff notified the resident's physician and family. 3. The DON or designee will complete an audit 5 times weekly x 2 weeks, then 1 audit weekly x 4 weeks of resident assessment to ensure identification of change in condition, intervention in place, family and physician notification completed. Audits will be brought to QAPI and reviewed for further recommendation.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide supervision and assistive devices to reduce risks to residents when staff transferred a resident without a gait belt for 1 of 1 residents reviewed (Resident #5). The facility reported a census of 48 residents.	F 689		

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F 689	Continued From page 11 Findings include: According to the annual Minimum Data Set (MDS) assessment tool dated 9/24/20, Resident #5 had diagnoses that included dementia, high blood pressure, edema, major depression, anxiety, and osteoarthritis. The MDS documented the resident demonstrated severe cognitive impairment and required extensive assist of 2 staff for transfers and walking. The Gait Belt Policy dated January 2015 directed all staff to utilize gait belts to allow for easier handling of residents and should help avoid injuries both to residents and staff. During an observation of care on 10/13/20 at 2:50 PM, Staff E and Hospice Staff transferred Resident #5 to her wheelchair by lifting her under the arms; neither staff used a gait belt. The resident did not stand or bear any weight. During an interview with the Administrator on 10/27/20 at 11:15 AM, he stated it is his expectation that staff transfer residents utilizing a gait belt.	F 689		
F 880 SS=K	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.	F 880		

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F 880	Continued From page 12 §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. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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	165193	A. BUILDING _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 880	Continued From page 13 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 follow proper infection control precautions and guidelines. The facility failed to follow current CDC guidance for staff returning to work after testing positive for Covid-19, staff did not appropriately use PPE with cares and when moving between resident rooms, and staff failed to provide adequate hand hygiene during cares for 5 of 5 residents reviewed (#4, 5, 6, 7, and #8). Due to these findings, an Immediate Jeopardy (IJ) was identified to resident health and safety. The facility reported a census of 48 residents. Findings include: The CDC website (https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-nc	F 880		

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F 880	Continued From page 14 ov%2Fhealthcare-facilities%2Fhcp-return-work.html) titled Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance, updated 8/10/20, gave the following guidance: Return to Work Criteria for HCP with SARS-CoV-2 Infection Symptom-based strategy for determining when HCP can return to work. HCP with mild to moderate illness who are not severely immunocompromised: At least 10 days have passed since symptoms first appeared and At least 24 hours have passed since last fever without the use of fever-reducing medications and Symptoms (e.g., cough, shortness of breath) have improved Note: HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test. HCP with severe to critical illness or who are severely immunocompromised: At least 10 days and up to 20 days have passed since symptoms first appeared At least 24 hours have passed since last fever without the use of fever-reducing medications and Symptoms (e.g., cough, shortness of breath) have improved Consider consultation with infection control experts Note: HCP who are severely immunocompromised but who were	F 880		

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F 880	Continued From page 15 asymptomatic throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test. As described in the Decision Memo, an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patient had replication-competent virus more than 20 days after onset of symptoms. The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered in determining the appropriate duration for specific HCP. For example, HCP with characteristics of severe illness may be most appropriately managed with at least 15 days before return to work. Test-Based Strategy for Determining when HCP Can Return to Work. In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, as described in the Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days. The criteria for the test-based strategy are:	F 880		

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F 880	Continued From page 16 HCP who are symptomatic: Resolution of fever without the use of fever-reducing medications and Improvement in symptoms (e.g., cough, shortness of breath), and Results are negative from at least two consecutive respiratory specimens collected =24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). HCP who are not symptomatic: Results are negative from at least two consecutive respiratory specimens collected =24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). The Infection Prevention and Control Manual for corporate policy on hand hygiene, gloves and gowns dated 2019 directed the following: - The single most effective means of reducing potential for transmission of infection is hand antisepsis before and after contact with residents, including glove removal. - Washing hands can accomplish hand antisepsis with soap and water or by using waterless alcohol based hand rub.	F 880		

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F 880	Continued From page 17 - During providing care for residents, gloves will be changed after contact with infective material that may contain high concentrations of microorganisms. - Wearing gloves is not a substitute for hand hygiene. Gloves will be removed and discarded before leaving the resident's room, followed by hand hygiene. - Don gowns upon entry into the room or cubicle. Remove the gown and observe hand hygiene before leaving the resident care environment. During an interview with the Nurse Consultant on 10/13/20 at 11:10 AM, she stated the facility's current census was 48 and all but 2 residents were currently positive for Covid-19. She added that the right hall has all Covid-19 positive residents and that is where they are staffing Covid-19 positive staff that are asymptomatic, center hall is full isolation with Covid-19 positive residents, and left hall has two residents that are Covid-19 negative and they have them cohorted at the end of the hall. Observation on 10/13/20 at 12:45 PM, revealed Staff B in a resident's room on center hall assisting Resident #4 with her meal wearing full PPE. She exited Resident #4's room, walked across the hall to assist Resident #5 in her room with her meal, but failed to change or remove her PPE. At 12:55 PM Staff B, exited the room without removing or changing her PPE and went to Resident #6's room to assist her with using the bathroom. Staff B shut the door, provided privacy, and explained cares. She then assisted the	F 880		

