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 _____	07/30/2020

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 -** 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, record review, staff interviews, and policy review the facility failed to prevent the risk for serious harm, transmission and infecting residents related to failure to separate COVID-19 positive and negative residents for 4 of 64 residents reviewed (Residents #6, #7, #8 and #9) and failed to implement complete and consistent screening of employees. The facility reported as of 7/28/20 that 47 out of 64 residents COVID-19 positive. The facility reported a census of 64 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #6 dated 5/13/20, included [DIAGNOSES REDACTED]. The assessment identified the resident with a Brief Interview for Mental Status (BIMS) score of 99, indicating unable to evaluate cognitive status. Review of Resident #6's Care Plan revised 7/16/20, revealed Resident #6 COVID- 19 positive. The Minimum Data Set (MDS) assessment for Resident #7 dated 6/10/20, included [DIAGNOSES REDACTED]. The assessment identified the resident with a BIMS score of 5, indicating severe cognitive impairment. Review of Resident #7's Care Plan revised 7/23/20, documented Resident #7 was COVID-19 positive. Observation on 7/22/20 at 1:00 p.m., revealed Resident #6 and Resident #7 residing together in room [ROOM NUMBER]. Review of Resident #7's Nursing Progress Notes documented: a. 7/17/20 at 8:13 a.m., resident with negative COVID results from 7/13/20. b. 7/23/20 at 9:54 a.m., family member aware of resident's positive COVID result. c. 7/23/20 at 7:02 p.m., physician's orders [REDACTED]. New order received to send resident to emergency room (ER) due to worsening condition and evaluation. d. 7/23/20 at 10:56 p.m., call placed to hospital for update on resident's condition. Resident's chest x-ray and tests reveal the resident diagnosed as COVID-19 positive, having pneumonia, as well as a urinary tract infection [MEDICAL CONDITION]. The resident's temperature at ER reached 104.0 Fahrenheit. Nurse reports resident's family wanted the resident sent to a hospital Intensive Care Unit (ICU) for further treatment. The Minimum Data Set (MDS) assessment For Resident #8 dated 7/20/20, included [DIAGNOSES REDACTED]. The assessment indicated the resident with a BIMS score of 5, indicating severe cognitive impairment. Review of Resident #8's Care Plan revised 7/16/20, revealed Resident #8 COVID- 19 positive. The Minimum Data Set (MDS) assessment For Resident #9 dated 6/14/20, included [DIAGNOSES REDACTED]. The assessment identified the resident had a BIMS score of 13, indicating no cognitive impairment. Review of Resident #9's Nursing Progress Note dated 7/23/20 at 11:29 a.m., documented family aware of resident's negative COVID result. Observation on 7/22/20 at 10:00 a.m., revealed Resident #8 and Resident #9 residing together in room [ROOM NUMBER]. During an interview on 7/22/20 at 12:45 p.m., Staff E, Director of Nursing (DON) confirmed Resident #6 was COVID-19 positive and Resident #7 was COVID-19 negative, residing together in room [ROOM NUMBER]. Staff E, DON also confirmed Resident #8 was COVID-19 positive and Resident #9 was COVID-19 negative, residing together in room [ROOM NUMBER]. Staff E, stated the plan was to move them but confirmed residents had not been separated. The facility failed to cohort or isolate COVID positive and COVID negative residents to reduce the risk of transmission of COVID-19 amongst residents. 2. During an interview on 7/22/20 at 10:08 a.m., Staff A, Certified Medication Aide (CMA) stated the following process for staff screening when entering the facility to work: take their own temperature, use hand sanitizer, ring the doorbell to get in, and hit confirm button on the time clock. During an interview on 7/27/20 at 9:00 a.m., Staff B, Certified Nurse Aide (CNA) stated the following process for staff screening when entering the facility to work: take your temperature, answer the questions on the time clock, and if the answer is yes then have to call a supervisor. Staff B, CNA stated she was falsifying the answers on the time clock questions as she had been exposed to COVID-19 in the building. During an interview on 7/27/20 at 9:55 a.m., Staff C, Licensed Practical Nurse (LPN) stated the following process for staff screening when entering the facility to work: answer questions on the time clock and take her own temperature. Staff C, LPN, stated the process switched