STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANDVIEW HEIGHTS INC	**910 EAST OLIVE MARSHALLTOWN, IA 50158**

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 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, record/policy review, and staff interviews, the facility failed to to be in compliance with the Center for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility reported a census of 67 residents. Findings include: 1. During an observation on 6/17/20 at 11:15 AM, Staff B, Certified Nurse Aide (CNA) applied a lift sling around Resident #4. Staff C, CNA approached and assisted with applying the sling to the resident and both staff transferred the resident from a recliner to a wheelchair with the lift, noting both staff touching Resident #4 during the transfer. Immediately after, Staff B, CNA and Staff C, CNA applied the same lift sling to Resident #5 and transferred Resident #5 from a recliner to a wheelchair with the same lift. Both staff failed to wash their hands or apply alcohol based hand rub (ABHR) after contact with Resident #4 and before or after contact with Resident #5. The lift was not disinfected between the 2 residents as directed per the CDC COVID-19, Preparedness Checklist for Nursing Homes and other Long Term Care Settings, dated 3/26/20, to complete frequent cleaning of high-touch surfaces and shared resident care equipment. During an interview with Staff D, Certified Medication Aide (CMA), Staff D stated the policy directed staff to wash hands between residents and use sanitizer if not able to wash hands. Staff D stated the procedure with lifts was to sanitize the lift with ill residents before the lift leaves the room, not between every use, only if the lift is soiled or with a sick resident. Review of an undated facility document titled Standard Precautions, documented wash hands between patient contact. During an interview on 6/17/20 at 4:00 p.m., Staff A, Unit Manager stated her expectation for staff to sanitize hands before and after contact with a resident. Staff A stated also expectations for lift sanitation was to sanitize with isolation residents only. 2. During an observation on 6/17/20 at 11:15 AM, in an alcove at the beginning of hall 300, 5 residents were sitting/reclining in recliner chairs with the chairs positioned side by side, with 2 feet or less between chairs. Staff B, CNA and Staff C, CNA transferred two of five residents to wheelchairs and positioned the residents in wheelchairs side by side, within 1 foot, of another resident in a wheelchair, failing to follow the 6 foot social distancing rule. Also noted all of these residents were not wearing masks. 3. During an observation on 6/17/20 at 11:40 AM, 14 residents were observed in the dining room with 2 residents seated at each of 7 tables, with the residents facing across from each other. The dining room table tops measured less than 36 inches. No residents were observed wearing masks and no masks were visible on the tables. The facility failed to maintain the residents at a distance of 6 feet apart for social distancing requirements as referenced in the CMS Memo dated 4/24/20 which contained Frequently Asked Questions (FAQ's). The FAQ's addressed residents eating in a dining room area who are without signs or symptoms of a respiratory infection and without a confirmed [DIAGNOSES REDACTED]. During an observational walk about the facility on 6/17/20, in a 10 minute time span from 3:50 p.m. to 4:00 p.m., observed 14 residents in the halls and all 14 residents noted without facemasks on. During an interview with Staff A, Unit Manager, on 6/18/20 at 8:15 AM, the surveyor asked about policy of residents wearing facemasks outside their room, Staff A stated, Do you wear a facemask in your home, this is their home. 5. During an observation on 6/17/20 at 3:30 PM, Resident #6 observed in room [ROOM NUMBER], revealing no Personal Protective Equipment (PPE) supplies outside of the room and no precaution signs posted on or near the door of room [ROOM NUMBER]. Review of the facility CMS-802 form documented Resident #6 was admitted to the facility on [DATE], which would require a 14 day quarantine per CMS guidelines and proper signage immediately outside of the resident's room to indicate appropriate precautions and required PPE as directed per the CDC COVID-19, Preparedness Checklist for Nursing Homes and other Long Term Care Settings, dated 3/26/20. During the Entrance Conference interview with the Administrator (ADM) and Staff A, Unit Manager on 6/17/20 at 8:40 a.m., Staff A stated the facility currently with no residents in the quarantine/isolation area, which is the 300 hall. Staff A stated new admissions are placed in isolation if they have not received a negative COVID -19 test. Staff A also stated new admits with a COVID-19 negative test results, are not placed in quarantine, new admits with a pending results are only quarantined until results received, and new admits with no COVID-19 test results are quarantined for 14 days. During an interview on 6/17/20 at 4:00 p.m., Staff A confirmed Resident #6 admitted from the hospital on [DATE] and placed in the isolation area as the facility had not received the result from the resident's COVID-19 test completed at the hospital. Staff A stated once the facility received Resident #6's negative test results, the resident was moved from the isolation area. Review of the Iowa Department of Public Health Interim Guidance for New Admissions or Return of Residents to Long-Term Care Facilities dated 4/13/20 directs that all new admissions or returning residents, no matter the source, test result, or COVID-19 status, be isolated for a minimum of the first 14 days of their stay.
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 resident, family, and staff interviews, the facility failed to notify the residents, resident representatives, and/or family members of three confirmed COVID-19 staff member infections as required per the Center for Medicare & Medicaid Services (CMS) Memorandum (Memo) dated May 6, 2020 that included COVID-19 Reporting Requirements. The Memo presented the subject entitled Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes. The Memo explained what and how a facility completed the reporting process. The facility reported a census of 67 residents. Findings include: 1. A Minimum Data Set ((MDS) dated [DATE] for Resident #1, documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating no cognitive impairment. During an interview with Resident #1 on 6/17/2020 at 11:00 a.m., the resident stated she had not been informed of staff members testing positive to [MEDICAL CONDITION]. She had heard rumors regarding staff being tested but nothing had been confirmed. 2. During an interview with Resident #2's family member on 6/17/2020 at 10:50 a.m., the family member reported receiving a letter with information about COVID-19, the visitation restrictions, and the implementation of the Magic Window for seeing Resident #2. The family member stated he was not aware of any staff members being tested nor any staff were COVID positive. The staff made him aware of the screening process of residents and taking of temperature, being able to call at any time to talk about his family member and they will call him with any changes in Resident 2's status or condition. 3. During an interview with Resident 3's family member on 6/17/2020 at 10:35 a.m., stated she did get an initial letter from the facility explaining COVID-19 but nothing specific communicated either by a letter or by a phone call, to inform family members of staff members testing positive. The family member reported she receives a monthly newsletter and was unaware whether Resident #3 had ever been tested . 4. During an interview on 6/17/20 at 1:30 p.m., Staff A, Unit Manager/Co-Director of Nursing confirmed 3 staff members tested positive for COVID-19 on the following dates: one on 6/7/20, one on 6/12/20, and one on 6/15/20. 5. During an interview on 6/17/20 at 1:58 p.m., the Administrator (ADM) confirmed the facility failed to notify the residents/resident representatives or family members of any of the staff confirmed COVID-19 infections.

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.