STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow and update a care plan to effectively treat a resident for one of one resident reviewed (Resident #1). The facility reported a census of 28. Findings include: The Minimum Data Set (MDS) completed on 5/18/20 showed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. The resident required total assistance of two staff members with bed mobility, transfers, bathing, and toileting in the previous seven days in the lookback period. Resident #1 required extensive assistance of one staff with eating in the last seven days in the lookback period. The resident's weight was 96 pounds (#) in the lookback period, with no significant weight changes. The resident had an impairment of one side on the upper and lower extremities. The resident was at risk for pressure ulcers with no current pressure, venous, or arterial ulcers. The resident had no healed pressure ulcers and used a pressure device for their bed. The resident had [DIAGNOSES REDACTED]. Observations: On 8/3/20 at 12:41 PM, Resident #1 sat alone at the table with a full plate of food and all fluids. Staff B, Certified Nurses' Aide (CNA), asked the resident if they would like help. The resident responded, and Staff B told the resident they would be right back. On 8/3/20 at 1:01 PM, the resident sat at the dining room table with a plate full of food with no staff assisting the resident. On 8/3/20 at 2:17 PM, witnessed the resident sitting on a honeycomb pressure reducing cushion with no cover. On 8/4/20 at 4:50 PM, observed the resident sitting in the dining room table with socks on and no boots to the resident's feet. Record review: On 7/20/20 at 9:51 AM, the Health Status Note showed the weekly skin assessment and noted the resident had two pressure areas to bilateral heels. The resident also had multiple bruising to bony prominences-a pillow was placed between legs when the resident rested in bed and repositioned frequently. On 7/20/20 at 4:39 PM, the Hospice Progress Note showed the resident was admitted to Hospice on 7/1/20 due to nutritional deficiency and comorbidity of dementia. The resident lost 10 percent (%) of their body weight since admission to the nursing home. The resident's appetite was poor, and their intake is limited to boost at meals, as this is all the resident will accept. Hospice received a call on 7/20/20 that the resident's heels were red, and she had multiple bruises over her body. Heel protectors were delivered. The resident used a hospital bed, air mattress, incontinent supplies, wheelchair, catheter supplies, and heel protectors. The Physician Communication form dated 7/29/20 showed the resident had uncontrolled pain. Due to the resident's weight of 78#, the pharmacist consulted to determine medication and dosage. The pharmacist recommended a [MEDICATION NAME] dose of 0.25 milliliter (ml) twice daily with a concentration of 20 milligrams (mg) per ml. The Physician responded, sounds good, thanks on 7/29/20. The Documentation Survey Report v2 for 8/20 indicated fluids offered on the day shift from 6:00 AM until 2:30 PM. The amount eaten documented a zero for all meals on 8/2/20, and breakfast on 8/3/20. The record showed multiple areas of missing documentation in all areas of the report. The Care Plan problem revised on 9/9/19 showed the resident had an indwelling catheter: due to a recent cardiovascular accident ([MEDICAL CONDITION]) causing [MEDICAL CONDITION]. The intervention dated 12/19/19 said to monitor and document intake and output as per facility policy. The Care Plan problem revised 2/4/20 showed the resident had increased risk for impaired skin integrity. The intervention dated 9/9/19 directed to monitor nutritional status, serve diet as ordered then monitor intake and record. The intervention dated 7/19/20 said to place a pillow or blanket between the resident's legs and encourage them not to cross their legs. The Care Plan problem dated 1/28/20 explained the resident had swallowing problems related to the swallowing assessment results. The goal revised on 7/16/20 said the resident would not have an injury related to aspiration through the review date. The intervention dated 4/20/20 said the staff would assist the resident with meals as they request. The Care Plan problem dated 8/3/20 showed the resident had an unplanned, unexpected weight loss due to poor food intake. The goal dated 8/3/20 said the resident would consume 50% of two of three meals a day through the review date. The interventions dated 8/3/20 indicated the staff was to give the resident supplements as ordered and to alert the nurse or Dietitian if the resident was not consuming on a routine basis. The second intervention said if weight decline persists, contact the Physician and Dietitian immediately. The third intervention indicated to monitor and record food intake at each meal. The Care Plan problem revised on 9/9/19 explained the resident had activities of daily living (ADL) self-care performance deficit related to activity intolerance. The goal revised on 7/16/20 said the resident would maintain the current functioning level (specify bed mobility, transfers, eating, dressing, toilet use, and personal hygiene) through the review date. The intervention dated 12/19/19 indicated the resident required the assistance of one staff for transfers. One assist with locomotion in the wheelchair through the facility; one assist for bathing, catheter cares, and ADLs. The Care Plan lacked documentation related to the use of pressure reduction boots. The Care Plan lacked documentation related to the resident was receiving Hospice level of care. On 8/4/20 at 10:49 AM, the Director of Nursing (DON) stated if the resident was supposed to have pressure reduction boots, it should be on the care plan. Also, if a resident requests assistance with eating, the staff should help them.