STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165316	A. BUILDING _____ B. WING _____	06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDORA SPECIALTY CARE	1510 22ND STREET ELDORA, IA 50627

(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 7.23.21 The following deficiencies relate to the facility's annual health survey and investigation of incident #91403-I completed June 21-24, 2021. Incident #91403 was substantiated. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.)	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Eldora Specialty Care does not admit that the deficiency listed on this form exists, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	July 23, 2021
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	**F550** This is my credible allegation of compliance to F550. This allegation does not constitute guilt but that the facility is in compliance to F550. Resident #30 is provided privacy during all cares. Resident #30 is kept covered and has her privacy curtain pulled to assist in ensuring that her privacy is maintained during hands on care. Staff are routinely knocking on her door prior and announcing their presence before entering her room.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/22/21

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview, and resident interview, the facility failed to provide privacy of a body during personal cares for 1 out of 1 sampled residents observed for cares, (Resident #30) and failed to provide privacy by not knocking on the door before entering the room for 6 of 9 residents. The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/26/21 for Resident # 30 documented diagnoses of Alzheimer's disease, anxiety and hypertension (high blood pressure). The MDS showed the Brief Interview for Mental Status (BIMS) was not completed. On 6/22/21 at 2:34 p.m., Staff M, Certified Nursing Assistant (CNA) entered Resident # 30's room and assisted her with getting a drink of water and repositioning her head. Staff M, CNA pulled Resident #30's gown up and pulled the sheet down exposing the resident's incontinence brief and upper thighs which were visible from the	F 550	**F550 continued:** Staff was educated on 06/24/2021 on the importance of using the privacy curtains in resident rooms along with the need to drape/cover the resident except for the area of the resident that is being cared for. Staff will continue to be audited for proper performance of hands on cares to assist in ensuring that privacy is being maintained during cares. Staff will continue to be audited for knocking on resident doors and announcing themselves prior to entering a resident room. Problems will be corrected as they are observed and appropriate corrections will take place as they are observed as well. The facility Stand Up Team will monitor that the audits continue to occur and that appropriate corrective actions occur for observed problems. The Stand Up Team will correct problems as they are noted.	

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F 550	Continued From page 2 doorway. Staff M, CNA did not close the privacy curtain or the door to the room. When Staff M, CNA completed her check she pulled Resident #30's gown back down and sheet back over the resident covering her. 2. Observation on 6/23/21 at 2:17 p.m., revealed Staff N, Housekeeping staff, bringing clothing from the laundry room to the resident's rooms. Staff N, Housekeeping staff observed entering 9 different resident's rooms without knocking and waiting for a response. Six of these rooms were occupied by residents. Review of the facility policy titled Resident Rights-general guidelines June 2011 edition revealed all staff should be encouraged and reminded to knock before entering a resident's room and to wait for a response. All staff should be encouraged and reminded to use the privacy curtain during personal cares. Interview on 6/23/21 at 3:17 p.m., with the Director of Nursing revealed she expects the staff to provide privacy at all times when providing care to any resident. She also revealed it is the expectation of all staff to knock on residents doors and wait for a response before entering.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609	**F609:** This is my credible allegation of compliance to F609. This allegation does not constitute guilt but that the facility is in compliance to F609. Resident #32 no longer resides in the facility as he has passed away. Staff B no longer works at the facility.	

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F 609	Continued From page 3 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, staff record reviews, and facility policy the facility failed to report a possible allegation of abuse to the facility Administrator, and the Department of Inspections and Appeals within the proper time period for one of one allegation of abuse from a resident about a staff member, (Resident#32). The facility reported a resident census of 34. Findings included: The Dependent Adult Abuse Policy dated 11/2019 edition documented under the page title Timely Abuse Reporting as follows; All allegations of resident abuse, neglect, exploitation, injuries of unknown origin and misappropriation should be	F 609	**F609 continued:** Facility residents continue to be free from abusive actions from staff. The facility has had NO allegations of abuse brought to their attention from residents, staff or families. Staff was educated on the importance of prompt facility management notification of any allegation of abuse so that the 2 hour limit for reporting guidelines can be met on 06/01/2021. Facility has had NO current allegations of abuse. Facility Stand Up Team will continue to monitor for any allegations of abuse. If there are any allegations of abuse the Stand Up Team will investigate the allegation and follow appropriate reporting guidelines to assist in ensuring that allegations of abuse are reported timely and that appropriate actions are taken to assist in ensuring resident safety is maintained throughout the facility.	

