STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

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GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 000 ✓ JB	INITIAL COMMENTS Correction date: 08/19/22, 09/04/22 Amended 8/25/22 The following deficiencies resulted from the facility's annual recertification survey with intakes #103335-C, #103357-C and #105219-C conducted on July 25, 2022 to August 4, 2022. Complaint #103335 was not substantiated Complaint #103357 was not substantiated Complaint #105219 was not substantiated See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	The Plan on Correction does not constitute an admission or agreement by Grandview Health Care Center of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Grandview Health Care Center credible allegation of compliance.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and staff interviews the facility failed to complete the quarterly review assessments for 2 of 15 residents reviewed (Residents #1 and #2), 14 calendar days after the assessment reference day (ARD). The facility reported a census of 26 residents. Findings Include: 1. Resident #1's Minimum Data Set (MDS) assessment identified an ARD of 11/7/21 and a	F 638	F638 1. Resident #1 had a Quarterly Review Assessment completed on 06/13/22. Resident #2 had an Annual Assessment completed on 06/20/22 2. An audit of Quarterly Review Assessments on current residents was completed by the DON/Designee on or before 09/04/22 and assessment added to schedule if warranted. 3. On or before 09/04/22 the Regional Director of Clinical Service educated the ADON/MDS nurse on timely completion of Quarterly Review Assessments. 4. DON//Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure Quarterly Review Assessments are completed timely. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

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

Interim Administrator | 08/26/2022

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 638	Continued From page 1 completion date of 2/7/22. Resident #1's MDS assessment identified an ARD of 3/13/22 and a completion date of 3/31/22. The facility failed to complete Resident #1's two MDS's within 14 calendar days after the ARD. 2. Resident #2's MDS assessment identified an ARD of 1/7/22 and a completion date of 3/9/22. Resident #2's MDS assessment identified an ARD of 3/20/22 and a completion date of 4/11/22. The facility failed to complete the two MDS's for Resident #2 within 14 calendar days after the ARD. On 8/2/22 at 12:36 PM, the Director of Nursing (DON) stated the facility had taken the default rate of payment for the Medicaid residents due to the MDS's not being completed and/or submitted timely. The DON stated she identified the MDS completion and submission concern when he started at the facility at the end of June. The DON reported that the facility needed to correct that. The DON explained that he noted improvement since the MDS nurse has been at the facility almost 3 months. The DON reported that the facility had staff in and out of the DON and MDS nurse roles. Without consistency of the staff he didn't know how long they MDS's done inconsistent. The DON explained that he expected the MDS's to be completed, submitted on time, and accurate, due to them being based on the resident's care. The DON stated the facility needed to get credit for what they were doing.	F 638		
F 644	Coordination of PASARR and Assessments	F 644		

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F 644 SS=D	Continued From page 2 CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer a resident to the appropriate state-designated authority for a Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination after a short-term approval ended for one of one residents reviewed (Resident #9). The facility reported a census of 26 residents. Findings include: 1. Resident #9's Minimum Data Set (MDS) assessment dated 7/20/22 included a diagnosis of Bipolar. Resident #9 used an antipsychotic for six out of seven days in the lookback period. Resident #9 used an antidepressant for seven out	F 644	F644 1. Resident #9 Level II PASARR was completed on or before 09/04/22 by an appropriate state-designated authority. 2. An audit was completed by the DON/Designee of current residents to ensure that their PASARR's are up to date. 3. On or before 09/04/22 the Regional Director of Clinical Service educated the DON and Social Service Designee regarding when a PASARR needs to be completed. 4. DON//Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure PASARR's are completed/updated timely. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

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F 644	Continued From page 3 of seven days in the lookback period. Resident #9 received antipsychotic medications on a routine basis only without a gradual dose reduction attempted. Resident #9's PASARR Level II Outcome dated 9/1/21 documented a short-term approval end date of 2/28/22. Due to Resident #9's service needs, he could only go to the following facility types: Nursing facility for persons with mental illness or nursing facility with intensive specialized services. During an interview on 7/26/22 at 4:33 PM, the Admission/Marketing Director confirmed a new PASARR referral did not get completed. During an interview on 7/27/22 at 3:18 PM, the Director of Nursing reported that he expected PASARR status changes/reviews to be completed.	F 644		
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 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	F 656	F656 1. By 9-4-22 the DON/Designee reviewed Resident #127 Comprehensive Care Plan and updated as warranted. 2. An audit was completed by DON/Designee on or before 09/04/22 of current resident Comprehensive Care Plans and updated if warranted. 3. On or before 09/04/22 the Regional Director of Clinical Service educated the ADON/MDS regarding completion comprehensive care plan timely. 4. DON//Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure new admission Comprehensive Care Plans have been developed timely. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

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GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 656	Continued From page 4	F 656		

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 clinical record reviews, resident and staff interviews, the facility failed to develop a comprehensive Care Plan that addressed a resident's medical, physical, mental, and psychosocial needs for one of twelve residents reviewed (Resident #127). The facility reported a census of 26 residents.

Findings include:

Resident #127's Minimum Data Set (MDS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 5	F 656		

assessment dated 6/22/22 included diagnoses of arthritis, hereditary and idiopathic neuropathy (condition that affects the peripheral nerves and causes numbness, tingling, and muscle weakness in the limbs), unspecified visual loss, and esophagitis (inflammation that causes damage to the esophagus). The MDS identified Resident #127's vision as severely impaired with no vision or sees only light. Resident #127 required extensive assistance of one person for dressing, eating, personal hygiene and extensive assistance of two persons for bed mobility, transfers, and toilet use. The MDS also identified Resident #127 required a pureed diet. Resident #127 showed risk for pressure ulcers. The MDS indicated that he received opioids (medication to treat moderate to severe pain) for seven out seven days in the lookback period. The MDS identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment for decision-making.

On 7/26/22 at 9:38 AM, Resident #127 reported that he is blind, on a puree diet, staff assist him with eating, and provide his care for him.

Resident #127's MDS Care Area Assessment (CAA) Summary dated 7/8/22, identified the following care areas triggered. The Care Plan decision question listed yes, indicating they would be added to the Care Plan: cognitive loss/dementia, visual function, activities of daily living, urinary incontinence, psychosocial well-being, falls, nutritional status, pressure ulcer, and pain.

Resident #127's Care Plan initiated 6/16/22, only documented A Focus related to his wishes for a do not resuscitate order. The Care Plan lacked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 656	Continued From page 6 additional Focus areas in the Care Plan. On 8/2/22 at 1:42 PM, the Director of Nursing explained that he expected a comprehensive Care Plan be completed with all care areas addressed.	F 656	F657 1. Resident #6 and #19 and/or their Responsible Party has been contacted by the DON/Designee on or before 09/04/22 and a Care Conference has been scheduled if desired. Resident #10 Antidepressant medication has been added to their Care Plan on or	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657	before 09/04/222 by the DON/Designee. 2. An audit was completed by DON/Designee on or before 09/04/22 of current resident to ensure that a Care Conference has been held in the last quarter and if not, one will be scheduled if desired. Current residents who receive antidepressant medication will have their care plans reviewed to ensure antidepressant medication is addressed and care plan updated if warranted. 3. On or before 09/04/22 the Regional Director of Clinical Services will reeducate DON/MDS Nurse on scheduling/holding of Care Conference and addressing antidepressant medication in Care Plans. 4. DON/Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure that Care Conferences are scheduled, and new antidepressant medication are Care Planned. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 7	F 657		

Based on clinical record reviews, resident and staff interviews, the facility failed to provide Care Conferences to residents for two of three residents reviewed (Residents #6 and # 19). In addition the facility failed to revise the Care Plan for a resident who used an antidepressant medication for one of 3 residents reviewed (Resident #10). The facility reported a census of 26 residents.

Findings include:

1. Resident #6's Minimum Data Set (MDS) assessment dated 7/22/22 indicated an admission date of 1/6/21. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition.

During an interview on 7/25/22 at 10:57 AM, Resident #6 reported that she never got invited or attended a Care Conference.

2. Resident #19's MDS assessment dated 5/5/22 indicated an admission date of 7/25/20. The MDS identified a BIMS score of 15, indicating intact cognition.

During an interview on 7/25/22 at 1:49 PM, Resident #19 explained that he had not been invited or attended any Care Conferences.

During an interview on 7/27/22 at 9:16 AM, the MDS Coordinator reported that she just working at the facility at the end of April. She explained that she is trying to get Care Plan Conferences set up on a schedule. The MDS Coordinator stated they currently did not have Care Conferences. The only conferences held were when residents discharge from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 657	Continued From page 8	F 657		

During an interview on 8/2/22 at 1:39 PM, the Director of Nursing stated he expected to have Care Conferences with the families and residents quarterly (every three months).

3. Resident #10's MDS assessment dated 6/2/22 identified a BIMS score of 00, indicating severe cognitive impairment. The MDS identified Resident #10 wandered daily in the last 7 days. The MDS coded that Resident #10 required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS included diagnoses of non-Alzheimer's dementia, diabetes, and hypertension. The MDS coded Resident #10 received antidepressant medications for seven of the last seven days in the lookback period.

The Care Plan for Resident #10 initiated date of 1/29/22, failed to identify a focus area, goal, and/or the interventions related to the use of antidepressant medications and the side effects of antidepressants.

The July 2022 Medication Administration Record (MAR) included an order dated 4/12/22 for trazodone (antidepressant) 25 milligrams (MG) daily for restlessness related to dementia without behavioral disturbance.

On 8/1/22 at 9:27 AM, the Director of Nursing (DON) confirmed that Resident #10's Care Plan failed to identify the use of trazodone, an antidepressant medication. The DON stated that he expected the classification of the medications to be included on the care plan with their side effects. The DON reported that it did not necessarily have to be the specific medication

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 9 due to the Certified Nurse Aides not knowing the specific medication, however, the classification. The DON stated that he reviewed the Care Plans with the MDS Coordinator and included the need of signs, symptoms, and side effects to observe for with psychotropic medication use.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced	F 661	F661 1. Discharged residents #11 and #25 has had their recapitulation of stay completed by the DON/Designee on or before 09/04/22. 2. An audit was completed by DON/Designee on or before 09/04/22 of residents that have discharged within the last 30 days to ensure that their recapitulation of stay has been done and competed if warranted. 3. On or before 09/04/22 the DON/Designee reeducated the IDT team on completing the recapitulation of stay upon discharge if warranted. 4. DON/Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure that recapitulation of stay have been completed at time of discharge if warranted. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

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F 661	Continued From page 10	F 661		

by:
Based on clinical record reviews, facility policy review, and staff interviews the facility failed to complete a recapitulation of stay, a final summary of the resident's status, for two of two residents reviewed (Residents #11 and #25) discharged from the facility. The facility reported a census of 26 residents.

Findings include:

1. Resident #11's Minimum Data Set (MDS) assessment dated 7/11/22, identified that she discharged to the community on 7/8/22. The MDS identified a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The MDS included diagnoses of anxiety, atrial fibrillation, and hypertension.

