STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165313	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKWOOD SPECIALTY CARE	200 16TH AVENUE EAST ALBIA, IA 52531

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 -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement CMS and CDC recommended infection control practices in order to control and prevent the potential spread of COVID-19 amongst residents and staff. The facility allowed staff to work and provide care to residents after reporting signs and symptoms of COVID-19, who later tested positive for COVID-19. Furthermore, the facility failed to ensure staff providing care to residents and working in COVID-19 positive resident areas wore appropriate personal protective equipment (PPE) when entering the unit. These facility staff cared for residents who tested positive for COVID-19, and then assisted with the care of other residents in the facility. The facility failed to thoroughly investigate an outbreak of COVID-19, in which 30 residents contracted the disease, and six expired. Additionally, the facility failed to ensure that all staff were thoroughly screened before beginning their scheduled shifts. A determination was made that the facility's noncompliance with one or more requirements of participation placed all residents in the facility in immediate jeopardy. On [DATE] at 2:15pm, the Administrator was notified of the immediate jeopardy at F880, Infection Prevention and Control. It was determined that the immediate jeopardy began on [DATE]. The immediate jeopardy was removed on [DATE] after the surveyor verified implementation of a removal plan. The scope and severity was lowered to an F. Findings include: - Review of resident (R1's) admission history and census, located in R1's electronic health record, documented that R1 admitted to the facility on [DATE], to room C-29. Review of R2's admission history and census, located in R2's electronic health record, documented that at the time R1 admitted to the facility, R2 resided in room C-25, on the same hall. Review of an interdisciplinary team (IDT) note, dated [DATE], documented that R2 enjoys walking/wandering around the facility with walker. checks each and every door (thinks it is his job to take care of everyone, makes sure they are ok.) On [DATE] at 8:50am, the Administrator indicated that the facility experienced an outbreak of COVID-19. The Administrator indicated that the facility accepted R1 who tested negative while in the hospital, but that 12 days following her admission to the facility, the resident developed symptoms of COVID-19 and subsequently tested positive. The Administrator indicated that the facility also housed R2, who wandered, and that the facility believed this wandering resident may have gotten into biohazardous materials from the COVID-19 positive resident, and that was how the disease spread throughout the facility. The Administrator indicated that approximately 30 residents became ill, and that six died during the outbreak. The Administrator indicated that two residents who developed COVID-19 remained on the isolation unit, but that [DATE] was the day they both were expected to leave the isolation unit. When asked for a summary of the outbreak, the Administrator indicated that the facility failed to complete an investigation into the outbreak, and that a summary of the incident had not been completed. On [DATE] at 9:00am, Nurse Aide (NA1) indicated that the facility experienced an outbreak of COVID-19 after newly admitted R1 developed symptoms of the disease and tested positive. NA1 indicated that R1 experienced a nagging cough, which staff didn't notice the first couple of days R1 was at the facility. R1 then developed a fever, and was tested . NA1 indicated that R2 regularly wandered throughout the facility, and was difficult to redirect. NA1 indicated that R2 tested positive for COVID-19, and that keeping him on the isolation unit was difficult, and at times R2 would leave the isolation unit and access other areas of the facility. NA1 indicated that after the outbreak began, she developed shortness of breath, reported the symptom on the employee screening logs, but was allowed to continue working. NA1 indicated that she collapsed at work and required emergency transportation to the hospital, where she tested positive for COVID-19. On [DATE] at 10:10am, R2 sat in a wheelchair on the isolation unit. NA2 and another staff person, both wearing facemasks and face shields, entered the unit. The staff failed to don any further PPE prior to entering the unit. The staff approached R2 and stopped to speak with him, each standing within six feet of R2. The staff then walked down the hall and stopped in front of the other isolated resident's room, and then donned isolation gowns and disposable gloves. After approximately five minutes, the staff exited the room and removed their isolation gowns and gloves in front of the door in the hallway, disposing of the supplies in a bin. They then walked down the hallway and exited the isolation unit. On [DATE] at 10:17am, NA2 indicated that she was on what the facility called the COVID corner, where residents who tested positive for COVID-19 resided. NA2 indicated that staff did not have to don full PPE, consisting of isolation gowns, face masks, gloves, and eye protection, prior to entering the isolation unit. NA2 indicated that the PPE was donned only when entering the individual resident rooms. NA2 then indicated that the isolation unit had no dedicated staff to care for the two residents housed there, and that the staff would go assist other residents throughout the facility with cares. NA2 indicated that the outbreak of COVID-19 began after R1 was admitted and then became symptomatic. NA2 indicated that R2 wandered throughout the facility, and was difficult to keep in his room. R2 also would enter other resident rooms and go through other resident's belongings. NA2 indicated that R2 later developed signs and symptoms of COVID-19, and tested positive. On [DATE] at 11:54am, facility staff exited a resident room on the isolation unit. The staff person was wearing an isolation gown, disposable gloves, a face mask, and eye protection. The staff member removed the isolation gown and gloves while standing in the hallway at the entrance to the resident room, then walked the length of the hallway to the double doors leading off of the unit. The staff person then asked another staff person for assistance. Both of the staff then reentered the unit and walked down the hallway to the resident room, failing to don the appropriate PPE prior to entering the isolation unit. On [DATE] at 1:29pm, Licensed Practical Nurse (LPN1) indicated that the facility had an outbreak of COVID-19. R1 admitted from a nearby hospital, where she initially was negative. After admission, R1 developed a cough, was tested , and shown to be positive. R2, who liked to get up and wander, and had a history of [REDACTED]. On [DATE] at 2:30pm, the Administrator indicated that because the residents last day on the isolation unit was to be [DATE], facility staff would not be expected to don full PPE prior to entering the isolation unit. - Review of the facility's Prevent COVID-19 screening logs documented the following: On [DATE], a facility staff person documented that they recently traveled outside of Iowa, lived with someone with symptoms or a positive test, provided care to a patient with COVID-19, and had close contact to someone with respiratory symptoms. The staff person documented a normal body temperature. The staffing sheet for [DATE] documented that the staff person was present that day. This staff person later tested positive for COVID-19. On [DATE], two facility staff people had temperatures logged, but failed to answer any screening questions. One of these staff later tested positive for COVID-19. On [DATE], a staff person reported having a new onset of coughing. Review of the staffing sheet for [DATE] documented the staff person was present that day. This staff person later tested positive for COVID-19. On [DATE], a staff person reported a new onset of coughing. The log documented that the staff person was allowed to begin working. This staff person later tested positive for COVID-19. On [DATE], a staff person documented a temperature of 99.1F, and failed to answer any screening questions. This staff person later tested positive for COVID-19. On [DATE], a staff person documented a temperature of 99.1F at the beginning of their shift, then left the facility, documenting an exit temperature of 99.6F. When the staff person returned to the facility, they documented an increased temperature of 99.7F. This staff person later tested positive for COVID-19. On [DATE] at 1:00pm, during a confidential interview, a facility staff person indicated that they had answered yes to some of the screening questions on the aforementioned dates. The staff person indicated that the facility allowed them to work

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) and did not question them about why the questions were answered yes. On [DATE] at 1:29pm, LPN1 indicated that a staff person had collapsed at work following the onset of the outbreak, and later tested positive as well. LPN1 indicated that she had also answered yes to some of the screening questions on the forms, but that no administration ever came to screen her further, and that she was allowed to work. On [DATE] at 2:13pm, the Administrator indicated that the expectation of staff would be to answer all screening questions, and if the answer to any screening questions was 'yes,' the staff person would not be allowed to work.