STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165591	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPURGEON MANOR	**1204 LINDEN STREET DALLAS CENTER, IA 50063**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility record review, the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals (DIA) within 24 hours for one of one residents reviewed who reported missing valuables (Resident #2). The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 revealed [DIAGNOSES REDACTED]. The MDS documented the resident had rejected cares 1-3 days but had no [MEDICAL CONDITION] or other behaviors during the look-back period. The Care Plan revised 5/4/20 revealed the resident had impaired cognitive function related to a [DIAGNOSES REDACTED]. The care plan indicated the resident had some personal effects in her memory box outside of her room. Staff directives included monitor and document behaviors whenever they occurred, and assist the resident to navigate to her room and activities as desired. A Missing Item Tracking report dated 11/5/19, completed by Staff D, Licensed Practical Nurse (LPN) revealed staff reported Resident #2 missing three band stackable wedding rings. The on-line abuse or incident reporting revealed the facility notified DIA on 11/7/19. A CNA (certified nurse aide)notified the CCDI (chronic confusion & dementing illness) unit charge nurse of Resident #2 missing rings. The resident normally wore the resident but the resident's rings were not on the resident's fingers that day. The charge nurse notified family of missing items on 11/6/19, and staff proceeded to look for the missing rings. The report documented the charge nurse was unaware of the policy for missing items because of status as a newer employee. Leadership was notified of the missing rings on 11/7/19, and an internal investigation initiated. On 11/7/19, the facility notified the resident's family the rings were not found after staff searched for them, and asked family if they wanted the missing rings reported. Family thought the facility should report the missing rings. The administrator reported the missing items to the local police department and DIA 11/7/19. In an interview 7/29/20 at 4:00 p.m., Staff J, Registered Nurse, reported she filled out a missing belongs form if she or someone reported items missing, then made the Administrator or environmental services staff aware of items missing. Staff J reported staff completes an inventory of belongings whenever a resident admitted to the facility and updated the list whenever items brought or taken from the facility. In an interview 7/30/20 at 12:45 p.m., Staff G, Licensed Practical Nurse (LPN), reported she completed a missing item report whenever someone reported belongings missing and gave the report to all of the department heads. Staff G reported staff searched for the missing item(s). Staff G reported she recalled Resident #2 wore rings that looked like costume jewelry. In an interview 7/30/20 at 1:40 p.m., Staff K, Certified Nursing Assistant (CNA), reported she recalled Resident #2 wearing rings on 11/4/19, but not on 11/5/19. Staff K stated if a resident missed belongings, she reported to the nurse and then looked for the item missing. Staff K reported residents in the dementia unit often times wandered and placed items in other locations or threw items in the garbage. In an interview 7/30/20 at 3:10 p.m., Staff D, LPN, reported Staff E, Certified Medication Assistant (CMA), informed her of Resident #2's missing rings, and stated the resident usually wore rings. At that time (11/5/2019), she saw a bruise on the resident's right arm where the resident normally wore her bracelet. Staff D stated she should have contacted the Director of Nursing that evening when Staff E reported the incident, but at that time, she didn't know the facility's policy or procedure very well and what she needed to do, or that she needed to report the incident right away. Staff D stated it's not uncommon for residents in the dementia unit to misplace things or place items in other locations, and she thought staff would find the rings. Staff D reported she completed the adult and child abuse course, and the facility covered the abuse policy during her orientation. Staff D stated she now knew she should have reported the missing belongings right away. In an interview 8/3/20 at 8:30 a.m., Staff E, CMA (certified medication aide), stated she reported missing belongings to to the charge nurse right away, filled out a missing item report form, looked for the item, and then followed up the next time she worked to see if anyone found the item. Staff E reported Resident #2 had Alzheimer's could not remember day to day. Staff E reported Resident #2 wore rings and a bracelet. Staff E recalled the resident wore the rings and bracelet because she made comments whenever she provided cares for the resident. Staff E reported the resident had a bruise on her right arm and she noticed the bracelet and rings gone. Staff E reported the rings missing to Staff D, LPN, on 11/5/19. Staff E stated she looked for the rings but never found them, and she was not sure if family had taken the rings home. In an interview 8/10/20 at 9:40 a.m., Staff L, LPN, reported she did not work on 11/5/19, the day staff noticed Resident #2's rings missing, but she worked the following days. Staff E reported to her about Resident #2's missing rings. Staff E stated she reported the missing rings to Staff D the day before. Staff L stated she then spoke with Staff D. Staff D knew of the missing rings but did not report the missing items or filled out