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F 609	Continued From page 4 reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals no later than two hours after the allegation is made. All allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, no later than two hours after the allegation is made, if the events that cause the allegation result in serious bodily injury. On 6/23/21 at 12:22 p.m. Staff B Licensed Practical Nurse (LPN) reported that she did hear Resident#32 tell the ambulance staff on 5/31/20 about being pushed down. Staff B, LPN did not report the residents allegation of being pushed down to the administrative staff as abuse due to the resident being of poor cognitive status. On 6/23/21 at 12:33 p.m., Staff C Registered Nurse (RN) reported that on 6/1/20 during shift report Staff A RN told her Resident #32 reported being pushed down on 5/31/20 to Staff B, Licensed Practical Nurse and the ambulance staff, when being picked up to go to the hospital. Staff C, reported she had talked with the Administrator about the accusation on 6/1/20, but the Administrator told her she did not know about it. Staff C, RN reported the Administrator immediately started an investigation after being aware of the accusation. Staff C, RN reported she had been written up for not reporting within 2 hours, of learning about the possible abuse. On 6/23/21 at 1:12 p.m. the Director of Nursing	F 609		

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F 609	Continued From page 5 (DON) reported she did not know about the accusation that Resident #32 had voiced to the Ambulance staff, and the facility staff, until 6/1/20. The DON reported the resident had stated to the Ambulance staff and facility staff that he had been pushed down by facility staff. The DON reported the staff involved had been disciplined for not reporting possible abuse within two hours The Nurses Note dated 5/31/20 at 1:35 p.m. documented new orders for Resident#32 to be sent by ambulance to the emergency room. The Nurses Note dated 5/31/20 at 2:30 p.m. documented the ambulance had been at the facility to transport Resident #32 to the hospital. The Nurses Notes for the date 5/31/20 lacked documentation that the staff had reported any resident accusation about being pushed down by a staff member when he fell. A Corrective Action Form dated 6/2/20 contained a verbal warning to Staff B, LPN. The description of infraction had been documented as follows; you heard a resident tell an ambulance tech that he was pushed. Corrective Action: documented as follows; Any allegation made by a resident should be reported to the Administrator or DON immediately, abuse allegations require a two hour reporting window. Don't hesitate to call anytime. A Corrective Action Form dated 6/2/20 contained a verbal warning to Staff A, RN. The description of infraction had been documented as follows; You were told by another nurse that a resident had fallen and the resident had told the ambulance tech that he was pushed. Corrective Action: documented as follows; Any allegation	F 609		

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F 609	Continued From page 6 made by a resident should be reported to the Administrator or DON immediately. Abuse allegation require a two hour reporting window. Don't hesitate to anytime day or night. A Corrective Action Form dated 6/2/20 contained a verbal warning to Staff C, RN. The description of infraction had been documented as follows: Your were told by another nurse that a resident had fallen and the resident told the ambulance tech that he was pushed. Corrective Action documented as follows: Any allegation made by a resident should be reported to the Administrator or DON immediately. Abuse allegations require a two hour reporting window. Don't hesitate to call anytime night or day. An x-ray report dated 5/31/20 documented Resident#32 had a slightly displaced fracture of the right hip, and that a orthopedic consultation had been recommended. An x-ray report dated 5/31/20 documented Resident#32 had a fight femur (upper leg bone) demonstrate a slightly displaced subcapital fracture.	F 609		
F 656 SS=D	.. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656	**F656:** This is my credible allegation of compliance to F656. This allegation does not constitute guilt but that the facility is in compliance to F656.	