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F 880	Continued From page 18 resident into the sit to stand lift sling, fastened it, took her into the bathroom, lowered the resident's pants and brief and then adjusted the lift. While still wearing the same PPE (including the same gloves first noted at 12:45 PM), she adjusted the blankets on Resident #6's recliner and grabbed some perineal wipes off the dresser. Staff B then re-entered the bathroom, raised the lift and provided perineal care with the wipes. She used one wipe for each swipe and started by cleaning the front vaginal area before moving to the rectal area, but did not remove the soiled gloves after she finished providing perineal care. She then pulled up the resident's brief and pants and moved the resident (while she remained on the lift) back to her recliner. While still wearing the same gloves, Staff B moved the resident's table away from her recliner, used the lift controls to lower the resident into the recliner, and removed the sling from around the resident. The aide then handed her the television remote, call light, and ice water. Staff B then left the room and went half way down the hall to a trash can and removed her gloves and gown, but never washed her hands or used hand sanitizer. Observation revealed Staff B left the center isolation hall to go into the dining room to obtain the ice chest, filled it with ice from the ice machine, and then went back to center hall. Staff B proceeded to don a new gown and gloves, but never washed her hands or used hand sanitizer prior to beginning to pass ice and water to the residents. During an observation of care on 10/13/20 at 2:20 PM, Staff C closed Resident #7's door, and explained cares to the resident. Staff D washed her hands and donned gloves. Both staff leaned the Resident #7 forward and applied a gait belt. Staff D held the resident while Staff C lowered the	F 880		

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F 880	Continued From page 19 resident's pants and brief. Staff C provided perineal care to the front groin area with one wipe in her left hand, then grabbed a wipe from the clean container with her dirty gloved left hand and wiped the rectal area. She then grabbed a wipe from the wipe container with her dirty gloved left hand and wiped the rectal area a second time. Staff C disposed of the wipes in a clear liner on the bed, pulled the brief out of the resident's pants, discarded it on the bed, grabbed a clean brief, inserted it into the pants and pulled up clean brief and pants. While wearing the same gloves, Staff C helped Staff D lower Resident #7 back into his recliner, and grabbed the walker to move it out of the way with her left hand while her right arm and hand were assisting the resident with repositioning. While wearing the same gloves, she moved his bed side table, applied his oxygen nasal cannula, adjusted his position with a wedge cushion, and gave him his call light. Staff D removed her gloves after cares, washed her hands, and then left the room. Staff C picked up the liner of trash and left the room while wearing the same PPE and proceeded up the hall. During an observation of care on 10/13/20 at 2:35 PM, Staff C and Staff D entered a resident room, washed their hands, and donned gloves. They provided privacy and then repositioned Resident #8 to the right side. Staff C used her gloves to check the brief for incontinence and stated the resident was dry. As the resident lay on her right side, the staff propped her with pillows. Staff D removed her gloves, washed her hands, and left the room. Staff C, wearing the same gloves, gathered supplies and provided oral care with toothettes, water, and mouth wash. Staff C then removed her gloves, washed her hands, and left the room.	F 880		

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F 880	Continued From page 20 During an observation of care on 10/13/20 at 2:50 PM, Staff E entered a resident room on the center hall to assist with Resident #5's cares. Hospice Staff was in the room with the resident and wore gloves. Staff E washed her hands, donned gloves, and assisted the resident to roll to her right side toward the wall while the hospice staff provided incontinence care. The Hospice Staff used wipes from a package and wiped front to back using one wipe at a time; she discarded the wipes in the trash can next to the bed. After the Hospice Staff finished providing incontinence care, she grabbed the wipes container and tossed it into Resident #5's bedside chair, applied a clean brief, and removed a lotion bottle from the bedside table while still wearing the same gloves. She then applied lotion to both of the resident's legs and then pulled up her pants. Both staff transferred the resident to her wheelchair and the Hospice Staff lowered the wheelchair pedals and unlocked the brakes before removing her gloves and performing hand hygiene. On 10/13/20 at 3:05 PM, Staff C left the right isolation hall while wearing only her mask and glasses on and walked to the nurse's station by the dining room. The nurse consultant stopped her and reminded her she could not to leave the right isolation hall because she had tested positive for Covid-19. At that time 2 other staff sat at the nurse's station less than 6 feet away from Staff C. The facility Covid-19 Isolation Plan dated 4/7/20 documented the following: - All employees working in an isolation area to provide patient care must wear appropriate	F 880		