Progress Notes Review
a. On 7/7/22 at 2:23 PM, the Order Note documented that Resident #11's primary care provider (PCP) saw her in the facility and gave an order for her to discharge home on 7/8/22. The order directed Resident #11 to go to a follow-up visit with her PCP and to have home health.
b. On 7/8/22 at 3:25 PM, the Discharge Status Note, indicated that Resident #11 discharged to her home with a family member. The nurse provided Resident #11 a medication list and answered her questions. The facility faxed the medication list to the pharmacy and the home health agency. The facility sent Resident #11's belongings home with her.

The clinical record lacked documentation of Resident #11's recapitulation of stay, or the summary of the resident status upon discharge from the facility on 7/8/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 661	Continued From page 11	F 661		

The facility document titled Discharge Planning, dated 4/2013 included procedure:
1. Initiate the Interdisciplinary Discharge Summary for an anticipated discharge.
2. Document all discharge plans in the resident medical record.
3. Initiate the Discharge Information and have the members of the IDT (interdisciplinary team) complete as indicated and provide a copy to the resident.
4. Complete the Interdisciplinary Discharge Summary.
5. Maintain all documents in the resident medical record.

On 7/28/22 at 11:17 AM Staff A, the Nurse Consultant, confirmed that the clinical record did not have a recapitulation of stay completed for Resident #11 when she discharged from the facility on 7/8/22.

2. Resident #25's MDS assessment dated 6/2/22, identified that she discharged to the community on 5/11/22. The MDS staff assessment indicated Resident #25's seemed ok for short-term memory and independent with cognitive skills for daily decision making. The MDS included diagnoses of diabetes, anxiety, and chronic obstructive pulmonary disease.

The Discharge Nursing Note dated 5/11/22 at 4:41 PM, documented that the facility received an order Resident #25 to discharge home with home health services. Resident #25's friend came to the facility and took her home. Resident #25 took her personal belongings, a medication list, and a list of current orders with her upcoming appointments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 661	Continued From page 12 The clinical record lacked documentation of Resident #25's recapitulation of stay, or the summary of Resident #25's status upon discharge from the facility on 5/11/22. On 7/28/22 at 10:45 AM, Staff A, the Nurse Consultant, confirmed Resident #25's clinical record did not have a recapitulation of stay. Staff A acknowledged that the facility didn't complete any recapitulations in the last three months for discharged residents. Staff A provided a report on the computer screen and stated that no recapitulation of stays got completed at the facility in the last 3 months. Staff A reported the system fell apart around that time. Staff A explained that she would check with the nursing staff. During a follow-up interview on 7/28/22 at 10:54 AM, Staff A explained that she checked with the other facility staff and confirmed that the facility did not do a recapitulation of stay for Resident #25 when she discharged from the facility on 5/11/22.	F 661		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that 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:	F 684	F684 1. Resident #128 skin was re-assessed by the licensed nurse on 08/19/22. 2. On 08/19/22 the DON/Designee completed skin re-assessments on any residents that was admitted in the last 30 days to ensure area of concerns are addressed. 3. On 08/19/22 the DON/Designee educated licensed nurses related to the requirements of completing skin assessments as part of the admission process. 4. DON//Designee will complete audits weekly for 12 weeks of new admissions to ensure skin assessments are completed at time of admissions. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	08/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 684	Continued From page 13	F 684		

Based on observation, clinical record review, policy review, resident interview, and staff interview the facility failed to assure a complete and thorough initial assessment and weekly follow up assessments were completed for 1 of 2 residents reviewed (Resident #128) with impaired skin. Resident #128 admitted to the facility from the hospital on 6/24/22. The facility failed to complete a full skin assessment for Resident #128, including the abdominal wound, present on admission to the facility, until 7/8/22. The facility failed to complete an assessment of an additional skin impairment identified on 7/9/22, until 7/17/22 when deterioration of the area noted and revealed 2 open areas. The facility reported a census of 26 residents.

Findings Include:

Resident #128's Minimum Data Set (MDS) assessment dated 7/7/22 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS coded that Resident #128 required extensive physical assistance of one to two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS included diagnoses of renal insufficiency, hypertension, renal insufficiency, diabetes, malnutrition, rash/other nonspecific skin eruption, and disorder of calcium metabolism. The MDS identified Resident #128 as a risk for developing pressure ulcers. She used a pressure reducing device for her bed and her chair. The MDS documented that Resident #128 received an application of nonsurgical dressings and an ointment/medications for skin and ulcer/injury treatment.

The facility failed to develop a comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 684	Continued From page 14	F 684		

care plan for Resident #128, that included a Focus area, a Goal and/or Interventions related to her risk for impaired skin integrity and/or actual skin impairment.

On 7/25/22 at 2:00 PM, Resident #128 sat in her recliner with her feet elevated wearing a hospital gown on. Staff E, Licensed Practical Nurse (LPN), informed Resident #128 that they would change the dressing on her abdomen. Resident #128 removed the old dressing dated 7/24/22 and revealed a large necrotic (dark black) area surrounded with redness along the bottom of her abdominal fold. Noted an open area with a red base along the bottom side, the length of the necrotic area that measured approximately 1 cm wide. Resident #128 stated that the area started as two scratches and bruises that developed into the large black scabbed area. Resident #128 said that dialysis told her the cause of the area happened by calcification under the skin. Resident #128 stated the wound deteriorated at home, as she did not go out for dialysis, and eventually got admitted to the hospital due to the pain of the wound.

On 7/26/22 at 10:37 AM, Resident #128 sat in her recliner with her feet elevated. Resident #128 stated that she just did not feel well that day and that she had pain. Resident #128 reported that she spoke with the nurse about it and she had received all the pain medications she could have. Resident #128 explained that she did not feel up to an interview at the time.

On 7/26/22 at 3:20 PM, Resident #128 sat in her recliner, with feet elevated and covered with a blanket. Resident #128 reported that she just took a bunch of medication and would like to take

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 684	Continued From page 15	F 684		

a nap, and did not feel like being interviewed.

The Progress Notes for Resident #128 revealed:

a. On 6/24/22 at 7:30 PM, the Admission Nursing Note documented that Resident #128 arrived at the facility via family care from the hospital.
b. On 6/24/22 at 12:00 AM, the Health Status Note (HSN) recorded that Resident #128 arrived at the facility from the hospital with family. The note indicated that Resident #128 able to make her needs known due to being alert and oriented. The resident had triple lumen to the upper right arm, a bruise noted across the abdominal area and fistula to the right upper arm with several bruises observed..
c. On 6/28/22 at 10:10 AM, HSN documented Resident #128 as alert and oriented to person, place, time, and able to make her needs known. Resident #128's skin appeared pale, warm, and dry as her baseline. The wound noted to her abdomen appeared without signs or symptoms of infection. Resident #128's left arm fistula with bruit and thrill, her port appeared to have no signs or symptoms of infection
d. On 7/6/22 at 3:02 PM, HSN indicated that Resident #128 continued with her abdominal treatment. The wound contained an intact scab that appeared to be tender to the touch. No new skin issues identified.
e. On 7/8/22 at 9:47 AM, HSN recorded a new order received from the Wound Center to apply iodine 10% (antimicrobial used to treat wounds) via a swab stick to the scabbed area on the abdominal wound. Continue the medi-honey (gel used for hard to dress wounds and dry to moderate draining wounds) to the open area below the scabbed area on the abdomen.
f. On 7/8/22 at 9:48 AM, HSN documented a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 684	Continued From page 16	F 684		

scabbed wound to Resident #128's abdomen that measured 17.5 centimeters (cm) in length x 5.4 cm in width x 0 cm in depth. The open area below the scabbed area measured 6.7 cm x 1.5 cm x 0.5 cm.
g. On 7/10/22 at 1:02 PM, HSN indicated that during Resident #128's shower, the staff observed a superficial area on her right buttock. The nurse cleaned the area, applied calmoseptine (ointment to prevent and heal minor skin irritations), and covered the wound with mepilex (foam dressing). The nurse sent a fax to Resident #128's primary care provider (PCP). Resident #128 continued with her wound treatment.
h. On 7/17/22 at 2:15 PM, HSN indicated that while performing the treatment to Resident #128's abdomen, Resident #128 said that she had a patch to her right hip area. The nurse noted a large bordered foam dressing dated 7/9/22. The nurse removed the dressing, then cleaned the area revealing two open wounds. Wound #1 (closest to the coccyx) measured 4 cm x 2.5 cm x 0.1 cm. Wound #2 measured 4.6 cm x 3.4 cm x 0.1 cm. The nurse applied Bactroban (ointment used to treat skin infections) to both of the areas and covered them with a bordered foam dressing. The nurse sent a fax to Resident #128's PCP.

Resident #128's Nursing Daily Skilled Assessment dated 6/25/22 - 7/27/22 lacked documentation of an assessment related to the abdominal wound and/or the skin impairment to the right buttock or hip area.

Resident #128's Weekly Skin Assessments revealed one assessment dated 7/27/22. The assessment identified intact dressings to her lower abdomen and her right buttock. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 684	Continued From page 17	F 684		

assessment lacked documentation of the open areas including measurements.

Resident #128's Resident Bath/Skin Observation documented the following:
1. On 6/25/22 - identified an abdominal area while applying betadine.
2. On 6/29/22 - no skin impairments identified.
3. On 7/6/22 - an open area to her lower abdomen, the nurse treated the wound.
4. On 7/10/22 - lower abdomen dressing intact and new area to her right buttock.
5. On 7/16/22 - lower abdomen dressing intact and no documentation related to the area on her right buttock

Resident #128's Wound Healing Center documentation included the following:
1. On 7/6/22 - midline abdomen, lower quadrant caused by calciphylaxis (serious uncommon disease where calcium accumulates in the small blood vessels of the fat and skin tissues, causing painful skin ulcers). Date acquired 5/1/22, 5 weeks of treatment. Measurements: 7 cm x 15 cm x 0.8 cm. Small amount of yellow, brown, and green purulent drainage. Large amount of eschar (black) tissue.
2. On 7/27/22
midline abdomen, lower quadrant measured 6 cm x 18 cm x 0.8 cm.
Right gluteus caused by calciphylaxis acquired on 7/1/22. Measured 2.5 cm x 6 cm x 0.1 cm. small amount of granulation with medium amount of slough.

The paper and electronic clinical record lacked weekly skin assessments of Resident #128's abdominal wound from her admission on 6/24/22 until 7/8/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 684	Continued From page 18	F 684		

Resident #128's paper and electronic clinical record lacked a thorough assessment of the areas identified on the right buttock on 7/9/22 until the identification of two areas on 7/17/22.

The facility failed to develop a comprehensive care for Resident #128.