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F 656	Continued From page 7 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident observations, clinical record review and staff interviews the facility failed to develop care plans to address resident's oxygen	F 656	**F656 continued:** Resident #4 and resident #30 have their use of supplemental oxygen on their care plans for staff referral for their needs. All residents who require the use of supplemental oxygen have that need reflected on their care plan to assist in meeting their needs. Staff was educated on 06/24/2021 to the fact that residents on supplemental oxygen must have that need reflected on their care plans. This education also included that O2 usage must be reflected on their Tasks/Kardex lists for aide referral so that they know who is on oxygen. The facility MDS/Care Plan nurse reviewed all care plans and updated care plans, tasks and Kardex so that residents who use supplemental oxygen have that need reflected on their care plans, tasks and Kardex so that staff know of that need and can provide that need.	

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F 656	Continued From page 8 usage for 2 of 2 sampled residents (Resident #4 and #30). The facility reported a census of 34 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated 5/5/21 for Resident # 4 documented diagnoses of abdominal aortic aneurysm (enlargement of the aorta, the main blood vessel that delivers blood to the body, at the level of the abdomen), hypertension (high blood pressure) and osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down). The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. Review of the MDS dated 6/8/21 revealed Resident # 4 used oxygen. Review of Resident #4's Care Plan, dated 6/1/21, on 6/22/21 at 10:28 a.m., lacked any documentation of oxygen usage. On 6/23/21 at 3:44 p.m., the MDS Nurse brought a copy of Resident #4's Care Plan for oxygen therapy with date initiated 6/23/21. 2. The Minimum Data Set (MDS) assessment dated 5/26/21 for Resident #30 documented diagnoses of Alzheimer's disease, anxiety and hypertension (high blood pressure). The MDS showed the Brief Interview for Mental Status (BIMS) was not completed. Review of the Medication Administration Record and Treatment Administration Record revealed an	F 656	**F656: continued** The MDS/Care Plan nurse will monitor orders for oxygen order changes so that care plans, tasks and Kardex can be updated accordingly. The facility Stand Up Team will monitor that new admissions that use oxygen have their care plans, tasks and Kardex updated with any oxygen order changes. Problems will be corrected as they are observed.	

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F 656	Continued From page 9 order for oxygen. Review of the Care Plan, dated 5/11/21, on 6/22/21 at 8:20 a.m., lacked any documentation of oxygen usage. On 6/23/21 at 3:44 p.m., the MDS nurse brought a copy of Resident #30's Care Plan for oxygen therapy with date initiated 6/22/21. Interview on 6/23/21 at 3:17 p.m., with the Director of Nursing revealed she expects all resident's care plans are to be up to date and they are to include oxygen usage. Review of facility policy titled Oxygen Administration January 2015 edition revealed resident care plan: identify problem, establish goals with resident input, and develop approaches with responsible disciplines identified. Review of facility policy titled Care Plan Process January 2015 edition revealed the care plan will be an ongoing reflection of the current treatment plan. Additions and deletions can be made on the plan of care (with resident approval) without holding a care plan conference, as long as the change does not constitute a permanent, significant change.	F 656		
F 689 SS=G	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	F 689	**F689:** This is my credible allegation of compliance to F689. This allegation does not constitute guilt but that the facility is in compliance to F689.	

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F 689	Continued From page 10 §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 observations, facility policy review and staff interviews, the facility failed to ensure supervision of residents during administration of medication and safe transfer assistance for 4 of 6 residents reviewed (Resident's #9, #11, #19 and #32). The facility reported a census of 34 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated 4/21/21 revealed Resident #19 had diagnoses of diabetes mellitus (DM), malnutrition and asthma. The MDS revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. The MDS further revealed Resident #19 required one person physical assist locomotion on and off the unit, dressing and toilet use. The Care Plan revised on 11/4/20 revealed Resident #19 used safety devices with a goal to remain safe in her environment. Observation on 6/22/21 at 9:00 AM revealed Resident #19 had a medication cup filled with medications left on her bedside tray table. Resident #19 was taking medications with no supervision. At 9:04 AM Resident #19 was still taking medications with no one watching. On 6/22/21 at 9:04 AM, Resident #19 was observed administering medication in her room	F 689	**F689: continued** Residents #9, #11, #19 are receiving their medication in a safe manner which includes observing them taking their medications. Resident #32 no longer resides at the facility as he has passed away. Residents are receiving their medications in a safe manner which includes observing them taking their medications. Residents are being transferred safely per their person centered care plans. Gait belts are being used when required for safe transfers such as assist of 1 or 2 staff members. Staff who are licensed and or certified to pass medication were educated on 06/24/2021 of proper med pass techniques which included the step of watching residents take their medication so that medications are not left at bed side and/or on a table. Staff who can perform resident transfers were educated on proper safe transfer techniques which included the use of gait belts on 06/24/2021. This education also pointed out that gait belts are part of their uniform.	