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F 880	Continued From page 21 personal protective equipment (PPE) as indicated by CDC guidelines for Standard, Control and Droplet Precautions. - Staff not assigned to work in the isolation area shall not go into isolation rooms or the isolation staff work space. During an interview with the Nurse Consultant on 10/13/20 at 3:45 PM she stated she expected staff to wash their hands and utilize PPE according to facility policy. The facility's Staff Member Covid-19 Positive form indicated Staff C tested positive on 10/4/20 and was asymptomatic with a 10 day return to work date of 10/15/20. The current working Certified Nursing Assistant Schedule dated 9/24/20 - 10/21/20 revealed the facility had removed Staff C from the schedule. During an interview with Staff C on 10/14/20 at 3:30 PM, she stated that she tested positive for Covid-19 on 10/4/20 and had no symptoms except for a stuffy nose, which she had until the weekend of 10/10/20. She reported the facility told her she could work but she had to stay down right hall and couldn't leave the hall until 10/15/20 and then she could work anywhere in the building. She added that she entered the facility and screened at the end of right hall door and even took her breaks down that hall. The facility's Staff Member Covid-19 Positive form indicated Staff I tested positive on 10/5/20 with a 10 day return to work date of 10/17/20.	F 880		

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F 880	Continued From page 22 The current working Certified Nursing Assistant Schedule dated 9/24/20 - 10/21/20 revealed the facility removed Staff I from work on 10/3/20 and she returned to work on 10/12/20. During an interview with Staff I on 10/14/20 at 3:44 PM, she stated she started having symptoms on 10/3/20 and tested positive for Covid-19 on 10/5/20. She reported she went back to work on 10/12/20 because she felt better and had worked on all of the halls of the facility. She added she had then contracted pneumonia and was off work again. The facility's Staff Member Covid-19 Positive form indicated Staff A tested positive on 10/1/20, was asymptomatic, and had a 10 day return to work date of 10/12/20. The current working Nurse Schedule dated 9/24/20 - 10/21/20 revealed the facility had not removed Staff A from the schedule, although she did not work on 10/7/20. An observation on 10/13/20 at 11:45 AM revealed Staff A at the nurse's station by the dining room, talking on the phone. During an interview with Staff A on 10/20/20 at 11:40 AM, she stated she tested positive for Covid-19 on 10/6/20 but didn't have any symptoms. She stated the facility was going to have her work just down right hall, but since all the residents on center hall had tested positive she was able to work there. She added that she completed her documentation at the nurse's station by the dining room but she never went down left hall. She stated that the first case of	F 880		

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F 880	Continued From page 23 Covid-19 was in the Assisted Living Facility (ALF). She added that the ALF staff or residents would call them for help so they would send staff over to assist. She stated they would wear masks and goggles when they went to the ALF. The facility's Staff Member Covid-19 Positive form indicated Staff J tested positive on 10/6/20 and had a 10 day return to work date of 10/15/20. During an interview with Staff J on 10/20/20 at 6:40 PM, he stated he tested positive for Covid-19 on 10/6/20. He explained he had woken up tired with aches on 10/6/20 and had a headache on 10/10/20, but had no other symptoms. He reported he returned to work on 10/13/20 and the facility directed he could work, but he had to stay away from Covid-19 negative residents. He added that he worked on all of the halls but only went to the doorway of Covid-19 negative residents and then occasionally to the ALF to check on the residents and answer call lights. The facility's Staff Member Covid-19 Positive form indicated the Social Service Director tested positive on 10/5/20 with a 10 day return to work date of 10/15/20. During an interview with the Social Service Director on 10/28/20 at 2:55 PM, she stated she had felt "off," so she scheduled a test and with was positive Covid-19 results on 10/5/20. She reported she went home and then began to experienced chest tightness, shortness of breath, and diarrhea. She added she returned to work on 10/13/20. The facility was notified of the IJ on 10/15/20. The	F 880		

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F 880	Continued From page 24 scope and severity of the deficiencies was lowered to a "D."on 10/16/20 when the facility abated the IJ by taking the following actions: 1. On 10/15/20, the facility educated staff (with any new hires and/or agency staff educated prior to the start of their shift) regarding the following information: - Proper hand hygiene; a review of the hand hygiene policy - Proper PPE usage throughout the facility - Process for asymptomatic positive staff working during their initial 10 days. 2. The DON or Designee will complete random audits x 90 days of random staff with respect to hand hygiene and proper PPE usage. The DON or designee will bring the audits to QAPI until substantial compliance has been met. 3. Effective 10/15/20 at 8:00 PM, the facility decided to no longer utilize the use of positive, asymptomatic staff until they have met the return to work criteria.	F 880		

F658 Services Provided Meet Professional Standards

Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.