The Skin Care and Wound Management policy dated 6/15, identified the components of the program to include: weekly monitoring of Resident #128 skin status, daily monitoring of existing wounds, and the interdisciplinary team (IDT) to review the identified skin impairments.
1. Procedure:
a. Complete admission skin sweep and the admission clinical information/readmission data collection and initial care plan on admission. Initiate weekly skin sweep thereafter. Identify areas of skin impairment and any pre-existing signs.
b. Develop a care plan with input from the IDT and Resident #128 and family. Document individualized goals and interventions to manage risk factors.
c. Communicate risk factors and interventions to the caregiving team, resident/family.
d. Evaluate for consistent implementation of the interventions and evaluate effectiveness of the interventions during care management meetings.
1. Treatment:
a. Select and complete the appropriate form: Skin Grid, Pressure or Skin Grid Other (all skin impairment issues that require measurement to indicate healing occurred)
b. Monitor and document progress towards goals
c. Evaluate effectiveness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 684	Continued From page 19 d. Modify and document goals and interventions On 7/26/22 at 11:15 AM, the Director of Nursing (DON) explained the the weekly wound assessments got documented in Resident #128's progress notes and denied having a separate skin book. The DON stated all of Resident #128's clinical record would be located in the hard chart and/or the electronic health record (EHR). On 7/28/22 at 7:19 AM, Staff A, Nurse Consultant, confirmed in an email that Resident #128 had wound clinic documentation from 7/6/22 and 7/27/22 with measurements. Staff A explained her next scheduled appointment as 8/8/22. Staff A acknowledged that during Resident #128 bath, the bath sheets acknowledged a wound for 6/25/22, 7/6/22, 7/10/22, and 7/16/22; however, the bath sheets lacked measurements. On 7/28/22 at 8:13 AM, the DON stated Resident #128 had a history of open areas with sores to her bottom and to her right hip. The DON explained that he started in the position after Resident #128's admission to the facility. The DON stated he believed that Resident #128 had the areas to abdomen and/or right buttock upon admission. The DON said that Resident #128 received dialysis and she had been in and out of the hospital. The DON reported that he ordered a new commode for Resident #128 due to the new area on her right hip and that he educated the bath aide (a Registered Nurse) about body assessments and measuring open areas. The DON confirmed Resident #128 did not have a complete thorough skin assessment upon admission and/or every week thereafter. The DON confirmed Resident #128 did not have an	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 684	Continued From page 20 assessment of her skin impairment identified on 7/9/22 to her right buttock until 7/17/22. The DON added that on a resident's admission to the facility, he expected a full head to toe assessment and initiation of the Care Plan immediately. The DON said the Baseline Care Plan could be a Pocket Care Plan and would expect Resident #128, her family, and the staff to be involved. The DON reported that he expected ongoing weekly skin assessments and an assessment of any new areas identified. The DON explained that he reviewed the facility protocol with the facility nurses on duty related to the skin assessments and expected all residents in the facility to have a skin assessment completed on 7/27/22 and/or 7/28/22. On 8/1/22 at 2:28 PM, Staff B, Licensed Practical Nurse (LPN), explained that the weekly skin assessments were completed under the assessment tab in the resident's EHR. Staff B reported that skin assessments should be done every week, however, they did not get assigned to anyone specifically. For that reason, the assessments do not get completed. Staff B reported that they worked one day a week, and when they arrived to work on Monday mornings the aides would report skin impairments to the agency nurses, who did nothing about them all weekend.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 686	Continued From page 21 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to complete assessments, follow physician's recommendations for appointments, and update the Care Plan for a Stage III pressure injury for one of two residents reviewed (Resident #15). The facility reported a census of 26 residents. Findings include: Resident #15's Minimum Data Set (MDS) assessment dated 4/30/22 included diagnoses of diabetes mellitus and renal insufficiency. The MDS documented Resident #15 needed extensive assistance of one person for bed mobility and personal hygiene. Resident #15 required extensive assistance of two persons for transfers, dressing, and toilet use. The MDS identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment for decision-making. On 8/1/22 at 3:23 PM, observed Resident #15's wound on his right heel. The open area appeared to be approximately the size of a pencil eraser with a purplish-red area surrounding it, that appeared to be approximately the size of a nickel.	F 686	F 686 1. Resident #15 has had a skin assessment completed, been seen by the Wound Clinic and Pressure Ulcer Care Plan reviewed and updated by the DON/Designee on or before 09/04/22. 2. An audit was completed by DON/Designee on or before 09/04/22 of resident with Pressure Ulcers to assure they have been assessed, have gone to scheduled Wound Clinic appointments if warranted and Pressure Ulcers Care Plans have been reviewed and updated if needed. 3. On or before 09/04/22 the DON/Designee reeducated License Nurses on pressure ulcers assessments, attending wound clinic appointments and Pressure Ulcer Care Plan are up to date. 4. DON//Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure new pressure ulcers are assessed, pressure ulcer care plans are up to date and residents are attending wound clinic appointments when scheduled. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 686	Continued From page 22	F 686		

Resident #15's Weekly Skin Assessment V1 labeled Admission dated 6/4/22, documented that he re-admitted to the facility with skin issues to his right foot. On his right heel, he had an open wound measuring 5 centimeters (cm) X (by) 4 cm. The wound bed appeared white surrounded by pink skin, with purulent drainage (type of liquid that oozes from a wound) noted upon removal of the dressing. Resident #15's assessed to have an area to his plantar area of his right foot. The area measure 3 cm X 2.8 cm X 0 cm. The area appeared to not be open with eschar.

Resident #15's progress note dated 6/30/22 at 4:30 PM identified that his Wound Center appointment got rescheduled from Friday 7/1/22 to Tuesday 7/12/22 at 10 AM.

Resident #15's Weekly Skin Assessment - V 1 dated 7/12/22 documented an open area to his right heel that measured 1 cm X 0.5 cm X 0.1 cm. Additionally his foot had an area to the medial section of his foot that measured 1 cm X 1.3 cm X 0.1 cm and an area to his great toe that measured 0.5 cm X 0.5 cm x 0.1 cm.

Resident #15's clinical record lacked an assessment related to the wounds on his right heel from 6/4/22 until 7/12/22.

The Wound Center report dated 7/12/22, documented that Resident #15 had a Stage 3 (full thickness tissue loss involving damage or necrosis, death, of subcutaneous, fatty layer of tissue under skin, tissue) pressure ulcer of his right heel and to another site. The report instructed for Resident #15 to return for an appointment in one week. The Assessment section reported the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 686	Continued From page 23	F 686		

a. Right calcaneus - open pressure injury
i. Measured 1 cm X 0.5 cm X 0.1 cm
ii. Medium amount (34-66%) of necrotic (death of cells or tissue through disease or injury) adherent (attached) slough (necrotic tissue that needs to be removed from the wound for healing to take place) tissue.
b. Right medial - open pressure injury
i. Measured 1 cm X 1.3 cm X 0.1 cm
ii. Large amount (67-100%) necrotic adherent slough tissue.
iii. Debrided (remove damaged tissue)
c. Right Toe Great - open pressure injury
i. Measured 0.5 cm X 0.5 cm X 0.1 cm
ii. Large amount necrotic, eschar, adherent slough tissue
The Provider Orders - Wound Treatment directed to clean the right foot's calcaneus and the medial area with normal saline, apply Bactroban, and cover with a Mepilex border 4 X 4 dressing once a day. The order added to remove the bandage to the right great toe before showering and apply Bactroban as directed, cover with a Mepilex foam 4 X 4 dressing and secure with Medipore soft cloth surgical tape once a day.

Resident #15's progress note dated 7/12/22 at 13:50 documented that he returned from the Wound Center with new orders for treatments to his right foot. The nurse completed a skin assessment with new measurements. The nurse updated the Medication Administration Record (MAR). Resident #15 had a follow-up appointment for Tuesday, 7/19/22.

The Wound Center report dated 8/2/22, directed for Resident #15 to return for an appointment in one week and for him to wear heel lift boot on both feet anytime they rested against a surface,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 686	Continued From page 24	F 686		

have an air mattress, turn, and reposition every two hours. The wounds measured
a. Right calcaneus - open pressure injury
i. Measured - 1 cm X 0.5 cm X 0.1 cm
ii. Medium amount of necrotic adherent slough
iii. Debrided
iv. no reduction in area or volume
b. Right Medial Foot - Healed pressure injury
c. Right Great Toe - open pressure injury
i. Measured 0.4 cm X 0.4 cm X 0.1 cm
ii. Large amount of necrotic eschar, adherent slough
iii. A reduction of 35.70% in area and 35.00% in volume.
The Treatment Notes instructed to clean the right foot's calcaneus with normal saline, apply Bactroban, and cover with a 4 X 4 Mepilex border dressing. The Treatment Notes continued to direct to clean the right great toe with soap and water by removing the bandage before showering, apply Bactroban, apply a Mepilex foam 4 X 4 dressing, and secure with Medipore soft cloth surgical tape.

On 8/1/22 at 2:00 PM, Staff B, Licensed Practical Nurse (LPN), reported that Resident #15's appointment for the wound center got canceled twice due to the facility not being able to transport him there. Staff B added that the skin assessments are to be done weekly but are not assigned to any specific nurse. Staff B explained that they used the Wound Clinic measurements for the assessments. Staff B confirmed the Wound Center note from 7/12/22 instructed Resident #15 to return in one week but the appointment did not get documented in book, so he did not have another scheduled appointment until 8/2/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 686	Continued From page 25 Resident #15's Care Plan Focus revised on 11/7/21 indicated that he had the potential for pressure ulcer development related to his disease process and limited mobility. The Care Plan lacked interventions related to Resident #15's pressure injuries to his right foot, including the directives received from the Wound Center. On 8/2/22 at 1:35 PM, the Director of Nursing stated he expected that skin assessments with measurements got completed every week, ensure residents get to scheduled appointments, and to update care plan.	F 686		
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 §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, clinical record reviews, and staff interviews the facility failed to adequately supervise, thoroughly investigate falls that occurred, and implement interventions to prevent further falls for 1 of 1 residents (Resident #10) reviewed. Resident #10 sustained falls on 6/1, 6/10, 6/12, and 6/26/22 without a thorough investigation and/or intervention implemented to prevent further falls. On 6/12/22, Resident #10 found on the floor in Resident #10's room with a deep cut to the back of head that required transfer to the emergency room, and resulted in	F 689	F689 1. Resident #10 Care Plan was reviewed by the DON/Designee on 08/19/22 to ensure appropriate interventions were in place and implemented to decrease chance of injury. 2. Residents with a fall that has incurred in the last 30 days were reviewed to ensure appropriate interventions were in place and implemented to decrease chance of injury. 3. On 08/19/22 the DON/Designee educated licensed nurses related to the initiation of investigation and interventions post fall. 4. 4. DON//Designee will complete audits weekly for 12 weeks of residents with falls to ensure investigation and interventions are initiated post fall. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	08/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 689	Continued From page 26	F 689		

staples being placed. The facility reported a census of 26 residents.