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide appropriate nutrition and care to prevent pressure ulcers for one of one resident reviewed (Resident #1). The facility reported a census of 28. Findings include: The Minimum Data Set (MDS) completed on 5/18/20 showed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. The resident required total assistance of two staff members with bed mobility, transfers, bathing, and toileting in the previous seven days in the lookback period. The resident required extensive assistance of one staff with eating in the last seven days in the lookback period. The resident's weight was 96 pounds (#) in the lookback period, with no significant weight changes. The resident had an impairment of one side on the upper and lower extremities. The resident was at risk for pressure ulcers with no current pressure, venous, or arterial ulcers. The resident had no healed pressure ulcers and used a pressure device for their bed. The resident had [DIAGNOSES REDACTED]. Observations On 8/3/20 at 12:41 PM, the resident sat alone at the table with a full plate of food and all fluids, Staff B, Certified Nurses' Aide (CNA), asked the resident if they would like help. The resident responded, and Staff B told the resident they would be right back. On 8/3/20 at 1:01 PM, the resident sat at the dining room table with a plate full of food with no staff assisting the resident. On 8/3/20 at 2:17 PM, witnessed the resident sitting on a honeycomb pressure reducing cushion with no cover. On 8/4/20 at 4:50 PM, observed the resident sitting in the dining room table with socks on and no boots to the resident's feet. Record review The Braden Scale completed 3/4/20 showed the resident had a score of 17, indicating mild risk. On 5/18/20 at 5:33 PM, the Nutrition Progress Note showed the quarterly assessment. The resident's weight was 96#, down 4% in 30 days and down 2% in the last 180 days, which were not significant weight changes. The resident consumed a regular diet, mechanical soft with ground chopped meat. The resident was assisted with eating by mouth

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

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) between 25-75%. The resident took a multivitamin supplement and took Boost 8 ounces (oz.) for weight management and gain. The resident's skin was intact with the care plan goal met. The Dietitian would monitor and continue with the current plan. On 7/1/20 at 12:49 PM, the Health Status Note showed the resident admitted to Hospice. The resident's weight record showed the following weights 6/10/20 96.4# 6/10/20 96.3# 6/17/20 93.0# 6/24/20 100# 7/1/20 92.6# 7/8/20 89.1# 7/22/20 78.4# The weight of 100# on 6/24/20 and weight of 78.4# on 7/22/20 showed a weight loss of 21.60% in 29 days. On 7/20/20 at 9:51 AM, the Health Status Note documented the resident had two new pressure ulcers to bilateral heels. The right heel was reddened measuring 4 centimeter (cm) by (x) 3.5 cm. The left heel was reddened measuring 2 cm x 2 cm. The skin was intact. Hospice notified. On 7/20/20, the Pressure Injury Weekly Assessment - Version 4 showed the resident had a facility acquired stage one on bilateral heels. The right heel measured 4.0 by (x) 3.5 x 0 and the left heel measured 2.0 x 2.0 x 0. The wound bed documented as reddened and intact. The surrounding skin was intact with normal skin color. The Physician notified on 7/20/20. On 7/21/20 at 10:57 AM, the Health Status Note showed the resident had two new pressure ulcers and hospice brought in boots. The resident wore boots to bilateral lower legs and feet. On 7/23/20 at 4:17 PM, showed the resident wore bilateral boots to heels at all times. On 7/24/20 at 9:50 AM, showed the resident continued with pressure reducing boots and was wearing them at the time. The Weekly Skin Assessment completed on 7/27/20 showed the resident had pressure areas to the right and left heels. The right heel measured 5 centimeters (cm) x 3.5 cm with skin intact. The left heel measured 5 cm x 5 cm with the skin intact. On 7/27/20, the Pressure Injury Weekly Assessment - Version 4, showed the resident had facility acquired stage one pressure ulcers to the bilateral heels. The right heel measured 7 x 3.5 x 0. The left heel measured 5 x 2 x 0. The wound bed appearance reddened but with the skin intact. The surrounding skin was normal in color and had intact skin. The Physician notified on 7/20/20. On 8/2/20 at 10:15 PM, the electronic medical record (eMAR) - Orders Administration Note for the boots on bilateral feet every shifts indicated the resident's boots were in laundry. The Weekly Skin Assessment completed on 8/3/20 showed the resident had pressure areas to the right and left heels. The right heel measured 5 cm x 3.5 cm with the skin intact. The left heel measured 5 cm x 5 cm with the skin intact. On 8/3/20, the Pressure Injury Weekly Assessment - Version 4, showed the resident had facility acquired stage one pressure ulcers to the bilateral heels. The