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F 689	Continued From page 11 without supervision. Resident #19 stated Staff L, Licensed Practical Nurse (LPN) always leaves her medications with her because she was "with it enough" and "all the nurse's leave medication with me in my room except one that doesn't trust me." Observed six medications in the medication cup. Resident #19 revealed she had had more medications but she had already taken some of them and "you're lucky you didn't come in here earlier because the potassium pill is so big I had to choke it down." On 6/22/21 at 9:06 AM, Staff L, LPN revealed she had left the medication with Resident #19 in her room as she had an order in place stating she can take medication unsupervised. Review of Physician Orders did not indicate Resident #19 had an order in place to self-administer medication while in the facility. During interview on 6/22/21 at 9:11 AM the Director of Nursing (DON) stated Resident #19 does not have an assessment for self-medication. A review of the Medication Administration Audit Report on 6/23/21 at 1:58 PM revealed Staff I, Licensed Practical Nurse (LPN), documented the administration of Resident #19's medications for 6/22/21 at 8:54 AM. Facility policy dated 1/2015, titled Medications Administration, revealed to assure each resident received the proper medications at the correct time as ordered by their physician, administer the medication, observe for the act of swallowing and observe resident for any adverse drug reaction.	F 689	**F689: continued** Staff will be audited on proper med pass techniques including watching residents taking their medications. This will be done 1 time per month for 3 months and then we will follow our facility protocol. Staff will be audited on proper transfer techniques to assist in ensuring that gait belts are used when needed to promote a safe transfer for residents who require staff assist for transfers. This will be done 1 time per month for 3 months and then we will follow our facility protocol. Problems will be corrected as they are observed. The facility Stand Up Team will monitor that audits continue for medication pass techniques as well as transfers requiring the use of gait belts to perform a safe transfer. The Stand Up Team will also monitor that staff have their gait belts on as required. Problems will be corrected as they are observed.	

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	165316	A. BUILDING _____ B. WING _____	06/24/2021

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F 689	Continued From page 12 2. Review of the MDS assessment dated 6/9/21 revealed Resident #11 had diagnoses of cerebrovascular accident (CVA), hemiplegia and hypertension. The MDS revealed Resident #11 had a BIMS of 13 out of 15 which indicated intact cognition. The MDS further revealed Resident #11 required set-up help with eating and one person physical assist with transfers, walking and dressing. During observation on 6/22/21 at 12:39 PM, noted half a bottle of TUMS sitting on Resident #11's night stand next to her bed. Resident #11 revealed her previous physician recommended she take TUMS for the additional vitamins. Observation on 6/23/21 at 1:01 PM, half a bottle of TUMS remained on Resident #11's night stand next to her bed. Review of Physician Orders did not indicate Resident #11 had an order in place to self-administer medication while in the facility. On 6/23/21 at 2:35 PM notified the Director of Nursing (DON) the resident had half bottle of TUMS on her night stand. Resident #11 informed the DON she took the TUMS when the facility didn't have any available at the facility and she had the TUMS since she admitted. The DON removed the TUMS and informed Resident #11 she would try to get an order for her to have the TUMS in her room. During interview on 6/23/21 at 11:10 AM, the DON acknowledged medications should not be left with a resident without supervision without an order to self-administer medication. 3. The MDS assessment dated 3/31/21 for	F 689		

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F 689	Continued From page 13	F 689		

Resident # 9 documented diagnoses of dementia, schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior) and hypothyroidism (underactive thyroid). The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.