Findings include:

The Minimum Data Set (MDS) assessment for Resident #10 dated 6/2/22, identified a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The MDS revealed Resident #10 required extensive physical assistance of one staff for bed mobility, transfers, ambulation, toilet use, and personal hygiene. The MDS coded Resident #10 ' s balance during transitions and walking, as not steady and only able to stabilize with staff assistance. The MDS coded Resident #10 as frequently incontinent of bowel and bladder. The MDS included diagnoses of hypertension, diabetes, non-Alzheimer's dementia, and repeated falls. The MDS identified Resident #10 fell since her admission/entry, reentry, or her prior assessment. The MDS coded Resident #10 had two or more falls with no injury, 2 or more falls with injury, and no falls with major injury.

The Care Plan with date initiated 1/29/22, identified Resident #10 had an actual fall with no injury related to poor balance and unsteady gait. The Care Plan interventions included:
a. Anti-roll back wheelchair to reduce the wheelchair rolling backwards when Resident #10 stands up and sits back down (2/25/22)
b. Assist x 1 with ambulation, after toileting, when Resident #10 became restless and attempting to get out of the wheelchair if restlessness continues (6/1/22)
c. Back of wheelchair seat to be lowered (4/2/22)
d. Continue interventions on the at-risk plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 689	Continued From page 27	F 689		

(1/29/22)
e. Ensure call light in reach, place on walker/wheelchair or near body (2/3/22)
f. Keep frequently used items on right side (3/12/22)
g. Keep walker and/or wheelchair in resident's reach for visual cue for safety (2/24/220
h. Anti-tip wheels on wheelchair if indicated (2/15/22)
i. Offer snacks and activities when up in wheelchair (4/3/22)
j. Pharmacy consult to evaluate medications (3/12/22)
k. Provide room in high traffic area (3/14/22)
l. Physical therapy consult for strength and mobility (3/12/22)
m. Ambulate resident three times a day (2/23/22)
n. Encouraged to propel self in wheelchair in hallway, instead of ambulating independently (2/23/22)
o. Resident to wear shoes when out of bed and non-skid socks in bed (1/30/22)
p. Avoid telling Resident #10 what you don't want her to do (2/18/22)
q. When not pushing wheelchair, ensure pedals are locked and to the side (4/29/22)
r. Encourage Resident #10 to use a controller to lower the footrest of the recliner (1/30/22)

The Care plan for Resident #128 with date initiated 1/29/22, identified Resident #10 mixed bladder incontinent related to dementia. The Care Plan interventions included:
a. Ensure unobstructed path to the bathroom (1/29/22)
b. Establish voiding patterns (1/29/22)
c. Check every 2 hours and as needed for incontinence (1/29/22)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 689	Continued From page 28	F 689		

On 7/25/22 at 10:22 AM, Resident #10 up in a wheelchair in the hallway, sitting outside of the door to the room. The resident was well-groomed with non-skid footwear on. The resident with hand up on forehead and leaning forward, eyes closed.

On 7/25/22 at 11:25 AM, Resident #10 at the dining room table in a wheelchair with nursing staff sitting with Resident #10.

On 7/26/22 at 8:52 AM, the nursing staff assisted Resident #10 in the dining room with breakfast. The resident had well-groomed and non-skid footwear on.

On 7/26/22 at 3:16 PM, Resident #10 in the hallway in a wheelchair. The resident had well-groomed and non-skid footwear on. The resident attempted to propel the wheelchair back and forth.

The Progress notes for Resident #10 revealed:
a. On 6/1/22 at 1:45 PM, The Alert Note (AN) identified Resident #10 observed on the floor on the left side in front of the wheelchair by the nurse's station. No sign/symptoms of injuries, bruising, laceration, or redness. The resident denied pain or discomfort. Range of motion (ROM) within normal limits. Assist of 2 for short walk, gait steady. Vitals sign stable and neurological assessment initiated. Family and physician notified.
b. On 6/1/22 at 3:46 PM, AN identified an intervention of assist x 1 with ambulation, after toileting, when Resident #10 became restless and attempted to get out of wheelchair if restlessness continued
c. On 6/10/22 at 4:08 PM, a health status note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 689	Continued From page 29	F 689		

(HSN) stated Resident #10 was on the floor, lying on the right side with a wheelchair behind. The resident was unable to explain what occurred. The resident denied pain and was able to demonstrate ROM to all extremities. No bruising or abrasions noted. The resident assisted by standing and in a wheelchair. The resident assisted at the nurse's station and provided. Family and physician notified.

d. On 6/12/22 at 11:41 AM, HSN revealed Resident #10 was found on the floor in a room with blood at the back of head, deep cut and bump notes. The resident was transferred to a wheelchair and sent to the emergency room after family and physician notification.

e. On 6/12/22 at 2:49 PM, HSN stated the facility received call from the emergency room (ER) and Resident #10 to return to the facility, and Resident #10 CT scan negative

f. On 6/12/22 at 4:32 PM, HSN stated Resident #10 returned to the facility with family, 3 staples placed to the left parietal scalp and to be removed on 6/19/22.

g. On 6/19/22 at 4:41 PM, HSN identified 3 staples removed from the back of Resident #10's head, area clean, dry, and intact. The resident denied pain or discomfort.

h. On 6/26/22 at 8:31 AM, HSN identified Resident #10 found on the floor of the room, on the left side with legs extended. The resident incontinent and briefly saturated, with yellow stain on bedding. The resident self-transferred from the bed. Neurological assessment initiated and Resident #10 denied pain or discomfort.

The Fall Investigation dated 6/1/22 at 1:45 PM, identified Resident #10 found lying on the left side in front of the wheelchair by the nurses station.

a. Immediate action: Intervention: assist of one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 689	Continued From page 30	F 689		

with ambulation after using the toilet when Resident #10 became restless and attempted to get out of her wheelchair.
b. Predisposing environmental factors: furniture
c. Predisposing physiological factors: gait imbalance and impaired memory
d. Predisposing situation: wanderer and ambulated without assist

The Fall Investigation dated 6/10/22 at 4:03 PM, identified Resident #10 found in the hallway lying on the floor with a wheelchair behind Resident #10.
a. Immediate action: Resident #10 assessed and vital signs obtained. ROM assessed Resident #10 assisted to wheelchair
b. Mental status: oriented to person
c. Predisposing physiological factors: gait imbalance and impaired memory

The Fall Investigation dated 6/12/22 at 11:27 AM, identified Resident #10 found on the floor in the room with blood at the back of head, deep cut and bump noted.
a. Immediate action: Resident #10 sent to the hospital
b. No injuries observed at time of the incident
c. Predisposing environmental factors: other
d. Predisposing physiological factors: confused, gait imbalance and impaired memory
e. Predisposing situation factors: used wheeled walker

The Fall Investigation dated 6/26/22 at 8:25 AM, identified Resident #10 found on the floor in the room on the left side with legs extended. The resident incontinent with saturated briefs and yellow stains on bedding. The resident self-transferred.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 689	Continued From page 31 a. Immediate action: neurological assessment b. No injuries observed at time of the incident c. Mental Status: oriented to person and place d. Predisposing environmental factors: other, detail in note e. Predisposing physiological factors: confused, incontinent, gait imbalance and impaired memory f. Predisposing situation factors: ambulated without assist and improper footwear g. Other information: intervention gripper socks and check and change every two hours The Emergency Room Provider Report dated 6/12/22 at 11:37 AM, identified Resident #10 ' s chief complaint as a fall with a head injury. Resident #10 presented to the ER by ambulance for a head injury associated with a fall. Resident #10 appeared at her baseline of confusion. The facility staff assumed Resident #10 fell out of bed onto the hard floor, approximately one to two feet. Resident #10 hit her head when she fell, resulting in an injury to the left occipital part of her head. Resident #10 had a history of recurrent falls. The section labeled Additional Documentation indicated that Resident #10 received three staples, antibiotic ointment, and a bulky dressing. The Radiology Impression identified a closed head injury with concussion, left parietal scalp hematoma, and laceration of the occipital scalp. On 8/1/22 at 9:23 AM, the Director of Nursing (DON) said the facility staff asked about Resident #10 falls when he started at the facility at the end of June 2022. The DON stated he inquired about a scooped mattress. The DON explained that Resident #10 did not have any further falls from her bed since placing the scoop mattress. The DON denied knowing the date of the placement of the scooped mattress on Resident #10's bed.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 689	Continued From page 32 The DON reported that he knew Resident #10 had a lot of falls from her bed. The DON explained that he did not have the chance to look into Resident #10's falls. The DON said he expected the falls to be looked into, to determine if the previous interventions implemented were sufficient. The DON added that within 24 to 48 hours he expected an intervention to be put in place following a fall and additional interventions to follow as needed. The DON acknowledged that falls needed to be looked at facility wide.	F 689	F 698 1. Resident #128 Pre/post Dialysis assessments were completed by the DON/Designee on or before 09/04/22 2. An audit was completed by DON/Designee on or before 09/04/22 of current resident that receive Dialysis regarding their pre/post Dialysis communication are being completed as schedule. 3. On or before 09/04/22 the DON/Designee reeducated License Nurses on completion of pre/post Dialysis assessments 4. DON//Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure that residents that receive Dialysis are having their pre/post assessments completed. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, resident, and staff interviews the facility failed to provide ongoing communication and collaboration with the outpatient dialysis facility. In addition the facility failed to complete full nursing assessments and monitoring of a resident before and after going to the outpatient dialysis center for treatment for 1 of 1 residents reviewed on dialysis (Resident #128). The facility reported a census of 26 residents. Findings include: Resident #128's Minimum Data Set (MDS) assessment dated 7/7/22 identified an admission date of 6/24/22. The MDS identified a Brief	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 698	Continued From page 33	F 698		

Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS coded that Resident #128 required extensive physical assistance of one to two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS included diagnoses of renal insufficiency, hypertension, diabetes, and arteriovenous fistula. The MDS identified that Resident #128 received dialysis during the lookback period.

The facility failed to complete a Comprehensive Care Plan for Resident #128, that included a focus area, goals, and/or interventions related to dialysis and/or nutrition.

During the initial tour of the facility on 7/25/22 at 1:55 PM, Resident #128 sat in a recliner with her feet elevated wearing a hospital gown. Resident #128 explained that the Certified Nurse's Aide (CNA) had assisted her to the recliner upon her return from dialysis. Resident #128 reported that she went to dialysis three times a week. Resident explained that she got worn out and wanted to rest.