Immediate action(s) taken for the resident(s) found to have been affected include:

Resident #5 has since discharged, no further action is required. Resident #9 on 10/23/2020 a medication error report was completed and facility protocol was followed. A review of resident current physician ordered medications was completed with resident's physician and new orders obtained and implemented.

Identification of other residents having the potential to be affected was accomplished by:

The facility has determined that all residents have the potential to be affected. A review of current resident medication orders was completed 01/21/2021 by the Interim Director of Nursing, no concerns were identified.

Actions taken/systems put into place to reduce the risk of future occurrence include:

A "5 Minute Meeting" notification was provided by the Director of Nursing on 10/23/2020 with Licensed Staff and Medication Aides reviewing process to notify Pharmacy of new medication orders for admissions and process for physician ordered medication administration.

How the corrective action(s) will be monitored to ensure the practice will not recur:

The Director of Nursing or Designee will complete an audit of Medication Administration during daily QA, any concerns identified will receive follow up by the DON or Designee as indicated. This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.

Please accept this credible allegation of compliance for Corrective action completion date: 01/21/2021

F684 Quality of Care

Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists.
This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.

Immediate action(s) taken for the resident(s) found to have been affected include:

Resident #2 has since discharged no further action is required at this time.

Identification of other residents having the potential to be affected was accomplished by:

The facility has determined that all residents have the potential to be affected. An audit of current resident conditions was completed on 10/21/20, residents with change in condition were assessed, physician and family notified. Documentation was entered in the resident medical record.

Actions taken/systems put into place to reduce the risk of future occurrence include:

Education was provided to staff on 10/21/2020, staff and agency staff members that have not acknowledged and or received education will be provided education prior to the next scheduled shift. Staff and agency staff is offered a copy of the education at the time of completion. A copy of the education is available for staff and agency staff reviews at the nurse's station.

How the corrective action(s) will be monitored to ensure the practice will not recur:

The Director of Nursing or Designee will complete an audit 5 times weekly x 2 weeks, then 1 audit weekly x 4 weeks of resident assessment to ensure identification of change in condition, intervention in place, family and physician notification completed.

Audit records will be brought to the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Please accept this credible allegation of compliance Corrective action completion date: 11/13/2020

F880 Infection Prevention & Control

Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists.
This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.

Immediate action(s) taken for the resident(s) found to have been affected include:

Resident #4, #5, #7, and #8 have since discharged from the facility, and no further action is required. Resident #6, an assessment was completed with no concerns identified.

Identification of other residents having the potential to be affected was accomplished by:

The facility has determined that all residents have the potential to be affected.

Actions taken/systems put into place to reduce the risk of future occurrence include:

On 10/15/2020 staff were educated on hand hygiene, a review of the hand hygiene policy was completed, proper PPE Usage throughout the facility, and process for asymptomatic positive staff working during their initial 10 days. A review of staff screeners was completed, any staff member who worked while COVID positive answered, "No" to all questions asked, denying presence of any symptoms noted. Facility followed the Approved Strategy to Mitigate Healthcare Personnel Staffing shortage dated 07/17/2020. Effective 10/15/2020 @ 2000, the facility will no longer utilize the use of positive asymptomatic staff until they have met the return to work criteria.
On 01/26/21 the staff completed watching the assigned videos per the Directed Plan of Correction received on 01/20/21, (PPE Lessons, Sparkling Surfaces, Cleaning Hands, and Keep COVID Out). Any staff member on leave or PRN will watch assigned videos prior to their next worked shift. The above listed videos will be added to new hire orientation to be completed in Relias.
On 01/21/21 the facility scheduled a root cause analysis of infection control practices for 01/26/2021 with Telligen per the Directed Plan of Correction received on 01/20/21.

4. **How the corrective action(s) will be monitored to ensure the practice will not recur:**

   The Director of Nursing or designee will complete random audits x 90 days of random staff on hand hygiene and Proper PPE Usage; the DON or designee will bring these audits to QAPI until substantial compliance has been met.

   Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

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F884

§483.80(g) COVID-19 reporting. The facility must--

§483.80(g)(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to—

(i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19;
(ii) Total deaths and COVID-19 deaths among residents and staff;
(iii) Personal protective equipment and hand hygiene supplies in the facility;
(iv) Ventilator capacity and supplies in the facility;
(v) Resident beds and census;
(vi) Access to COVID-19 testing while the resident is in the facility;
(vii) Staffing shortages; and
(viii) Other information specified by the Secretary.

§483.80(g)(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention's National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general public.