right heel measured 7 x 3.5 x 0. The left heel measured 5 x 2 x 0. The wound bed appearance reddened but with the skin intact. The surrounding skin was normal in color and had intact skin. The Physician notified on 7/20/20. On 7/20/20 at 9:51 AM, the Health Status Note showed the weekly skin assessment showed the resident had two pressure areas to bilateral heels. The resident also had multiple bruising to bony prominences-a pillow was placed between legs when the resident rested in bed and repositioned frequently. On 7/20/20 at 4:39 PM, the Hospice progress note showed that the resident was admitted to Hospice on 7/1/20 due to nutritional deficiency and comorbidity of dementia. The resident lost 10 percent (%) of their body weight since admission to the nursing home. The resident's appetite is poor, and their intake is limited to boost at meals, as this is all the resident will accept. Hospice received a call on 7/20/20 that the resident's heels were red, and she had multiple bruises over her body. Heel protectors were delivered. The resident used a hospital bed, air mattress, incontinent supplies, wheelchair, catheter supplies, and heel protectors. The Documentation Survey Report v2 for 8/20 indicated fluids offered on the day shift from 6:00 AM until 2:30 PM. The amount eaten documented a zero for all meals on 8/2/20, and breakfast on 8/3/20. The record showed multiple areas of missing documentation in all areas of the report. Care Plan review The Care Plan problem dated 1/28/20 explained the resident had swallowing problems related to the swallowing assessment results. The goal revised on 7/16/20 said the resident would not have an injury related to aspiration through the review date. The intervention dated 4/20/20 said the staff would assist the resident with meals as they request. The Care Plan problem revised 2/4/20 showed that the resident had increased risk for impaired skin integrity. The intervention dated 9/9/19 said to monitor nutritional status, serve diet as ordered then monitor intake and record. The intervention dated 7/19/20 said to place a pillow or blanket between the resident's legs and encourage them not to cross their legs. The Care Plan problem dated 8/3/20 showed that the resident had an unplanned, unexpected weight loss due to poor food intake. The goal dated 8/3/20 said the resident would consume 50% of two of three meals a day through the review date. The interventions dated 8/3/20 indicated the staff was to give the resident supplements as ordered and to alert the nurse or Dietitian if the resident was not consuming on a routine basis. The second intervention said if weight decline persists, contact the Physician and Dietitian immediately. The third intervention indicated to monitor and record food intake at each meal. The Care Plan lacked documentation related to the use of pressure reduction boots. On 8/4/20 at 10:49 AM, the Director of Nursing (DON) said if the resident is supposed to have pressure reduction boots, it should be on the care plan. Also, if a resident requests assistance with eating, the staff should help them. During a follow-up interview on 8/4/20 at 4:53 PM, the DON said they were not sure if the resident's boots were back from the laundry. The DON reported putting the boots in the laundry a couple of days before because they had orange juice all over them. The DON said the resident needed to get a pair that fit her.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to aseptic catheter care for one of one resident reviewed (Resident #1). The facility reported a census of 28. Findings include: The Minimum Data Set (MDS) completed on 5/18/20 showed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. The resident required total assistance of two staff members with bed mobility, transfers, bathing, and toileting in the previous seven days in the lookback period. The resident had an indwelling catheter. The resident had [DIAGNOSES REDACTED]. Observations: a. On 8/3/20 at 2:13 PM, observed Staff B, Certified Nurses' Aide (CNA), remove gloves from the box, and place it on the counter. Staff B then washed hands and applied the gloves. Staff B walked over to the resident, removed the alarm box, and placed onto the tray table. Staff B explained to the resident; they were waiting for other staff to help them. Staff B than with the same gloves on walks over to the door opens it and asks staff to get some briefs and wipes. Staff B walked over to the resident's wheelchair and removed the footrests. Staff B removed the catheter from the privacy bag and placed the privacy bag on to the floor. Then Staff B placed the gravity catheter bag on the floor with no barrier, lifting the tubing to drain into the bag. Staff B picked up the privacy bag from the floor and placed it onto the nightstand. Staff B went into the bathroom and got the graduate, a paper towel, and an alcohol wipe. Staff B put the paper towel on the floor and then placed the graduate on the towel. Staff B opened the alcohol wipe and placed on the floor next to the graduate. Staff B emptied the catheter bag, cleaned the drainage tube with an alcohol wipe, then threw away the towel and alcohol wipe. Staff B took the graduate with urine into the bathroom and then cleaned the graduate with an alcohol wipe. Staff B exited the bathroom with the same gloves on, then removed the gloves and washed hands. b. On 8/3/20 at 2:22 PM, Staff B attached the