Review of the Progress notes for Resident #128 revealed:
1. On 6/24/22 at 7:30 PM, admission nursing note - the resident arrived at the facility via family care from the hospital.
2. On 6/24/22 at 12:00 AM, the Health Status Note (HSN) - the resident arrived at the facility from the hospital with family. The resident is alert and oriented and able to make needs be known. The resident had triple lumen to the upper right arm, bruise noted across the abdominal area and fistula to the right upper arm.
3. On 6/28/22 at 10:10 AM, HSN - the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 698	Continued From page 34	F 698		

alert and oriented to person, place and time; able to make needs known. The left arm fistula with bruit and thrill present and port noted without signs and symptoms of infection.
4. On 6/28/22 at 10:49 AM, HSN - the resident taken to dialysis
5. On 6/30/22 at 10:09 AM, HSN - the resident out for dialysis with facility transportation
6. On 6/30/22 at 4:45 PM, HSN - the resident returned to the facility without incident. Dialysis days changed to Monday, Wednesday, and Friday at 9:30 AM. Transportation and family are notified.
7. On 7/1/22 at 2:14 PM, HSN - the resident returned from dialysis
8. On 7/4/22 at 9:09 AM, HSN - the resident out of the facility for dialysis via facility transportation and paperwork sent.
9. On 7/6/22 at 4:22 PM, HSN - the resident returned from dialysis, blood sugar 165, and denied pain or discomfort

Review of the Dialysis Communication sheets for Resident #128 revealed:
1. 6/25/22
   a. Entire assessment completed
2. 7/4/22
   a. Section A (Facility to complete before dialysis) and Section B (Clinical Communication to Dialysis Center) completed.
   b. Section C (Dialysis Center to Complete) and Section D (Post Dialysis Assessment) remained blank.
3. 7/6/22
   a. Section A and Section B completed.
   b. Section C and Section D left blank.
4. 7/8/22
   a. Section A completed with a weight from 7/6/22 and vital signs from 7/7/22 at 4:36 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 698	Continued From page 35 b. Section B completed. c. Section C and Section D left blank. 5. 7/18/22 a. Section A completed with a weight from 7/6/22 b. Section B completed c. Section C and Section D left blank 6. 7/20/22 a. Section A and Section B completed. b. Section C and Section D left blank. Resident #128's chart lacked additional Dialysis Communication assessments. The facility document titled Dialysis Communication included: 1. Facility to complete prior to dialysis: a. Date b. Most recent weight c. Most recent blood pressure d. Most recent temperature e. Most recent pulse f. Most recent respirations g. Most recent blood glucose h. Dietary concerns i. Medications resident taking and last administered j. Medications to be administered at dialysis 2. Clinical Communication to the Dialysis Center a. Clinical change in condition since last dialysis b. Clinical assessment of the resident prior to transfer to dialysis c. Signature of the nurse completing 3. Dialysis center to complete a. Arrival time b. Post dialysis weight c. Blood pressure d. Pulse	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 698	Continued From page 36	F 698		

e. Temperature
f. Respirations
g. Glucose/blood sugar
h. Access/shunt
i. Bleeding
J. Bruit present
k. Site dressing change
l. Lab information sent
m. Were medications administered
n. Complications during treatment
o. Instructions for the nursing home staff
p. Condition of the resident post treatment
q. Signature of the dialysis nurse and date

4. Post Dialysis assessment
a. Return date and time
b. Post dialysis weight
c. Blood pressure
d. Pulse
e. Temperature
f. Respirations
g. Pain
h. Access site appearance
i. Bruit present
j. Bleeding
k. Complete post dialysis assessment and document
l. Nurse signature with date

Resident #128's June 2022 Treatment Administration Record (TAR) and Medication Administration Record (MAR) lacked an area to document dialysis assessments, including an assessment of the dialysis access site. The MAR/TAR included an area to document vital signs every shift for Skilled Nursing Facility (SNF) assessment. The Vital Sign section documented the same vitals signs for the following dates:
a. 6/26/22 (AM shift, 5 AM - 5 PM, and PM shift, 5 PM - 5 AM), 6/27/22 (AM and PM shifts), and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 698	Continued From page 37	F 698		

6/28/22 (AM Shift) - Blood pressure (b/p): 163/84, Temperature (temp): 97.7, Pulse (P): 71, Respirations (R): 18, and Oxygen Saturations (O2 Sats): 99%.
b. 6/29/22 and 6/30/22 (AM and PM Shifts): b/p: 124/78, Temp: 98, P: 90, R: 18, O2 Sats: 96%.

Resident #128's July 2022 TAR and MAR included the following:
1. Dialysis communication under assessments to be filled out and sent with the resident to dialysis every Monday, Wednesday, and Friday, order date on 6/30/22.
a. 7/18/22, lacked documentation to show completion
b. 7/22/22, documented a 9 indicating other / see Nurse Notes.
2. Dialysis Monday, Wednesday, Friday at 9:30 AM, order date 6/30/22.
a. 7/18/22 blank, lacked documentation to show completion.
3. The Order of vital signs every shift for SNF assessments dated 6/24/22
a. 7/11/22 and 7/17 (PM Shift) lacked documentation to show completion.
b. 7/19/22, (AM and PM shifts) lacked documentation to show completion

Resident #128's Weight Summary
1. 6/24/22 - 227 pounds (#)
2. 6/25/22 - 227 #
3. 7/6//22 - 224 #

On 7/27/22 at 9:20 AM, the Director of Nursing (DON) explained that the Dialysis Communications and Assessments are located in the resident's electronic health record (EHR) under the assessment tab, labeled as Dialysis Communication. During a joint review with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 698	Continued From page 38	F 698		

DON discovered that the Dialysis Communication assessments in Resident #128's EHR included the following assessments: 6/25/22, and partial for 7/4/22, 7/6/22, 7/8/22, 7/18/22, and 7/20/22. After the DON reported that the nurses could have documented in Resident #128's nurses notes, a joint review occurred. The DON said that he expected the Dialysis Communication form and assessment to be completed when Resident #128 went to dialysis and when she returned from dialysis.

On 7/28/22 at 7:18 AM, an email from Staff A, the Nurse Consultant, confirmed that Resident #128's Comprehensive Care Plan got opened on 7/27/22 and the facility provided Resident #128 a copy. Staff A confirmed Resident #128's Dialysis Communication assessments did not get consistently completed, and only got completed in its entirety on 6/25/22. Staff A confirmed that only the pre-assessment portion got completed on 7/4/22, 7/6/22, 7/8/22, 7/18/22, and 7/20/22.

On 7/28/22 at 8:22 AM, the DON stated he expected all Dialysis information to be on Resident #128's Care Plan, including diet, pre-assessment, post assessment, vital signs, check the access site, and weight. The DON stated he communicated with the dialysis center about getting the information back required by the facility with the completion of the post assessment. The DON stated he expected the assessments in the EHR to be completed in its entirety. The DON reported that he expected Resident #128's Care Plan to include diagnosis and transportation, to be individualized to the resident.

On 7/28/22 at 1:40 PM, in a follow up interview,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 698	Continued From page 39 the DON reported that the facility did not have a policy related to dialysis.	F 698	F 758 1. Resident #4 PRN Lorazepam has been discontinued by the DON/Designee on or before 09/04/22 2. Current residents PRN psychotropic medications orders were reviewed to ensure that all orders are limited to only 14 days or less. 3. On or before 09/04/22 the DON/Designee has reeducated the License Nurse regarding the 14 day limit to PRN psychotropic medication. 4. DON//Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure that new PRN psychotropic medication have a 14 day less time limit. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 758	Continued From page 40	F 758		

are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, facility policy review, interview with the Consulting Pharmacist, and staff interviews the facility failed to ensure that psychotropic medications ordered as needed got limited to 14 days for 1 of 4 residents reviewed (Residents #4) that took psychotropic medications. The facility reported a census of 26 residents.

Findings Include:

Resident #4's Minimum Data Set (MDS) assessment dated 7/11/22 identified a BIMS of score of 4, indicating severe cognitive impairment. The MDS identified no behaviors in the last 7 days. The MDS listed diagnoses of non-Alzheimer's dementia, anxiety, depression, and a psychotic disorder. The MDS coded that Resident $4 received antipsychotic medication and antidepressant medications for seven out of seven days in the lookback period.

The Care Plan Focus date initiated 10/8/19, identified Resident #4 utilized an antidepressant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 758	Continued From page 41	F 758		

medication related to depression. The Care Plan Interventions initiated on 10/8/19 included:
a. Educate the resident, family, and caregivers about the risks, benefits, side effects, and/or toxic symptoms of antidepressant medications given.
b. Give the antidepressant medications as ordered by the physician. Monitor and document any side effects and the medications effectiveness such as: dry mouth, dry eyes, constipation, urinary retention, and suicidal ideation.
c. Monitor, document, and report to the physician as needed about ongoing signs and symptoms of depression unaltered by the antidepressant medication such as: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideation, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, and lethargy

The Care Plan initiated on 12/21/20 identified Resident #4 used psychotropic medications related to behavior management. The Care Plan Interventions initiated on 12/21/20 included:
a. Administer medication as ordered and monitor/document for side effects and effectiveness
b. Consult pharmacy and the physician to consider dosage reduction when clinically appropriate
c. Discuss with the physician and family regarding the ongoing need for the use of the medication
d. Educate the resident/family/caregiver about the risk, benefits, and the side effects and/or toxic symptoms
e. Monitor/record occurrence for target behaviors
f. Monitor/record/report to the physician as needed side effects and adverse reaction of the psychoactive medications: unsteady gait,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 758	Continued From page 42	F 758		

shuffling gait, rigid muscles, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, loss of appetite, weight loss, and muscle cramps

Resident #4's July 2022 Medication Administration Record (MAR) identified an order dated 12/21/21 for lorazepam 0.5 milligram (mg) 1 tablet every 4 hours as needed for striking out, yelling, pacing, and exit seeking as related to anxiety.

Review of the MAR's for Resident #4 revealed the resident received the lorazepam as needed medication:
a. December 2021, 7 times
b. January 2022, 14 times
c. February 2022, 3 times
d. March 2022, 2 times
e. April 2022, 2 times
f. May 2022, 4 times
g. June 2022, 4 times
h. July 2022, 4 times

The clinical record review revealed the as needed lorazepam got ordered on his re-admission to the facility on 12/21/21 without a stop date.

The Consultation Report from the pharmacist identified Resident #4 had an order for lorazepam 0.5 mg to be given every 4 hours as needed. The section labeled Recommendation directed that if the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for the use, the intended duration of the therapy, and the rationale for the extended time period. The Rationale for Recommendation: CMS (Center for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 758	Continued From page 43	F 758		

Medicare and Medicaid Services) required that as needed orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documented the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the as needed order. The pharmacist sent the document to the physician on 2/17/22, 3/22/22, and 5/17/22. The facility received no physician response to the request for 2/17/22 and 3/22/22. On 5/24/22, the physician declined the recommendation, identifying that Resident #4 had multiple behaviors and hospitalized geriatric psych. The section for duration of therapy remained blank without documentation.

The Quality Improvement: Consultant Pharmacist Summary dated 7/1-7/31/22, identified a pattern observed related to appropriate documentation for as needed psychotropic medications used greater than 14 days. The Pharmacist documented that he discussed the concern with the leadership team. The facility reported that they repeatedly addressed this but still don't get a stop date. The Pharmacist recommended to follow-up with the physician. The Pharmacist discussed with the Director of Nursing (DON), who indicated that he would add a template in electronic health record to prevent those medications from going beyond a certain time frame.

