STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. BUILDING _____ B. WING _____	**07/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROTARY SENIOR LIVING	**500 SOUTH BLAINE AVENUE EAGLE GROVE, IA 50533**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to immediately inform a resident's family of a significant change in the resident's condition requiring transfer to the hospital for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 32 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident depended on staff for activities of daily living (ADL's) including bed mobility, dressing, hygiene, and toilet use. The resident had [DIAGNOSES REDACTED]. The Care Plan revised 4/11/20, identified the resident preferred to participate in activities of interest to her. The interventions included her family member visited often and took outside when nice out. The Progress Notes dated 7/2/20 at 12:19 p.m. documented a late entry for 7/1/20 at 9 p.m Staff spoke with the physician by phone regarding the resident's worsening condition and received a verbal order to transport the resident by ambulance to the hospital for evaluation. The Admission Record showed the resident listed a family member as her emergency contact. The clinical record lacked documentation the facility notified the family member of the resident's worsening condition or transfer to the hospital. The Progress Notes dated 7/1/20 at 9:20 p.m. documented the resident left the facility via ambulance to the hospital. The resident had a temperature ranging from 101.5 to 103.2 degrees. The resident's respirations were 28 and labored. The Progress Notes dated 7/1/20 at 10:44 p.m. documented receipt of a call from the hospital for information, including information about a power of attorney or living will. The resident was non-responsive and unable to answer for self. The facility provided the family member's phone number. At 11 p.m. the facility received a call from the resident's family member apparently upset, with concerns about the resident's transfer. During an interview on 7/13/20 at 10:05 a.m. the resident's emergency contact stated the facility did not call him when they transferred the resident to the hospital. He received a call from the doctor in the emergency room with the resident because she was unconscious. During an interview on 7/13/20 at 12:05 p.m. the Director of Nursing (DON) stated the resident was her own responsible party but she did have a family member identified for emergency contact. At 1 p.m. the DON said staff should have notified the emergency contact of the transfer. An education sign in sheet documented a new policy regarding notification of families for all new orders or change in condition effective 4/18/20. All new orders must have same day notification of family, with no exceptions. If you get new orders on the day or evening shift you must call and notify the family ASAP. If you get no answer or leave a message you still chart to show attempts to contact family.
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 observation, record review, and staff interview the facility failed to assure appropriate infection control interventions for 3 of 4 residents reviewed (Resident #2, #3, and #4) and during random observations. The facility reported a census of 32 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with toilet use. The resident's [DIAGNOSES REDACTED]. The resident's comprehensive Care Plan revised 3/15/20 identified the risk of psychosocial well being concern related to medically imposed restrictions due to Covid-19. The interventions included educating staff, resident, family and visitors of Covid-19 signs, symptoms and precautions, and following the facility protocol for Covid-19 screening and precautions. During an observation on 7/13/20 at 11:28 a.m. Staff A, Certified Nursing Assistant (CNA) and Staff F, CNA assisted the resident with the sit to stand lift, changing an incontinent pad and pants, and incontinent care. Staff did not wear eye protection, and Staff A's mask did not cover her nose. The resident did not wear a mask. 2) According to the MDS assessment dated [DATE], Resident #3 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with toilet use. The resident's [DIAGNOSES REDACTED]. The resident's comprehensive Care Plan revised 3/15/20 identified the risk of psychosocial well being concern related to medically imposed restrictions due to Covid-19. The interventions included educating staff, resident, family and visitors of Covid-19 signs, symptoms and precautions, and following the facility protocol for Covid-19 screening and precautions. During an observation on 7/13/20 at 11:45 a.m. Staff A and Staff E, CNA provided care for the resident. Both staff wore a mask, but Staff A did not have her nose covered, Staff did not wear eye protection, and the resident did not wear a mask. While wearing gloves Staff A scratched her head, moved the bed, took the resident's left hearing aide out, and touched her facemask multiple times, then performed incontinent care wearing the same gloves. 3) According to the MDS assessment dated [DATE], Resident #4 scored 12 on the BIMS indicating some cognitive impairment. The resident required extensive assistance with toilet use. The resident's [DIAGNOSES REDACTED]. The resident's comprehensive care plan Care Plan revised 3/15/20 identified the risk of psychosocial well being concern related to medically imposed restrictions due to Covid-19. The interventions included educating staff, resident, family and visitors of Covid-19 signs, symptoms and precautions, and following the facility protocol for Covid-19 screening and precautions. During an observation on 7/13/20 at 11:35 a.m. Staff A and Staff E assisted the resident to bed with the total mechanical lift and placed her on a bedpan. Staff wore masks, but no eye protection. The resident did not wear a mask. Random observations on 7/13/20: a. At 11 a.m. Staff A walked through the common area wearing a mask that did not cover her nose, and no eye protection. Staff A repositioned a resident in a chair. b. At 11:08 a.m. Staff A and Staff B, CNA wearing masks, but no eye protection, applied a gait belt on a resident in the common area, assisted him to stand and into his wheelchair, at times within inches of resident (not wearing a mask). Staff wheeled the resident to the bathroom and Staff A pulled her mask down. c. At 11:12 a.m. Staff C, Licensed Practical Nurse (LPN) assisted a resident (not wearing mask) reposition. Staff C wore a mask and glasses but no eye protection. Staff C had goggles on top of her head. d. At 11:18 a.m. Staff D, Certified Medication Aide (CMA) walked out of the kitchen with her mask hanging off an ear and sat a container with juice and applesauce on the med cart. At 11:20 a.m. Staff D came out of the kitchen again with the mask not covering her mouth or nose and walked by a resident (with no mask on) to the nurses's station, then the med cart. She did not cover her mouth or nose and apply goggles until she entered a resident room. During an interview on 7/13/20 at 12:05 p.m. the Director of Nursing stated staff were to wear goggles with all resident care/interactions. An April 6th education documented all staff from all departments in contact with residents must wear eye protection while having interaction with the residents, in addition to wearing a mask with all interaction. A facility Visitation and Infection Control Police updated to address the Coronavirus Disease 2019 (Covid-19) documented healthcare personnel (HCP) were on the front line of caring for patients. HCP's could minimize their risk of exposure by following CDC infection prevention and control guidelines, including use of recommended personal protective equipment (PPE). Employees were educated and reminded to clean their hands according to CDC guidelines. The Iowa Department of Public Health 4/1/20 recommended healthcare

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) workers providing patient care in long term care facilities should use a minimum level of personal protective equipment (PPE) for all patient care activities. These healthcare workers should use a face mask and eye protection for all patient encounters. The CDC Strategies for Optimizing the Supply of Facemasks revised 6/28/20 documented the extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters. HCP should take care not to touch their facemask. If touched or adjusted they must immediately perform hand hygiene.