gravity bag to the pocket of her pants. Staff B and Staff C, CNA, assisted the resident in bed, lifting the resident into bed without the resident's feet touching the floor. Staff C placed the resident's gravity catheter bag onto the foot of the resident's bed. Staff B checked the resident for stool incontinence by pulling the resident's buttock apart with a gloved hand. Staff B reported the resident had a stain so they would complete perineal care for good measure. With no hand hygiene and the same gloved hand picked up the resident's alarm and handed to Staff C. Staff C handed Staff B the wipes to perform perineal care. After Staff B completed the perineal care on the backside of the resident, Staff B removed gloves, went to the sink, and washed hands. Staff C, then completed perineal care to the front side of the resident. After finishing the perineal care, Staff C closed the new wipes package without removing gloves or performing hand hygiene. c. On 8/4/20 at 4:50 PM, observed the resident sitting in the dining room at the table, the catheter hanging down from the resident. The privacy bag noted under the wheelchair with the catheter bag outside the privacy bag and the tubing resting on the floor. The Documentation Survey Report v2 for 8/20 showed multiple missing areas of documentation regarding catheter output. The documented output varied from 150 to 300. The catheter care showed numerous areas of missing documentation showing that the resident had an indwelling catheter and catheter care provided. The Care Plan problem revised on 9/9/19 showed the resident had an indwelling catheter: due to a recent cardiovascular accident ([MEDICAL CONDITION]) causing [MEDICAL CONDITION]. The intervention dated 12/19/19 said to monitor and document intake and output as per facility policy. The Care Plan problem revised on 9/9/19 explained the resident had activities of daily living (ADL) self-care performance deficit related to activity intolerance. The goal revised on 7/16/20 said the resident would maintain the current functioning level (specify bed mobility, transfers, eating, dressing, toilet use, and personal hygiene) through the review date. The intervention dated 12/19/19 indicated the resident required the assistance of one staff for transfers. One assist

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) with locomotion in the wheelchair through the facility; one assist for bathing, catheter care, and ADLs. During interview on 8/4/20 at 10:49 AM, the Director of Nursing (DON) stated staff should not place the catheter bag on the floor while performing catheter care. Policy review The Handwashing policy dated 3/15 explained that handwashing was mandated between resident or patient contact to prevent the spread of infection. Hands must be washed after the following, including but not limited to 1. Contact with blood or bodily fluids 2. Contact with contaminated items or surfaces 3. Contact with the resident or patient 4. Initiating a clean procedure 5. Removal of gloves
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, interviews, and record review, the facility failed to provide appropriate infection control to prevent the spread of the novel coronavirus 2019 (COVID-19) which resulted in an immediate jeopardy to the residents health and safety. On 7/10/20, the Administrator worked while experiencing cough and allergy-like symptoms. On Monday, 7/13/20 went to the Doctor, who ordered a COVID-19 lab test. On 7/21/20, the lab result returned positive for COVID-19. The Administrator remained off work until 7/22/20. On 7/22/20, the Administrator worked from approximately noon until 3:00 PM for meetings with the Corporate Nurse and Director of Nursing (DON). Staff report the Administrator was coughing and showing symptoms while in the building. The Administrator did not return to work until 7/27/20. On 7/30/20, the Business Office Manager directed the surveyor to take their temperature (temp) and answer the screening questions, while standing inside the building. On 8/3/20, observed the therapist screen themselves before exiting the facility. Per the DON and other staff, the staff was to screen themselves when coming to work or leaving work. Observed multiple staff wearing their face masks under their nose and one nurse removed the mask from the face while at nurses' station with other staff at the station. The facility did not have designated personnel to work the COVID-19 wing with three patients in the wing, two residents that returned from the hospital, and one new admission. The facility reported a census of 28 residents. Findings include: Observations: a. On 7/30/20 at 1:21 PM, the Business Office Manager came to the door wearing a mask with the nose exposed and no face shield, instructed the surveyor to take their own temperature then complete the screening form. After asking how to use the thermometer, the Business Office Manager took the surveyor's temp by touching the thermometer to the surveyor's head and then placing a thermometer on the table without cleaning. b. An undated sign in the entranceway instructed that before entering a person must 1. Spray body, clothes, and personal items with disinfectant spray. 2. Take temp a. Place scanner near forehead but don't touch the skin. b. Then press scan. c. If you have a fever of 100.0 or above, you may not enter the facility. 