On 6/21/21 at 12:24 p.m., observation of a medication cup with several medications including orange pills was noted on her lunch tray sitting to the left of the resident's recliner in her room. No nursing staff observed in the room or hallway outside of the resident's room.
4. The Annual Minimum Data Set (MDS) with reference date of 4/15/20 documented Resident#32 had diagnoses including Parkinson's disease, stroke, cognitive communication deficit, and dementia. The MDS documented the resident had a BIMS score of 6 out of 15, which indicated severely impaired cognitive skills. The MDS documented the resident could sometimes understand, and sometimes make concrete requests. The resident had difficulty focusing attention. The MDS documented the resident required extensive assistance of one staff member for transfers, walking in his room, and toilet use.

The Care Plan revealed the resident had a focus area of potential for falls secondary to impaired balance, visual impairment, and had a history of falls initiated on 4/13/18. The Care Plan included an intervention dated 11/2/18 that showed the resident was to have assist of 2 staff and walker for ambulation.

A Witnessed Fall Report dated 5/30/20 with time of 7:50 p.m., documented as follows; This nurse

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F 689	Continued From page 14 down center hall way passing medication, certified nurses aide (CNA) called this nurse to the residents room as the resident had been lowered to the floor. Upon entering the room the nurse observed the resident sitting on the floor beside his bed with legs bent up. Resident assisted up with two staff and with a gait belt to the bed. Noted the resident had a 5.5 centimeter by 4.5 centimeter abrasion to the outer right knee area. The area had been cleansed with wound cleanser and left open to the air. No rotation or shortening noted to the residents legs. Pedal pulses palpable. Vitals completed. Immediate action taken post fall had been documented as follows; the resident would be transferred by two staff when going to bed at bedtime with a gait belt. The Fall Report documented predisposing situation factors happened during the transfer, the resident did not have on proper footwear (gripper socks), and a gait belt had not been used during the transfer. Witness to the fall had been documented as Staff K, CNA. The person documented as preparing the report had been Staff A, Registered Nurse. An Employee Coaching Worksheet dated 5/30/20 documented Staff A, Registered Nurse (RN) had coached Staff K, CNA to use a gait belt on residents when transferring whether to bed, or bathroom, or just to the wheelchair, and even when walking a resident. Staff A, RN, and Staff K both signed the Coaching document. The Nursing Guidelines and Procedure Manual dated 1/2015 edition contained a policy titled Gait Belts (for use in ambulation and transfer). The policy documented gait belts should be used by all staff, to allow for easier handling of residents which should help to avoid injuries both to	F 689		

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F 689	Continued From page 15 residents and staff. The Guidelines were documented as follows: 1. Each staff member will have a gait belt readily available for use, when on duty. 2. Provide instructions to the resident. 3. Apply the belt around the resident's waist snug enough to eliminate the possibility of sliding up on the ribs. 4. Assist the resident to the edge or the chair/bed/surface, with both feet flat on the floor. 5. Staff are to use proper body mechanics: Bend and lift with your knees and not your back, Keep your back straight at all times. 6. Bring the resident to a standing position by grasping the with both hands, while remaining upright yourself. 7. Use the gait belt during ambulation to stabilize the resident by grasping the belt firmly in the middle of the resident's back. 8. Walk along side and slightly behind the resident, while holding onto the belt. 9. If a resident begins to lose their balance, draw resident close to you ease him/her down with your hold of the gait belt. this protects you and the resident from head or body injury. Call for assistance and do not move the resident until he/she has been assessed by the nurse. A Case Summary with submitted date 6/14/20 by the facility Administrator documented the company policy had been that all resident transfers of any type require a gait belt for the safety of the resident. The Administrator documented that during an interview Staff K reported she had been oriented to the use of a gait belt, and she said, "Unless it's right there I don't use it. I have one floating around here somewhere". The Administrator documented the interview had been witnessed by her and the	F 689		