a report. Staff L gave Staff D instructions on what she needed to do. Review of employee file revealed Staff D hire date of 9/26/19, and orientation checklist completed 9/27/19. The orientation checklist included instructions on the policy and procedure for resident abuse prevention, reporting, and investigation. An employee coaching dated 11/8/19 revealed a coaching notice in Staff D's file that identified she did not report missing items during her shift. Staff D received education and acknowledged abuse policy education during orientation, and reviewed the abuse policy again. A facility policy titled Abuse Prevention, Identification, Investigation, and Reporting dated 7/2019, revealed all allegations of resident abuse and misappropriation of resident property required a report to the charge nurse immediately, and to DIA no later than two hours after the allegation made.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **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, staff interview, and policy review, the facility staff failed to followed infection control practices in order to prevent or reduce the risk of spreading infection and disease. The facility reported a census of 44 residents. Findings include: 1. During observation 7/29/20 at 11:55 a.m., Staff A, Registered Nurse (RN), obtained supplies from a medication cart, donned a pair of gloves, and performed a blood sugar on a resident. After Staff A completed the blood sugar, she disposed of a used cotton ball and lancet, obtained a disinfectant wipe and cleansed the glucometer and a small tray, then removed her gloves. 2. During observation 7/29/20 at 12:05 p.m., Staff M, housekeeper pushed a cart down the(NAME)hallway by the resident rooms. Staff M wore a mask over her mouth, and had goggles on top of her head. 3. During observation 7/29/20 at 12:20 p.m., Staff N, dietary cook served food from the Eby unit kitchenette. Staff N wore a mask and hairnet, but had no goggles or faceshield on. 4. During observation 7/30/20 at 9:53 a.m., Staff B, Certified Nursing Assistant (CNA) and Staff O, CNA stood by Resident #8 in his room. A Quarantine sign hung on the resident's door. Staff B wore no gown , and Staff O wore no goggles or faceshield. Staff B removed a gown off the hook by the resident's door and donned the gown quickly. Staff B and Staff O, assisted the resident to stand and transferred the resident to a chair. At 9:58 a.m., Staff B removed the gown and gloves, and pushed the weight chair into the hallway by the resident's door. Staff B walked across the hallway and washed her hands in the sink adjacent to the kitchenette. Staff O continued to wear the

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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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) gown and walked into the hallway by the resident's room, placed a bag of trash on the floor, then went back into the resident's room and removed her gown and gloves. At 10:05 a.m., Staff B pushed the shower/weight chair to the central bath room and sanitized her hands. Staff failed to disinfect the shower/weight chair. 5. During observation 7/30/20 at 1:10 p.m., Staff F, physician, entered resident room [ROOM NUMBER]. A Quarantine sign hung on the door. Staff F had no gown or gloves on when he entered the resident's room. In an interview 7/30/20 at 1:15 p.m., Staff B , CNA, reported whenever a resident on isolation or quarantine, the staff needed to wear a gown before they entered the resident's room. Staff B reported whenever a resident came from the hospital, the facility placed the resident in isolation/quarantine for 14 days. Staff should wear a gown, mask, gloves, and eye protection before entering the resident's room. Staff B confirmed she did not wear a gown on when she entered Resident #8's room [ROOM NUMBER]/30/20 a.m., and stated she should have worn a gown. In an interview 7/30/20 at 2:00 p.m., Staff C, RN, reported a sign placed on the door of the resident's room whenever a resident in isolation. Staff C reported whenever a resident admitted from the hospital, they placed the resident on droplet precautions for 14 days. Staff required to wear gloves, gown, mask and goggles before entering the resident's room, and the gown and gloves removed before staff left the room. In an interview 8/6/20 at 3:45 p.m., the infection preventionist reported quarantine and droplet precautions meant the same thing. The infection preventionist stated the facility placed a resident on droplet precautions for 14 days whenever admitted to the facility from the hospital because the resident was presumed positive for COVID-19. The infection preventionist reported she expected staff to wear a gown, gloves, mask and goggles or faceshield before they entered a resident's room whenever a resident on droplet precautions or quarantine status. The infection preventionist reported all staff required to wear a mask and goggles or faceshield when in resident care areas. A facility policy titled Standard Precautions revealed standard precautions used to prevent the transmission of infectious agents. The policy revealed gloves changed between tasks and procedures, and patient care equipment cleansed and sanitized between uses. A facility policy for initiation of isolation precautions revealed standard precautions used for all residents whenever cares provided regardless of the resident's [DIAGNOSES REDACTED]. Droplet precautions used for a resident known or suspected of infection with a microorganism transmitted by droplets generated during coughing, sneezing, or talking.