3. Fill out visitor or staff log accordingly 4. Use hand sanitizer 5. Then you may enter the building - do not push the red button, we want the alarm to sound so that we are aware of your arrival. **Visitors, including deliveries, are not allowed to go beyond the family room entrance. Please call the facility to alert staff of your arrival and wait for a staff member to come.** c. An additional undated sign in the entranceway said to please remember to put an answer in every box when coming to work. The sign included a handwritten section of first and last names. d. A handwritten sign dated 4/14/20 related to thermometer use said to turn on the thermometer, hold close to your forehead, scan, then record your temp before and after your shift. e. On 7/30/20 at 1:56 PM, observed Staff A, Licensed Practical Nurse, sitting alone behind the nurses' station without a face shield and the face mask pulled down below their chin. The north hall has a stop sign on the door with a COVID-19 update and an isolation kit hanging from the west door, both doors closed. f. On 7/30/20 at 2:00 PM, observed Staff J, Dietary Assist, wearing a face shield and mask below the nose. g. On 7/30/20 at 2:04 PM, a non-facility employee entered the facility and completed the screening form. The Business Office Manager unlocked the door and allowed the person to enter the building. h. On 8/3/20 at 11:12 AM, Staff A observed sitting at the nurses' station with mask below chin and face shield off. i. On 8/3/20 at 12:41 PM, observed three staff members at the nurses' station with their face shields and masks off while eating. One staff member, Staff E, Registered Nurse (RN), was sitting on one side of the nurses' station. The other two staff, Staff B, CNA, and Staff C, were standing on the other side facing Staff B. The two were approximately two feet apart. After the staff observed the surveyor, Staff B applied a face mask with a face shield and went out to the dining room to check on the residents that were eating. The other two staff applied a face mask and shield before going into the dining area. No hand hygiene observed by the staff before assisting the residents. Staff E then sanitized their hands. j. On 8/3/20 at 12:48 PM, Staff A walked through the dining room with a face shield and mask on exposing their nose. After arriving at the nurses' station, Staff A removed the face shield and moved the face mask to their chin. Staff I, Dietary Assist, began to walk out of the kitchen with no face mask or shield until another dietary staff redirected them to put on their mask. k. On 8/3/20 at 1:53 PM, the Administrator wore the face mask upside down and face shield, the face mask slipped down below their nose. The Administrator adjusted the mask to cover their nose two times without completing hand hygiene. l. On 8/3/20 at 2:04 PM, Staff E and Staff A sat at the nurse's station with face shields off, and masks pulled down below their nose. Staff H, Dietary Assist, and Staff I sat at the dining room table, wrapping silverware with face shields and face masks exposing their nose. m. On 8/3/20 at 2:07 PM, Staff E moved face mask over their face covering their nose, no hand hygiene observed. n. On 8/4/20 at 8:17 AM, Staff D, RN, exited the designated COVID-19 wing, removed face mask, left face shield in place, and walked into the nurses' station then into the supply room to get a new face mask. Staff D applied a new face mask covering the nose and mouth. o. On 8/4/20 at 8:20 AM, the Dietary Assist brought out the fluids for the residents from the kitchen uncovered. Staff L, CNA, took the cart and passed out the drinks. p. On 8/4/20 at 8:21 AM, Staff L saw with face shield on and face mask covering the mouth, leaving the nose exposed. q. On 8/4/20 at 8:22 AM, Staff D observed picking things off the floor went to the medication cart pulled mask down to their chin. No hand hygiene completed. r. On 8/4/20 at 8:25 AM, Staff L returned the cart with fluids back to the kitchen uncovered. s. On 8/4/20 at 8:28 AM, Staff D walked into the hallway, pulled mask back onto the face. Without hand hygiene, Staff D walked down the hall with the assessment supplies in a clear plastic tote. Staff D walked into room ten and placed the clear plastic tote with assessment supplies on the counter with no barrier. Staff D used a [MEDICATION NAME] thermometer, took the resident's temperature, and then put it into the tote. Took out the fabric wrist blood pressure cuff and took the resident's blood pressure. Without cleaning blood pressure cuff, placed into the tote. Staff D then rubbed face through face mask without hand hygiene and gave residents their medication. Staff D took the medication cup and placed it into the clear plastic tote with the assessment supplies. t. On 8/4/20 at 8:34 AM, Staff D exited room ten and went to the medication cart. Staff D placed the clear plastic tote on the medication cart without a barrier. Checked the computer and then left the medication cart with a clear plastic tote of assessment supplies. Staff D entered room [ROOM NUMBER], placed clear plastic tote with assessment supplies on the counter without barrier. Staff D took the fabric wrist blood pressure cuff on the resident and took the resident's blood pressure. After taking the resident's blood pressure, Staff D placed the cuff without cleaning into the clear plastic tote. Staff D removed the [MEDICATION NAME] thermometer to take the resident's temp and returned the thermometer into the