The facility Policy titled Psychotropic Medication Use revised 1/1/22, directed the following
a. As needed psychotropic medications should not be ordered for more than 14 days. Each resident who takes an as needed psychotropic medication would have their prescription reviewed by the physician or the prescribing practitioner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 758	Continued From page 44 every 14 days and by the pharmacist every month. b. For psychotropic medications, excluding antipsychotics, that the attending physician believed that an as needed medication ordered is appropriate for more than 14 days, the physician could extend the prescription beyond the 14 days for the resident by documenting the rationale in the resident's medical record. On 7/27/22 at 9:20 AM, the DON explained that he met with the Consulting Pharmacist the week before related to the follow-up on the pharmacy reviews. The DON explained that upon starting at the facility, he had a large pile of pharmacy papers that he didn't know if the recommendations got sent to the appropriate physicians. The DON said the Consulting Pharmacist had informed him the facility did not have a consistent DON and he didn't know if documentation got sent to the physicians and they never received it back or if it didn't get sent. The DON explained that some of the facility nursing staff would send the pharmacy recommendations to the physicians, however, it didn't get done consistently. The DON stated he knew that the facility had a lot of as needed psychotropic medication orders and had reviewed them with the Consulting Pharmacist. The DON added that he had informed the facility nursing staff that all as needed psychotropic orders required a two week stop-date and they could call for an extension as needed. The DON confirmed that Resident #4 had an as needed lorazepam order with a start date of 12/21/21 and that it did not have a stop date. The DON reported that he expected as needed psychotropic medications to have a two week stop-date when ordered.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 758	Continued From page 45 On 7/28/22 at 12:24 PM, the Consulting Pharmacist explained that they did the monthly pharmacy reviews on the residents at the facility. The Consulting Pharmacist acknowledged that when they knew about the as needed psychotropic orders, they requested clarification. The Consulting Pharmacist explained that recently it got difficult getting the recommendations addressed, but they met with the DON last week and reviewed the concerns. The Consulting Pharmacist said they would send the recommendations by email to the facility for the facility staff to follow-up with the physician to review. The Consulting Pharmacist added that they expected those recommendations to be back by next the monthly visit. The Consulting Pharmacist stated as needed psychotropic medications should only be ordered for 14 days, however, the physician is not good about giving stop dates. The Consulting Pharmacist stated they would ask for the as needed psychotropic medications to be discontinued. If the physician declined, they would request a stop-date and request the physician to provide rationale.	F 758		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role;	F 868	F 868 1. QA meeting has been scheduled on or before 09/04/22 by the Administrator. 2. QA meetings will be scheduled by the Administrator for the third Thursday of the month. 3. The Administrator will re-educate the QA team on the scheduled day and review their responsibility. 4. Administrator/Designee will audit QA minutes monthly for 3 months to ensure meetings are being held and recommendations are being followed. Results of these audits will be presented to the Quality Assurance and Performance Improvement meeting monthly for 3 months for review and recommendations as needed. The Administrator is responsible for monitoring and follow up as needed.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 868	Continued From page 46 §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility record review the facility failed to have Quality Assessment and Assurance (QAA) committee meetings quarterly and attended by the required members. The facility reported a census of 26 residents. Findings include: The facility provided Quarterly Assurance Process Improvement (QAPI) Committee Meeting Agenda/Minutes dated 11/5/21, 1/8/22, and 4/15/22 documented only the Administrator and Medical Director attended the meetings. During an interview on 7/28/22 at 10:05 AM, the Maintenance Director stated he is a QAA member and attended a QAA meeting a couple of weeks ago. Before that he would say at least 6 months, but it could have been longer, since the facility had a QAA meeting. The Maintenance Director also stated he signs in at every meeting so if he didn't sign, the facility did not have meeting. During an interview on 8/2/22 at 1:30 PM, the Director of Nursing stated he expected QAA meetings to be held every quarter and attended by the required members.	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 47 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of 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:	F 880	F880 1. Resident #24 has been assessed for signs and symptoms of UTI by the DON/Designee on or before 09/04/22 and physician notified if warranted. Residents #10, #24, and #128 were assessed for signs and symptoms of Covid by the DON/Designee on or before 09/04/22 and physician notified if warranted. Staff were screened for Covid Infection upon arrival for their scheduled shift on or before 09/04/22 by the DON/Designee with Covid infection intervention initiated if warranted. 2. An audit was completed by DON/Designee on or before 09/04/22 of current resident with foley catheters to ensure tubing was not lying on the floor. Current residents will be assessed for Covid infection on or before 09/04/22 by the DON/Designee and physician notified if warranted. Telligen will be contacted on or before 09/04/22 by the DON/Designee to schedule a meeting to review the facilities root cause analysis of infection control practice. 3. On or before 09/04/22 the DON/Designee reeducated facility staff on keeping Foley Catheter tubing off the floor, Residents are required to have a Covid assessment completed at least daily if not in outbreak status, and staff to be screened for Covid Infection upon arrival for their scheduled shift. Facility staff will complete state directed videos: PPE lessons, Sparkling Surfaces, Clean Hand, Keep COVID OUT on or before 09/04/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 48 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, and staff interviews the facility failed to adequately utilize proper infection control practices related to the care of catheters for one of one resident reviewed (Resident #24). In addition the facility failed to establish and/or implement a surveillance plan for the novel Coronavirus 2019 (COVID) that included the surveillance of fevers, respiratory illnesses, or other signs or symptoms of COVID at least daily for 3 of 3 residents reviewed (Residents #10, #24,	F 880	cont. 4. DON/Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure foley catheter tubing is not lying on floor, Residents are being assessed at least daily for Covid if not in outbreak status and staff are screened for Covid infection upon arrival for their scheduled shift. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

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F 880	Continued From page 49	F 880		

and #128). Furthermore, the facility failed to screen a staff member upon arrival for their scheduled shift for COVID signs and symptoms. The facility reported a census of 26 residents.

Findings Include:

Resident #24's Minimum Data Set (MDS) dated 7/6/22 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS indicated that Resident #24 required extensive physical assistance of one to two persons for bed mobility, transfers, toilet use, and personal hygiene. The MDS documented that Resident #24 had an indwelling catheter. The MDS included diagnoses of hypertension, anxiety, and depression.

Resident #24's Care Plan revised 9/1/21, indicated that she had a catheter related to urinary retention. The interventions dated 9/1/21 included:
Complete catheter care every shift
Monitor for any discomfort or pain related to the catheter
Peri-care after toilet use

On 7/25/22 at 11:16 AM, observed Resident #24 in her recliner in her room with her feet elevated. Noted the urinary catheter drainage bag on the side of the recliner, lying on the floor. The urinary catheter drainage bag contained dark yellow urine.

On 7/26/22 at 10:04 AM, witnessed Resident #24 in her recliner, covered with a blanket up to her nose. Resident #24 reported that she preferred to keep covered up. Resident #24 explained that she felt so, so that day, and denied any specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

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F 880	Continued From page 50	F 880		

complaints. Observed Resident #24's catheter drainage bag on the side of her recliner, lying on the floor, half full of dark yellow urine.

On 7/28/22 at 9:27 AM, observed Resident #24 in her recliner with her feet elevated and covered with a blanket. The catheter drainage bag appeared full of dark yellow urine laid on the floor next to her recliner.

On 7/28/22 at 9:31 AM, with the Director of Nursing (DON) observed Resident #24's catheter drainage bag lying on the floor beside her recliner. The DON explained that he expected that the catheter drainage bag should not be on the floor and he would get that fixed. The DON placed the catheter drainage bag in the pocket on the side of Resident #24's recliner.

Resident #24's electronic health record (EHR) contained an assessment labeled COVID-19 Observation - V2. The review completed on 7/28/22 at 1:20 PM of Resident #24's COVID-19 Observation - V2 assessments dated 5/1/22 - 7/27/22, revealed the form had been completed 13 times in May, no assessments completed in June, and the EHR lacked assessments in July until 7/26/22.

The review of Resident #24's EHR for the months of June 2022 and July 2022 determined that the facility failed to assess her at least daily for COVID signs and symptoms.

2. Resident #10's MDS assessment dated 5/4/22 identified a BIMS score of 00, indicating severe cognitive impairment. The MDS included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 51	F 880		

diagnoses of non-Alzheimer's dementia, diabetes, and hypertension.

Resident #10's EHR contained an assessment labeled COVID-19 Observation - V2. The review completed on 7/28/22 at 1:16 PM of the COVID-19 Observation - V2 dated 5/1/22 - 7/27/22 for Resident #10, revealed the form had been completed 16 times in May, no assessments completed in June, and the EHR lacked assessments in July until 7/26/22.

The review of Resident #10's EHR for the months of June 2022 and July 2022 determined that the facility failed to assess her at least daily for COVID signs and symptoms.

3. Resident #128's Minimum Data Set (MDS) assessment dated 7/7/22 identified an admission date of 6/24/22. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS coded that Resident #128 required extensive physical assistance of one to two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS included diagnoses of renal insufficiency, hypertension, diabetes, and arteriovenous fistula.

Resident #128's EHR contained an assessment labeled COVID-19 Observation - V2. The review completed on 7/28/22 at 1:14 PM of the COVID-19 Observation - V2 determined the first assessment got completed on 7/26/22.

The review of Resident #128's EHR for the months of June 2022 and July 2022 determined that the facility failed to assess her at least daily for COVID signs and symptoms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 880	Continued From page 52	F 880		

On 7/28/22 at 8:28 AM, the DON explained that COVID assessments for residents included checking the resident's temperature daily while checking for COVID signs and symptoms in the assessment located in the resident's EHR under the assessment tab. The DON said that the COVID assessment should be completed daily. The DON added that the previous Interim DON informed the current MDS nurse that the COVID assessments had stopped and the vitals entered daily. However, the DON stated he did not know why the COVID assessments stopped. During a joint review with the DON of the COVID-19 Observation - V2 assessments in Resident #10, Resident #24, and Resident #128's EHR, the DON confirmed the COVID assessment did not get completed for the month of June and the month of July did not get done until 7/26/22. The review continued with Resident #10, Resident #24, and Resident #128's vital signs where the DON verified the daily temperature. The DON, however, reported that he didn't know where the COVID screening for symptoms got documented.

On 8/1/22 at 2:28 PM, Staff B, Licensed Practical Nurse (LPN), said the COVID assessments needed to be completed daily. The assessments included screening for symptoms, for all of the residents. Staff B reported that the COVID assessments should be completed in the resident's EHR, under the assessment tab. Staff B explained that the day shift obtained the resident's temperature, pulse, respirations, oxygen saturations and documented them. The night shift completed the symptom part of the assessment. Staff B explained that the night shift contained agency staff, and had been that way for over a year.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 880	Continued From page 53	F 880		

On 8/1/22 at 4:01 PM, the DON stated he did not believe the facility had a COVID policy, only the policy titled Pandemic COVID-19 Plan.

On 8/2/22 at 9:14 AM, Staff F, Nurse Consultant, reported they couldn't locate the COVID policy and procedures related to resident surveillance. Staff F stated the facility followed the CDC guidelines and the QSO (Quality Safety & Oversight) memos related to COVID surveillance.

On 8/2/22 at 10:07 AM, Staff F stated they spoke with the Corporate Infection Preventionist and the facility did not have a policy related to COVID surveillance, as they utilized the QSO memo.