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F 689	Continued From page 16 Nurse Consultant. The Orientation Checklist: Nursing Assistant dated 5/17/19 for Staff K, CNA documented she had been instructed on assist ambulation with use of a gait belt, and resident transfers. The Nurses Note dated 5/31/20 at 6:00 a.m. documented the resident had yelled out in pain when his right leg had been moved, staff assisted the resident to sit at the side of the bed, with maximum assist of two staff. The resident had not been able to bear weight, and the resident complained of pain to the right upper leg, the staff then laid him back down in bed. An x-ray report dated 5/31/20 documented the resident had a slightly displaced fracture of the right hip, and a orthopedic consultation had been recommended. The x-ray report documented the resident had a fight femur (upper leg bone) demonstrate a slightly displaced subcapital fracture. The Nurses Note dated 5/31/20 at 1:35 p.m. documented new orders for the resident to be sent by ambulance to the emergency room. The Nurses Note dated 6/5/20 at 1:35 p.m., documented the resident had returned to the facility after a right hip repair surgery. On 6/22/21 at 10:45 a.m. Staff H, CNA, reported that during a one person assist transfer the gait belt is put on the resident before the transfer. On 6/22/21 at 10:45 a.m. noted Staff H, CNA had a gait belt on her waist.	F 689		

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F 689	Continued From page 17 On 6/22/21 at 10:50 a.m., Staff D, Certified Medication Aide (CMA) reported that during a transfer gait belts are used for all two person and one person transfers. On 6/22/21 at 10:50 a.m. noted Staff D, had a gait belt around her waist. On 6/22/21 at 11:03 a.m. Staff G, CMA reported Resident#32 could be, a one assist or even two assist at the time of his fall on 5/30/20, and always use a gait belt with any transfers. Staff G reported staff had been provided education to wear the gait belts if not in use. On 06/22/21 at 3:00 p.m. Staff I, Licensed Practical Nurse (LPN) the resident had been a transfer of one to two people depending on his status, for example in the morning it maybe ok to use one staff member, and then two in the afternoon maybe needed for safety. Staff I reported that gait belts should be use with all transfers. On 6/22/21 at 3:33 p.m., Staff A, RN reported Resident#32 had been a transfer of one with a gait belt, at the time of his fall on 5/30/20. Staff A, RN reported she heard Staff K, CNA yell her name for help, she entered the residents room and the resident was on the floor. Staff K did not use a gait belt when she transferred the resident, and no other staff had been in the room. Staff A reported there had been no gait belt in the room, on the resident, or on Staff K, CNA. Staff A, RN stated the gait belt could have helped with the fall and injury. Staff A, LPN reported that after the fall had been assessed by the management team there had been in services about gait belt use.	F 689		

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F 689	Continued From page 18 On 6/22/21 at 12:03 p.m. the Director of Nursing reported gait belts should be use for all transfers. On 6/23/21 at 12:22 p.m. Staff B, reported gait belts should always be used for transfer that require one or two staff members to assist a resident. On 6/23/21 at 12:33 p.m. Staff C, RN reported that on 5/30/20 the resident would have been a one to two person assist with transfers, and a gait belt should always be used for those type of transfers.	F 689	**F880:** This is my credible allegation of compliance to F880. This allegation does not constitute guilt but that the facility is in compliance to F880. Residents are being care for using appropriate and approved infection control techniques. Staff was educated on 06/24/2021 by the DON/Infection Preventionist on the appropriate way to handle clean and dirty linen to potentially decrease the chances of cross contamination from laundry to uniform and vice versa as well as proper use of PPE/Masks when in the facility. Staff will also be educated via watching the following YouTube videos: "Know How to Wear Your Face Mask Correctly" by the CDC, "Infection Control Basics for Healthcare Laundry Services" Part 1 and 2 by the Oregon Health Authority through a grant from the CDC. These videos will be watched by midnight on Friday, July 23rd by all staff.	
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	F 880		

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F 880	Continued From page 19 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 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	F 880	**F880 continued:** Through root cause analysis the facility determined the root cause of the staff's improper use of protective face masks was a decrease in facility staff's concerns about contracting Covid after being vaccinated, along with a decrease in management's enforcement of proper mask usage. Root cause analysis, using the 5 Why's Method, determined that improper linen handling was due to the lack of scheduling and staffing since our laundry service was brought back to the facility during Covid. Previously laundry had been transported out to a sister facility nearby. Proper education upon the return of laundry services was not provided at that time. Facility management will audit staff for proper linen handling along with the wearing of protective face masks properly when in the facility. Further education will be provided to assist in correcting any observed issues.	