tote. u. On 8/4/20 at 8:36 AM, Staff L sat with Resident #1 assisting with their meal. Staff L's face mask was down below the nose, only covering their mouth. Interviews: a. On 7/30/20 at 1:30 PM during the entrance conference, the Administrator reported the facility only had one staff member that tested positive for COVID-19, and they were currently off work. The facility had another staff waiting for test results and they weren't allowed to work until the results returned. b. On 7/30/20 at 1:56 PM, Staff A reported there are two residents in the COVID wing, one new admission and one that returned from the hospital. c. On 7/30/20 at 2:40 PM, the Director of Nursing (DON) reported baseline testing completed on all staff and residents with negative results. The door is locked at all times to the facility. People that come into the facility screen themselves, and at night someone is supposed to sit at the entrance to make sure they are doing it. d. On 7/30/20 at 3:07 PM, a Resident Representative reported the Administrator sent a letter to the families that the facility had a positive COVID-19 test. Staff told the Resident Representative that the person was the Administrator. The Administrator was staying mostly in the office. The Administrator was wearing a face mask with a shield and told staff they were following the Center's for Disease Control (CDC) guidelines. The Resident Representative said they just received another email saying there was another case of COVID-19. This case was a Certified Nurses' Aide (CNA), and they were concerned with how bad this could be for the residents. The families used to be able to do a drive-up visit with the residents, but one incident of COVID-19 for the staff canceled that. e. On 7/30/20 at 4:00 PM, the Administrator reported one Department Head tested positive for COVID-19. The person that was positive with COVID-19 was the Administrator. The test was completed on 7/13/20, and the results came back a week later. The Administrator reported not working for 14 days. f. On 8/3/20 at 9:15 AM, the Administrator denied remember coming to the facility on [DATE]. The Administrator said they would look and get back to the surveyor. The Administrator said she had symptoms a couple of days before but has allergies [REDACTED]. On the morning of 7/13/20, the Administrator reported calling their Physician, who suggested getting tested for COVID-19. The Administrator

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) said it was the worst on Sunday before she called the Physician. g. On 8/3/20 at 9:49 AM, the Administrator said the symptom onset date was 7/10/20 and tested on [DATE]. The results came back on 7/21/20. The Administrator reported they took a couple of extra days off work just to be safe. The Administrator said that if she had symptoms, she never would've come into work. The symptoms started late on 7/10/20 but unsure of the exact time. The Administrator said she could return to work on the 22nd but took extra time off. The Physician was extra cautious. The Administrator stated she came in on 7/22/20 for corporate meetings with the Nurse Consultant. Worked on 7/10/20 but just in the office area had much staff off, then worked from home until 7/27/20. The Corporate Office decides when the staff can return to work. Based on this, the Administrator could return on 7/21/20, not 7/20/20. h. During a follow-up interview on 8/3/20 at 10:29 AM, the Administrator reported the staff that attended the meeting on 7/22/20 was the Nurse Consultant and the DON, unsure if anyone else was in the meeting. The shortness of breath gone for quite a while, the only remaining symptoms were allergy symptoms. The Administrator reported knowing the difference between the COVID-19 signs and allergy symptoms, as they took allergy medications all the time. The Physician was just safe to allow them to rest. The Administrator said she only came in on 7/22/20 and no other time. On 7/22/20, she had no fever, but when everything started, she had a fever, but it didn't last that long. The fever was only in the first couple of days; she has everything recorded at home. The only reason the fever was known was because of taking temperatures and couldn't come in if the temperature was over 100 degrees Fahrenheit (F). The baseline testing for all staff and residents started around 6/11/20. i. On 8/3/20 at 11:12 AM, Staff C, CNA, reported seeing staff come into the facility showing symptoms. The person was coughing and hacking all over everyone. The person did not have a lot of personal protective equipment (PPE) and stayed up front most of the time. There were lots and lots of staff up there. j. On 8/3/20 at 11:30 AM, Staff F, CNA, stated to come to work screening was a do it yourself type thing with a sheet of paper. k. On 8/3/20 at 11:37 AM, the Social Worker said per the guidelines they could return to work on 8/7/20. Staff from the Corporate office said that even though the test was negative, she needed to remain out of work for the full ten days. The Social Worker stated the Administrator came into work with a cough. The Social Worker said the Administrator reported it was a cough, but it was just allergies [REDACTED]. The Social Worker said they were concerned that everyone should get tested as they were exposed to the Administrator. The Administrator was wearing a face shield and mask while in the building from approximately noon until 3:00 