4. The facility's Daily Schedule dated 7/28/22, listed Staff D, Agency Certified Medication Aide (CMA), scheduled to work from 6:00 AM - 12:00 PM.

The facility Staff Screen Log dated 7/28/22, lacked documentation showing that Staff D got screened before the start of her scheduled shift.

On 7/28/22 at 9:40 AM, the Director of Nursing (DON) stated Staff D would have been screened upon arrival to work and asked about her vaccine status. The DON said he expected Staff D to be tested upon her arrival to work if she did not have the COVID vaccine.

On 7/28/22 at 11:58 AM, during a joint review of the facility staff screening logs for 7/28/22 with the DON. He confirmed that the agency CMA, Staff D, who was working in the facility at the time of review, did not get identified on the staff screening log. The DON said he would follow up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 880	Continued From page 54 with Staff D. On 7/28/22 at 12:10 PM, the DON stated that Staff D claimed that she got screened in and a facility CNA confirmed it. The DON stated Staff D and the facility CNA explained the screening area had no pen available at the time, so they did not document that she got screened in. The DON reported that Staff D became upset about being questioned and talked about criminal charges. The DON informed Staff D to count the narcotics with the nurse on duty and leave the facility. On 8/1/22 at 11:11 AM, the DON said that he expected all staff and visitors to get screened before coming into the facility. The DON stated that the staff screen in before and after every shift with a fellow staff member to verify. On 8/3/22 at 1:53 PM, the DON confirmed in an email that Staff D did not get tested upon her arrival to her scheduled shift on 7/28/22. The DON reported that they required Staff D to leave the facility after they confirmed she did not get screened at the beginning of her shift, as she lied to the surveyor, and did not have proper PPE (personal protective equipment). The DON reported that he informed the Agency that Staff D could not return to the facility.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must:	F 882	F 882 1. DON/Designee, on or before 09/04/22, will ensure that a nurse will become the designated Infection Control Nurse that completed the specialized training related to infection prevention and control. 2. The DON/Designee will assign a License Nurse on or before 09/004/22 to complete with in the next 30 days of the specialized training related to infection prevention and control as a back-up to ensure that infection process continues. 3. On or before 09/04/22 the Regional Director of Clinical Services will reeducate the DON on the requirements of having an Infection Preventionist on staff. 4. DON/Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure that facility has a Certified Infection Preventionist. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 882	Continued From page 55	F 882		

§483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;

§483.80(b)(2) Be qualified by education, training, experience or certification;

§483.80(b)(3) Work at least part-time at the facility; and

§483.80(b)(4) Have completed specialized training in infection prevention and control.

§483.80 (c) IP participation on quality assessment and assurance committee.
The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and the Centers for Medicare and Medicare Services (CMS) the facility failed to provide the residents with a certified Infection Control Nurse that completed the specialized training related to infection prevention and control. The facility reported a census of 26 residents.

Findings Include:

During the Entrance Conference on 7/25/22 at 10:15 AM, the Director of Nursing (DON) reported that he was working on the Infection Prevention Certification. The DON stated the facility's Corporation had a certified Infection Preventionist that assisted the facility with Infection Control.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 882	Continued From page 56 On 8/1/22 at 11:11 AM, during a follow-up interview, the DON explained that he did not have a certificate related to infection control and prevention. The DON said he went to the Centers for Disease Control and Prevention (CDC) website, but he did not enrolled in the class at that time. The Center of Clinical Standards and Quality/Survey and Certification Group Ref: QSO-20-38-NH dated 8/26/20 indicated that the Infection Preventionist should complete the specialized training in infection prevention and control.	F 882	F 885 1. Residents and families/Responsible Party were notified/re-notified on or before 09/04/22 by the DON/Designee of staff that had tested Positive on: 1. On 6/22/22 an agency Registered Nurse (RN) 2. On 7/19/22 a Certified Medication Aide (CMA) 3. On 7/22/22 a Certified Nurse's Aide (CNA) 4. On 7/24/22 an Licensed Practical Nurse (LPN). 2. An audit was completed by DON/Designee on or before 09/04/22 to ensure that notification of Staff with Covid is entered into resident's progress notes.	
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a	F 885	3. On or before 09/04/22 the Regional Director of Clinical Services educated the DON and Social Service Designee of requirements of notifying resident and resident family/responsible party of staff or resident have tested positive for Covid and notification is charted in resident's progress notes. 4. DON/Designee will complete audits weekly for 4 weeks then monthly for 2 months to ensure that notification to resident's and family/responsible party of Covid positive staff or resident is completed timely and documentation of notification is in resident progress notes. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 885	Continued From page 57	F 885		

confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, staff interviews, and the Centers for Disease Control and Prevention (CDC) recommendations the facility failed to notify all residents and families of new confirmed positive cases of COVID-19 (novel Coronavirus 2019). Since 6/22/22, the facility reported 4 staff members that had confirmed positive cases of COVID-19. The facility reported a census of 26 residents.

Findings Include:

On 7/25/22 at 10:15 AM, during the Entrance Conference the Director of Nursing (DON) reported the facility provided notification to families related to COVID-19 by phone calls, but had several families on vacation, so they did not want phone calls. The DON stated the facility also sent letters to the families related to positive COVID-19 staff and/or residents. The DON stated no residents tested positive for COVID-19. The facility did have two staff that tested positive, but he didn't know for sure the dates.

Review of the untitled facility log of the dates the facility staff tested positive for COVID-19 indicated the following staff members tested positive.
1. On 6/22/22 an agency Registered Nurse (RN)
2. On 7/19/22 a Certified Medication Aide (CMA)
3. On 7/22/22 a Certified Nurse's Aide (CNA)
4. On 7/24/22 an Licensed Practical Nurse (LPN)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 885	Continued From page 58	F 885		

On 7/28/22 at 3:30 PM, the Director of Nursing (DON) reported that the residents' families got notified of the positive COVID-19 cases. The resident's clinical record would contain the documentation in their progress notes. During a review with the DON of Resident #128's progress notes, the DON confirmed the record lacked documentation of notification to Resident #128's family member when the facility staff tested positive for COVID-19 on 6/22 and 7/19. The DON added that when the Agency nurse tested positive on 6/22/22, the facility did not get notified until 6/27/22 when the facility called the agency for that nurse to work. The DON stated the facility did not know the Agency nurse tested positive on 6/22/22 until 6/27/22.

On 8/1/22 at 9:35 AM, the DON said the facility sent letters to the residents, the residents' families, and placed phone calls when residents and/or facility staff tested positive for COVID-19. The DON confirmed he couldn't find the documentation related to the notification in the residents' clinical records. The DON reported that he found old documentation when residents and/or staff tested positive for COVID-19 but nothing recent. The DON stated he couldn't find the documentation of the current staff positive with COVID-19 that families had been notified. The DON stated he reviewed progress notes and did not find any documentation. The DON denied knowing if the Marketing Director sent weekly letters related the COVID-19 status in the facility. The DON said that he expected the notification to families and residents regarding positive confirmed COVID-19 cases of either resident or staff to be in the progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

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F 885	Continued From page 59 The facility provided 13 emails sent to the families on 6/29/22 and 15 emails sent to the families on 7/20/22. The facility couldn't provide documentation in the resident's clinical record for the remaining notifications to residents and families of the staff's confirmed cases of COVID-19. The Center for Clinical Standards and Quality/Quality, Safety, & Oversight Group Ref: QSO-20-29 NH dated 5/6/20, under Infection Control section COVID-19 reporting: the facility must inform residents, their representatives, and families of those residing in facilities by 5:00 PM the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more resident or staff with a new onset of respiratory symptoms occurring within 72 hours of each other.	F 885		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886	F 886 1. DON/Designee will test staff C – Certified Nurse Aide and Staff D – Certified Medication Aide for COVID on or before 9/4/22. 2. DON/Designee on or before 09/04/22 will ensure that staff Covid testing is up to date. 3. On or before 09/04/22 the Director of Clinical Services will reeducate the DON regarding Staff Vaccination Matrix and completing covid testing per CMS guideline. 4. DON//Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure Staff Vaccination Matrix and Staff Covid testing are current. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 60	F 886		

(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 61	F 886		

emergencies due to testing supply shortages, contact state
and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on facility personnel records, facility policy review, the Centers of Disease Control and Prevention (CDC) recommendations, Centers of Medicare & Medicaid Services (CMS) guidelines, and staff interviews the facility failed to complete facility staff testing for the novel Coronavirus 2019 (COVID) in accordance with the CDC guidance for 2 of 3 staff reviewed (Staff C, Certified Nurse Aide, and Staff D, Certified Medication Aide). The facility reported a census of 26 residents.

Findings Include:

1. The undated facility Staff Vaccination Matrix indicated that Staff C, Certified Nurse's Aide (CNA), got approved for a religious exemption for the COVID vaccination.

The Personnel file for Staff C documented a hire date of 5/16/22. The Personnel filed contained a Religious exemption for the COVID vaccine; undated, unsigned, and no documentation related to approval by the facility.

The Staff COVID testing facility document dated 5/5/22 - 6/9/22, lacked documentation that Staff C received testing twice a week.

The facility's Daily Schedule indicated the following information regarding Staff C:
a. 5/20/22: Staff C, 6:00 AM to 2:00 PM (6-2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 62	F 886		

CNA, negative with a line drawn through it. The bottom of the page had three names indicating negative test results including Staff C.
b. On 5/22/22 - Staff C, 6-2 CNA and the second page contained three names with negative, one included Staff C.
c. On 6/3/22 - documented four staff tested with negative results, one included Staff C.
d. On 6/5/22 - the COVID testing documented two staff with negative results, one included Staff C.

Staff C's Time Card Report for dates of 5/16/22 - 6/8/22 identified that she worked on the following days: 5/20/22, 5/21/22, 5/22/22, 5/25/22, 5/27/22, 5/31/22, 6/3/22, 6/4/22, 6/5/22, and 6/8/22.

The facility document titled Weekly County Rates revealed the following level of community transmission rates:
a. 5/15/22 - substantial
b. 5/22/22 - high
c. 5/29/22 - high
d. 6/13/22 - high
e. 6/19/22 - high
f. 6/26/22 - high
g. 7/17/22 - high
h. 7/24/22 - high

The facility failed to test Staff C for COVID from 5/22/22 - 6/3/22.

2. The facility's Daily Schedule dated 7/28/22, listed Staff D, Agency Certified Medication Aide (CMA), scheduled to work from 6:00 AM - 12:00 PM.