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F 880	Continued From page 20 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, staff interview, and record review, the facility failed to provide appropriate infection control standards for 11 residents of 11 residents observed. The facility reported a census of 35 residents. Findings include: 1. Observation on 6/22/21 at 2:39 p.m., revealed Staff N, housekeeping staff, delivering laundry to rooms in hallway A. Laundry cart with clean clothing was sitting in the hallway uncovered. Staff N, housekeeping staff, came out of the room and proceeded to push the cart down the hallway uncovered to the next room. Staff N, housekeeping staff, took the clothing off of the rack and placed them under their arm against their uniform and walked into the room and placed residents' clothing into the closet. 2. Observation on 6/23/21 at 2:17 p.m., revealed Staff N, housekeeping staff, delivered laundry to the rooms in hallway B and C. Laundry cart with clean clothing covered from the top down exposing the bottom of the residents' clothing hanging on the bar in the hallway at the beginning of the clothing being passed. Staff N, housekeeping staff uncovered half of the clothing and left uncovered walking down the hallway. Staff N, housekeeping staff, was observed 8 times holding clothing up against their uniform while delivering clothing. Staff N, housekeeping	F 880	**F880 Continued:** The facility Stand Up Team will ensure audits occur and that proper corrective actions occur following audits if needed. Problems will be corrected as they are observed.	

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F 880	Continued From page 21 staff was observed to have their mask below their nose while delivering laundry to 4 separate rooms before pulling the mask up and did not perform hand hygiene after pulling the mask up. 3. Observation on 6/23/21 at 2:34 p.m., Staff O, Certified Nursing Assistant (CNA) observed with mask below nose passing ice water to residents in hallway B. Staff O, CNA, observed passing water to 3 different resident rooms before pulling her mask up and performing hand hygiene. During interview on 6/23/21 at 3:17 p.m., the Director of Nursing(DON) stated that all staff are expected to hold linens away from their scrubs, that is an infection control issue as they eat and work in their scrubs. The DON revealed she would expect all staff to wear their masks above their nose. Review of facility policy titled Preventing Spread of Infection, March 2013 edition revealed transport carts with clean linens are to be completely covered during transport. Review of facility policy titled Linens, March 2013 edition revealed facility staff will handle, store, process and transport linens so as to prevent the spread of infection. Review of the facility policy titled COVID-19 Visitation policy updated April 1, 2021 revealed core principles of COVID-19 infection prevention included face covering or mask covering mouth and nose and appropriate staff use of personal protective equipment (PPE). Centers for Disease Control and Prevention website titled, Recommendations for Healthcare	F 880		

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F 880	Continued From page 22 Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic, visited 6/24/21 and updated 2/23/21, revealed Healthcare Personnel (HCP) should wear well-fitting source control (use of well-fitting face masks to cover a person ' s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing) at all times while they are in the healthcare facility. The website further revealed, if worn properly a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces.	F 880		

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: #9040		Date: July 13, 2021
Facility Name: Eldora Specialty Care		Survey Dates: June 21-24, 2021
Facility Address/City/State/Zip 1510 22nd Street Eldora, IA 51360	MW/DC	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	she transferred the resident, and no other staff had been in the room. Staff A reported there had been no gait belt in the room, on the resident, or on Staff K, CNA. Staff A, RN stated the gait belt could have helped with the fall and injury. Staff A, LPN reported that after the fall had been assessed by the management team there had been in services about gait belt use. On 6/22/21 at 12:03 p.m. the Director of Nursing reported gait belts should be use for all transfers. On 6/23/21 at 12:22 p.m. Staff B, reported gait belts should always be used for transfer that require one or two staff members to assist a resident. On 6/23/21 at 12:33 p.m. Staff C, RN reported that on 5/30/20 the resident would have been a one to two person assist with transfers, and a gait belt should always be used for those type of transfers. **FACILITY RESPONSE:** This is my credible allegation of compliance. This allegation does not constitute guilt but that the facility is in compliance.			7/23/21

Susan [illegible] 7-22-21

Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).