PM on 7/22/20. The Administrator did not leave the office or conference room that day. l. On 8/3/20 at 1:01 PM, Staff B reported no designated staff for the COVID-19 wing but stated that it would be nice. m. On 8/3/20 at 1:53 PM, the Administrator reported not being able to find the screening sheets from 7/10/20 through 7/12/20 but has messages out to staff, as three department heads were off work. To prevent losing the screening sheets, they were going to scan the papers into the computer and email them to the Corporate Nurse. n. On 8/3/20 at 3:11 PM, the Corporate Nurse reported not knowing the COVID wing needed to have dedicated staff and was surprised the boss missed that. o. On 8/3/20 4:10 PM, the Corporate Nurse stated the COVID-19 statement said when the staff was available. The Administrator reported that their symptoms improved on 7/22/20. p. On 8/4/20 at 8:45 AM, the Administrator reported still looking for the screening sheets dated 7/10/20 - 7/12/20 as the entire team was working that day. q. On 8/4/20 at 10:34 AM, Staff D reported being the nurse for the north (COVID-19 wing), east, and west halls. Staff D said an aide was sitting in the COVID-19 hall. Staff D stated there was no designated equipment for the COVID-19 wing. After using the supplies, Staff D said they placed them on a cart, cleaned the equipment with Sani-cloth plus wipes. r. On 8/4/20 at 10:49 AM, the Corporate Nurse said they expected each resident on the COVID-19 wing to have their own designated vital sign equipment. s. On 8/4/20 at 12:04 PM, the DON reported no staff planned to work the COVID-19 wing if a positive case occurred. The facility only had one staff member that agreed to work the floor, but they were currently in Wisconsin. The DON stated other staff said they would not work the COVID-19 wing due to other co-morbidities. t. On 8/4/20 at 1:40 PM, the Dietary Supervisor reported Staff H was new to the facility and still learning. u. On 8/4/20 at 4:34 PM, the Corporate Nurse said if there was anything not given to the surveyor, the facility was unable to find it. Record Review: a. The facility's undated supplied symptom tracker showed the Administrator's last date of contact with the facility was 7/10/20. The Administrator's date of illness onset was 7/10/20 of cough, headache, and shortness of breath. The ten-day post-onset date noted to be 7/20/20. Other health conditions documented as unknown. The Administrator tested on [DATE], with positive results on 7/21/20. b. The undated blank Staff Screening Log showed the staff needs to take their temp and answer the questions before their shift. If they have a temp of 100.0 F or greater, cough with shortness of breath, they couldn't work and must-see their Doctor. The staff must wear a mask and face shield when they are within six feet of a resident; this was not optional. The questions asked were the following. 1. Staff Name: All staff are required to wear a mask 2. Date 3. Take temp. For temp 100 degrees or greater, see the nurse. 4. Taken a cruise anywhere in the world in the last 14 days? Yes or no, if yes, you must isolate for 14 days from the last day of the cruise. 5. Live with someone who has symptoms of COVID-19 or tested positive for COVID-19? Yes or No. 6. Provided care for a patient with symptoms of COVID-19 or tested positive for COVID-19 without using PPE? Yes or No. 7. Had close contact (within six feet for more than two minutes) with a visibly sick person with respiratory symptoms (examples sneezing or coughing) or saying they are sick with a fever or respiratory symptoms? Yes or No. 8. Have you (or within the past seven days) cough with shortness of breath, pneumonia, or flu recently? Yes or No. 9. List any of the following symptoms you are currently having: Sore throat, headache, fever, chills, muscle pain, diarrhea, repeated shaking with chills, the new loss of taste or smell. If you have two or more symptoms, report to your supervisor immediately. 10. End of shift temp. For temp 100 degrees or greater, see the nurse. 11. Have you developed any symptoms listed in the previous screening questions today? Yes or No. If you answer yes, report to a nurse immediately. c.The COVID Visitor Screening Log dated 7/7/20 asked for the date, visitor's name, resident's name and the following 1. Have you been in contact with someone who had symptoms of COVID-19 or tested positive for COVID-19? Yes or no. 2. Do you currently have a new onset of cough, shortness of breath, sore throat, headache, fever, chills, muscle pain, diarrhea, repeated shaking with chills, a new loss of taste or smell? Yes or no. 3. Temp 4. In time 5. Out time d. On 7/22/20, the Administrator sent an email to the residents' representatives explaining a positive case of COVID-19 in the facility. The individual was receiving medical treatment and will remain in isolation per the CDC and Centers for Medicare and Medicaid Services (CMS) guidelines. e. On 7/22/20, the Administrator sent an email to the residents' representatives explaining that due to the increase of COVID-19 in the county, the vehicle visits would stop. f. On 7/28/20, the Administrator sent an email to the resident's representatives explaining there were now two positive cases of COVID-19. The individual was receiving medical treatment and will remain in isolation per the CDC and CMS guidelines. The email described the health and safety of their loved ones was their top