The facility Staff Screen Log dated 7/28/22, lacked documentation showing that Staff D got screened before the start of her scheduled shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 63 The Religious Exemption from COVID Vaccination facility form dated 1/18/22 identified Staff D received an approval for exemption to taking the COVID vaccination. The facility failed to test Staff D on 7/28/22 upon arrival to her scheduled shift. The facility policy titled COVID Immunizations: Unvaccinated Employees dated 1/2022 stated: a. An employee who declined to get vaccinated or did not have proof of obtaining the COVID vaccination would be required to wear an N 95 or equivalent respirator with a face shield for source control, regardless of whether providing direct care to or otherwise interacting with residents. The N 95 and face shield may only be removed in the building when the employee is alone and in a designated office space or breakroom b. Any exempt staff and not fully vaccinated staff will be required to test at least twice a week, regardless of the level of the community transmission. c. Those unvaccinated or exempt employees will be required to adhere to universal source control, including in areas that are restricted from resident access. This includes areas such as the meeting rooms, break rooms, kitchen, etc. d. Failure to adhere to this policy will lead to progressive discipline up to and including termination. The Center for Clinical Standards and Quality/Survey & Certification Group Memo Ref: QSO-20-38-NH revised 3/10/22 provided the following direction for testing: a. Routine testing of staff who are not up to date, should be based on the extent of the virus in the	F 886	F 886 1. DON/Designee will test staff C – Certified Nurse Aide and Staff D – Certified Medication Aide for COVID on or before 9/4/22. 2. DON/Designee on or before 09/04/22 will ensure that staff Covid testing is up to date. 3. On or before 09/04/22 the Director of Clinical Services will reeducate the DON regarding Staff Vaccination Matrix and completing covid testing per CMS guideline. 4. DON//Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure Staff Vaccination Matrix and Staff Covid testing are current. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 64	F 886		

community. Staff who are up to date, do not have to test routinely.
b. Facilities should use their community transmission level as the trigger for staff testing frequency.
c. Routine testing intervals by county COVID level of community transmission minimum testing frequency for staff who are not up to date:
1. Low (blue): not recommended
2. Moderate (yellow): once a week
3. Substantial (orange): twice a week
4. High (red): twice a week

On 7/27/22 at 9:18 AM, the Dietary Manager (DM) reported being unvaccinated for COVID with a religious exemption. The DM stated the facility offered the COVID vaccination and they declined. The DM explained that the facility requires them to wear an N 95 mask and face shield. The DM added that facility did not allow them to wear eye protection glasses as it had to be a face shield. The DM verified that the facility tested them for COVID twice a week and if they didn't work for an extended period of time the facility required them to get tested. The DM acknowledged understanding of the facility policy if no they didn't have the vaccine, to wear a N 95 mask and face shield in addition to the extra testing.

On 7/28/22 at 9:10 AM, Staff D reported they worked at the facility every once in a while and had worked at the facility in a couple of weeks. Staff D said that they had the COVID vaccine. Staff D explained that the facility did not ask if they got tested recently when she arrived to work and no one tested her. Staff D reported that she tested the previous day at another facility. Staff D wore a surgical mask and prescription eye glasses without eye protection in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 65 On 7/28/22 at 9:40 AM, the Director of Nursing (DON) said that he believed Staff D had an exemption in place. According to the DON, he believed that Staff D was the only contract staff that did not have their vaccine. The DON denied knowing if Staff D got tested upon her arrival to work. The DON stated Staff D would have been screened upon her arrival to work and asked about vaccine status. The DON said he expected Staff D to be tested upon her arrival to work if she did not have the COVID vaccine. The DON explained that Staff D possibly received their vaccination since she last worked at the facility. On 7/28/22 at 9:46 AM, the DON confirmed Staff D had religious exemption for the COVID vaccination. The DON stated if Staff D had vaccination but the facility did not have a record would go by the exemption. On 7/28/22 at 10:48 AM, the DON provided Staff D's religious exemption dated 1/18/22. The DON confirmed that Staff D had a surgical mask in place and prescription eyewear without wearing eye protection. On 7/28/22 at 10:50 AM, the DON confirmed that Staff C had a religious exemption, however the document remained unsigned and without a date. The DON stated that typically the corporate office would review and approve the exemptions related to the COVID vaccination. The DON said that after the investigation the facility reported that the previous Administrator approved Staff C's exemption. The DON reported that he called Staff C, and got told she completed the religious exemption upon hire and it went in her file.	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 66	F 886		

On 7/28/22 at 11:39 AM, the DON stated that he would fix the process by asking the new staff to bring their COVID vaccination card, check the immunization database, and/or check with the physician's office for their COVID vaccination status. The DON explained that the onboarding system for new hires asked if they had the COVID vaccination. The DON denied knowing how the process used to be done before. The DON stated no staff should be working with residents if the staff did not have an exemption or a COVID vaccine. The DON said additional interventions got put in place for staff who did not have the COVID vaccine including the twice a week testing, N 95, and face shield unless in office with the door shut and no one else in the office. The DON explained that he expected the staff to follow the CDC & CMS standards, however, if they worked at the facility he also expected them to follow the facility policy.

On 7/28/22 at 11:58 AM, during a joint review of the facility staff screening logs for 7/28/22 with the DON, he confirmed that the agency CMA, Staff D, who was working in the facility at the time of review, did not get identified on the staff screening log. The DON said he would follow up with Staff D. An observation of a posted sign by the staff screening instructed that all staff needed to test twice a week due to recent a COVID positive staff.

On 7/28/22 at 12:10 PM, the DON stated that Staff D claimed that she got screened in and a facility CNA confirmed it. The DON stated Staff D and the facility CNA explained the screening area had no pen available at the time, so they did not document that she got screened in. The DON reported that Staff D became upset about being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 67	F 886		

questioned and talked about criminal charges. The DON informed Staff D to count the narcotics with the nurse on duty and leave the facility.

On 7/28/22 at 3:30 PM, during a joint review of the testing logs with the DON, he confirmed that Staff C didn't have a documented COVID test result until after her positive test on 6/8/22.

On 8/1/22 at 11:11 AM, the DON reported that he expected the unvaccinated staff to be tested twice a week, and wear an N 95 mask, and a face shield. The DON added that he continued to look for Staff C testing results. The DON said that he expected all staff and visitors to get screened before coming into the facility. The DON stated that the staff screen in before and after every shift with a fellow staff member to verify. The DON explained the facility required unvaccinated staff to test twice a week due to high transmission and positive staff.

On 8/1/22 at 1:02 PM, Staff C reported that she started at the facility in May, but didn't remember the exact date. Staff C stated the facility offered the COVID vaccine, however, she completed a religious exemption. Staff C explained that facility required her to complete a form with her initial paperwork before starting to work at the facility. She got informed that her exemption got approved before she started at the facility. Staff C stated the first form did not go into detail regarding the reason for the exemption. Staff C remarked that she typed a letter with the reason she did not want to get vaccinated. Staff C added that she got tested prior to ever working on the floor with the residents. Staff C explained that before she could even clock in to work, she had to test and a receive a negative result. Staff C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 886	Continued From page 68 said she got tested two days a week by the nurse. Staff C stated she did not know where they documented the results. Staff C explained that she always got tested two times a week. Staff C stated since not she did not have the vaccine, the facility required her to wear a N 95 or a K 95 mask and a face shield. On 8/3/22 at 1:53 PM, the DON confirmed in an email that Staff D did not get tested upon her arrival to her scheduled shift on 7/28/22. The DON reported that they required Staff D to leave the facility after they confirmed she did not get screened at the beginning of her shift, as she lied to the surveyor, and did not have proper PPE (personal protective equipment). The DON reported that he informed the Agency that Staff D could not return to the facility.	F 886		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for	F 888	F 888 1. The DON/Designee on or before 09/04/22 will verify that staff have Covid vaccination documentation or have a completed and approved exemption. 2. The facility Staff Vaccination Matrix will be audited and updated by the DON/Designee if needed on or before 09/04/22. 3. On or before 09/04/22 the Director of Clinical Services will reeducate the DON regarding Staff Vaccination Matrix and keeping updated. 4. DON/Designee will complete audits weekly for 4 weeks then monthly for 2 months of to ensure Staff Vaccination Matrix is up to date. Results of these audits will be provided to the Quality Assurance and Performance Improvement Committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up.	09/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 888	Continued From page 69	F 888		

the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 888	Continued From page 70	F 888		

additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 888	Continued From page 71	F 888		

vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on observations, facility record review, and staff interviews the facility failed to have a system or process in place to track and securely document the novel Coronavirus 2019 (COVID) vaccination status for all staff. The facility reported a census of 26 residents.

Findings Include:

During the Entrance Conference on 7/25/22 at 10:15 AM, the Director of Nursing (DON) received notice of the facility information required for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 888	Continued From page 72	F 888		

recertification survey. Based on the information provided the facility had four hours to provide the COVID Staff Vaccination Policy and Procedures with the COVID Staff Vaccination Matrix. The DON verbalized understanding of the required information.

On 7/26/22 at 10:47 AM, the DON indicated that he continued to work on the staff vaccination list (COVID Staff Vaccination Matrix).

On 7/26/22 at 3:20 PM, the DON indicated that he had all of the staff vaccination information but it had not been recorded on the staff vaccination tracking log. The DON added that he could provide an incomplete log at that time. The DON provided the Staff Vaccination Log and identified that the log had three staff members listed on the staff list. The Staff Vaccination Log did not include those three staff members, but it did include seven staff members that did not have the COVID vaccine or a qualified exemption listed.

On 7/27/22 at 9:20 AM, the DON reported that he continued to update the Staff Vaccination List to include all of the facility staff.

On 7/27/22 at 11:15 AM, the DON confirmed that the Facility Staff List provided on Monday, 7/25/22, was correct and included the current facility staff. However, he continued to work on the Staff Vaccination Matrix.

On 7/27/22 at 2:28 PM, the DON said that he sent the Staff Vaccination Matrix to the Corporate Infection Control Nurse to confirm and verify its accuracy.

On 7/27/22 at 4:15 PM, Staff A, the Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH CARE CENTER	508 2ND STREET NE DAYTON, IA 50530

(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 888	Continued From page 73	F 888		

Consultant, said that the entire system for tracking staff vaccinations and exemptions fell apart with no one responsible to complete and/or update it.

On 7/27/22 at 4:30 PM, the DON provided the Staff List that showed a total of 33 staff members, and a Staff Vaccine Log that listed 36 staff with 31 vaccinated and 5 exemptions. Upon review found three staff not listed on the Staff Vaccination Log and one staff member listed on the third version of the log without a recorded vaccination and/or exemption.

On 7/28/22 at 8:28 AM, the DON reported that he spent all week delaying the survey process trying to find the requested information. During the joint review with the DON, he confirmed that four of the staff did not get listed the second provided Staff Vaccination List.

On 7/28/22 at 11:39 AM, the DON said that he expected the process to be to verify the COVID vaccination information before the staff could start working. The DON explained that the onboarding system for new hires asked if they had the COVID vaccination. The DON denied knowing how the process used to be done before. The DON stated no staff should be working with residents if the staff did not have an exemption or a COVID vaccine. The DON said additional interventions got put in place for staff who did not have the COVID vaccine including the twice a week testing, N 95, and face shield unless in office with the door shut and no one else in the office. The DON explained that he expected the staff to follow the CDC & CMS standards, however, if they worked at the facility he also expected them to follow the facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 888	Continued From page 74 On 7/28/22 11:47 AM, the DON provided a third copy of the Staff Vaccination Matrix and said that he believed the Staff Matrix should be current.	F 888		