STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DONNELLSON HEALTH CENTER	**901 STATE STREET DONNELLSON, IA 52625**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a physician visited residents at least once every 30 days for the first 90 days after admission for 2 of 5 residents reviewed (Residents #1 and #2). The facility reported a census of 51 residents. Findings include: 1. Resident #1's Face Sheet documented an admission date of [DATE]. Review of the Clinical Record revealed a physician visited Resident #1 on 4/27/20 and 6/15/20. The facility failed to ensure Resident #1 had a physician visit from 4/27/20 to 6/15/20. 2. Resident #2's Face Sheet documented an admission date of [DATE]. Review of the Clinical Record revealed Resident #2 had a physician's visit on 7/28/20. The facility failed to ensure Resident #2 had a physician's visit from 5/19/20 (admission) to 7/28/20. During an interview on 8/11/20 at 10:00 a.m., the Administrator confirmed the residents were not seen by a physician any additional times. The facility policy Physician Visit Policy and Procedure, dated 8/31/19, stated the facility would ensure residents had a physician's visit every 30 days for the first 90 days.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to implement CDC recommended infection control practices in order to control and prevent the potential spread of COVID-19 for 4 of 8 sampled (Resident #1, #4, #7 and #8) on the Chronic Confusion or Dementing Illness (CCDI) unit. The facility placed new admissions and readmissions in a room with another resident. Resident #1 transferred to the Emergency Department and returned to the facility with a pending COVID-19 test. Resident #1's test returned positive. The CCDI unit had a census of 20. The facility reported a total census of 51. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired cognition. During an observation on 8/3/20 at 1:10 p.m., revealed Resident #1 lying in bed. In the same room, Resident #7 (roommate) sat on a sofa. Observation on 8/3/20 at 2:40 p.m., revealed Resident #1 and Resident #7 remained in the same room. Observation on 8/4/20 at 7:25 a.m., revealed Resident #1 lying down in bed, Staff entered the room with a breakfast tray. Resident #7 walked over to Resident #1's bed and woke up Resident #1 up by nudging her legs. The Progress Notes dated 7/25/20 at 11:55 a.m., revealed Resident #1 had chest pains and transferred to the Emergency Department. At 4:38 p.m., Resident #1 returned to the facility. A Laboratory sheet printed on 7/28/20 revealed Resident #1 had COVID-19 test on 7/25/20 and result of COVID-19 detected. The Room Locations sheet dated 8/6/20 revealed Resident #1 returned from the Emergency Department and resided in the same room with Resident #7. 2. The Resident Matrix sheet revealed Resident #4 admitted to the facility on [DATE]. Observation on 8/3/20 at 1:10 p.m. revealed Resident #4 lying in bed. Resident #4 had a roommate (Resident #8) who occupied the same room. The Room Location sheet documented Resident #8 occupied the room when Resident #4 admitted to the facility on [DATE]. The Resident Admission/Readmission Policy for Dementia and Behavioral Persons dated 6/1/20, failed to align with current CDC guidelines and stated if a private room was not available the facility would place new admissions with roommates and place both residents on isolation precautions. The Admission of New COVID-19 Positive Resident policy, dated 5/19/20, failed to align with current CDC guidelines and directed staff to place COVID-19 positive residents in private rooms as much as possible and stated if a private room was not available, the facility would place that resident in a room with another resident. Current CDC guidelines @cdc.gov directed Long Term Care facilities to place newly admitted or readmitted residents into a single-person room or a separate isolation area for a period of 14 days. During an interview on 8/4/20 at 8:46 a.m., the Administrator stated Resident #1 went to the emergency roiagnom on [DATE] and returned to the facility the same day. She stated on 7/28/20, the hospital called and informed the facility the resident had a positive COVID-19 test. She stated if the facility was able to do so, they placed residents who returned from the ER and new residents in private rooms. She stated the facility did not have enough rooms to do this for Residents #1 and #4 and so they placed them in a room with another resident. During an interview with Iowa Department of Public Health (IDPH) Nurse Clinician on 8/5/20 at 11:15 a.m. revealed the facility Nurse Consultant had a conference call with IDPH on 7/28/20. The Nurse Consultant reported Resident #1 had a positive COVID-19 test. IDPH directed the facility to place Resident #1 in a private room. The Nurse Consultant informed IDPH that Resident #1 was in a private room. On 8/4/20 at 11:37 a.m. the State Agency informed the facility of the Immediate Jeopardy. The facility abated the Immediate Jeopardy on 8/5/20 by educating staff on the policy for admission and readmission of residents by placing them in a isolation room for the duration of the 14 day isolation, the facility implemented designated isolation rooms to meet the need of readmissions and admissions, and implemented a plan in collaboration with Public Health for release of restrictions for residents on isolation on the CCDI unit. After the corrective actions the scope and severity lowered from K to E.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interview, the facility failed to notify the residents, resident representatives, and/or family members of a resident with a confirmed case of COVID-19, as required per Center for Medicare and Medicaid Services Memorandum dated 5/6/20 that included COVID-19 reporting requirements. The memorandum directed the facility to report a single confirmed case of COVID-19 to residents, resident representatives, and/or family members by 5 p.m. the next calendar day. The facility reported a census of 51. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 7/7/20, listed Resident #5's Brief Interview for Mental Status score of 13, indicating intact cognition. Nursing Notes, dated 7/31/20, stated the facility attempted to call the family with an update. The resident's record lacked documentation the facility attempted to notify the family by 5 p.m. the next calendar day (following a 7/28/20 positive COVID-19 case). During an interview on 8/3/20 at 12:15 p.m., the resident stated no one from the facility informed her of any residents testing positive for COVID-19. 2. The MDS assessment tool, dated 5/21/20, listed Resident #2's BIMS score as 15 out of 15, indicating intact cognition. Nursing notes, dated 7/31/20, stated the facility attempted to call the family with an update. The resident's record lacked documentation the facility attempted to notify the family by 5 p.m. the next calendar day(following a 7/28/20 positive COVID-19 case). During an interview on 8/4/20 at 7:20 a.m., the resident stated no one from the facility informed her of any residents testing positive for COVID-19. 3. A hospital laboratory report, dated 7/28/20, stated Resident #1 tested positive for COVID-19. The undated facility policy COVID-19 Protocol stated the facility would inform residents and resident families of all positive COVID-19 tests by 5 p.m. the following day. During an interview on 8/4/20 at 8:46 a.m., the Administrator stated Resident #1 went to the emergency roiagnom on [DATE] and returned to the facility the same day. She stated on 7/28/20, the hospital called and informed the facility the resident was positive for COVID-19. The Administrator stated the facility informed the families in Resident #1's unit on 7/28/20 but did not notify the family members of residents on other units until 7/31/20. She stated she did not notify the family members of the residents on other units prior to 7/31/20 because Resident #1's unit was in a separate area. During an interview on 8/5/20 at 12:00 p.m., the Administrator stated she did not inform any residents of Resident #1's positive COVID-19 test. She stated she did not know this was a requirement.

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

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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