priority. The facility was doing everything it could to stop the spread of COVID-19 within the facility and protect their loved ones. The facility would continue to screen all employees before the beginning of their shift; any employee with symptoms will not be allowed to work. g. On 7/22/20, the Staff Screening Log showed the Administrator screened into the facility with a temperature of 97.1 F. The question regarding current symptoms or within the last seven days had a cough with shortness of breath, pneumonia, or flu recently showed documentation of no. The end of shift temp was 99.3, with no newly developed symptoms listed in the previous screening questions as no. The Handwashing policy dated 3/15 explained that handwashing was mandated between resident or patient contact to prevent the spread of infection. Hands must be washed after the following, including but not limited to 1. Contact with blood or bodily fluids 2. Contact with contaminated items or surfaces 3. Contact with the resident or patient 4. Initiating a clean procedure 5. Removal of gloves The facility was notified of the immediate jeopardy on August 3, 2020 at 3:00 pm when the IJ template was provided to them. On August 3, 2020 the facility initiated proper door monitoring and staff education on screening, returning to work after having COVID-19 symptoms and proper wear and use of face masks. The Nurse Consultant educated the Administrator on the process for COVID-19 and returning to work with improved symptoms and without symptoms. On August 4, 2020 observations were made of staff still not wearing face masks correctly. The Director of Nurses identified those staff and provided additional coaching. The Immediate Jeopardy was abated on August 4, 2020.
F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	Based on record review and staff interview the facility failed to complete staff testing for Coronavirus (COVID-19) per direction of the Centers for Medicare & Medicaid Services (CMS). The facility reported a census of 25 residents. Findings Include: During Entrance Conference on 9/14/20 at 11:50 AM, the Administrator stated the facility did not have any residents or staff with positive COVID-19 or with any COVID-19 symptoms. The Administrator stated the facility was completing routine staff COVID-19 testing per CMS guidance. During interview on 9/14/20 at 12:30 PM, the Administrator stated the county positivity rate was 18.6% and as of 9/7/20, the facility were performing staff COVID-19 testing twice per week per CMS guidance. The Administrator stated the facility had a Point of Care (POC) machine to perform the COVID-19 testing at the facility. Review of the facility schedules revealed 42 staff had worked from 9/7/20 - 9/12/20, and only 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLEASANT ACRES CARE CENTER	**309 RAILROAD STREET HULL, IA 51239**

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

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F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) staff had completed the twice per week COVID-19 testing during that time. During interview on 9/14/20 at 2:06 PM, the Administrator confirmed a dietary aide was last tested for COVID-19 on 9/3/20. The Administrator stated the facility began twice per week testing on 9/7/20 and the dietary aide should have been tested more recently due to her last test being on 9/3/20. The Administrator stated she was unsure if there were adequate testing supplies. During interview on 9/15/20 at 9:25 AM, the Nurse Consultant stated the facility identified on 9/11/20, the facility staff had not been properly tested for COVID-19 and testing was being completed today. The Nurse Consultant stated there was not a concern with supplies, and corporate was keeping track in addition to the facility. During interview on 9/15/20 at 9:32 AM, the Director of Nursing (DON) stated all facility staff are tested for COVID-19 and currently to be tested twice per week. The DON stated she was not able to complete all the staff COVID-19 testing on her own. The DON stated the staff that were working on 9/11/20 and 9/13/20, were tested . The DON stated the Department Heads were to manage their departments and make sure their staff were getting tested . The DON stated the Nursing staff were aware they needed to be tested twice per week. The DON stated she did not know if there were enough supplies for twice per week testing, assumed others were managing the testing supplies. During interview on 9/15/20 at 9:45 AM, Staff A, Registered Nurse (RN) stated staff were to be tested for COVID-19 twice per week. The RN stated she was called the first week to come in and get tested , however, does not remember after that. The RN stated she does not recall the last time she was tested , possibly a week and a half ago. During interview on 9/15/20 at 11:20 AM, the Administrator confirmed there were numerous staff who had not been tested for COVID-19 and others that were only tested on e time. The Administrator stated she would expect all staff to have been tested for COVID-19 twice per week beginning the week of 9/7/20. The Administrator stated it was made clear that the expectation was all staff would be tested twice per week. The Administrator stated 4 nurses were trained to perform the COVID-19 POC testing. The Administrator stated she would have expected staff to be called to come in for testing or test prior to working.