to staff checking the documented temperature of the staff before you with the memory on the thermometer. Staff C, LPN stated around 1:30 p.m. on an unknown date, Staff G, CMA reported to Staff C, LPN that she had upper respiratory symptoms and a cough, but no temperature throughout the shift. Staff G, CMA also reported to Staff C, LPN the same symptoms were reported to a nurse at the beginning of her shift and the nurse told Staff G, she was fine to work. Staff C, LPN stated she questioned Staff G regarding the need to go home and Staff G stated she felt okay. Staff C did not report Staff G's symptoms to her supervisor, did not send Staff G home, and reported was unaware if Staff G completed her shift. During an interview on 7/23/20 at 2:50 p.m , Staff G, CMA reported working the whole shift on 7/3/20 with a dry cough, body aches, not feeling well and no temperature throughout the shift. Staff G stated symptoms were reported to Staff C, LPN. Staff G, also reported she tested COVID 19 positive on 7/9/20. During an interview on 7/27/20 at 1:16 p.m., Staff D, Registered Nurse, (RN) stated the following process for staff screening when entering the facility to work: questions on the time clock are answered and take own temperature. If staff temperature was 100.3 or above then the staff had to go home. If staff answered yes on the time clock, the staff had to be seen by a supervisor. Staff D, RN stated she had not screened any staff members due to the time clock questions. Staff D, reported she allowed Staff B, CNA to work an entire shift on an unknown date with knowledge of Staff B having symptoms of a cough, dizziness, and overall not feeling well. Staff D, RN stated Staff B did not have a fever and stated guidance from Administration was staff can work if have no fever. Staff D, RN was unable to verify direct guidance from a supervisor. Staff D explained Staff B's symptoms were not reported to a supervisor. In review of eighteen pages of untitled documents dated 7/21/20 - 7/28/20, noted staff names and temperatures documented only 238 of 660 entries of staff temperatures documented checked or initialed by staff as verified. The facility failed to follow facility policy and procedure. Review of an undated facility policy titled, Covid-19 Screening Policy and Procedure stated the following: a. Staff will self-screen and verify temperatures. b. Take your temperature and write your name and temperature in the self-temperature book. c. The previous staff member will verify the temperature from the memory of the thermometer and initial next to the temperature. d. Answer the questions on the time clock. If you answer yes to any of the questions, a nurse will come to the door to assess the staff member prior to clocking in and entering the building. The nurse will then determine if the staff member may enter the building or be advised to go home. In review of facility's documents titled COVID-19 Employee Time clock Responses the following noted: a. 36 sheets dated 7/1/20 - 7/7/20. b. 37 sheets dated 7/8/20 - 7/15/20. c. 5 sheets dated 7/25/20 - 7/26/20. The facility failed to have all signs and symptoms of COVID-19 in the staff screening process per Centers for Disease Control and Prevention (CDC) guidelines dated 5/13/20 to include: a. Screen all health care personnel at the beginning of their shift for fever and symptoms of COVID-19. b. Actively take their temperature and document absence of symptoms consistent with COVID-19. c. Assess for fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. d. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. e. If health care personnel develop fever (100.0 F) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace. During an interview on 7/30/20 at 10:05 a.m, Staff E, DON, stated, Prior to our Immediate Jeopardy (IJ), staff would enter the front door, take their own temperature, and write it down on the flowsheet (on the table). The next staff to follow staff in would check the memory on the thermometer, circle and initial the employee entry before them. Obviously, that wasn't getting done 100% of the time but my expectations were that

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 -** Some	(continued... from page 1) staff were doing this as directed. The incident detailed above resulted in determination of Immediate Jeopardy for the facility and notified of such on 7/28/20 at 5:00 p.m The Facility Staff abated the Immediate Jeopardy situation on 7/29/20 through the following actions: a. One COVID-19 positive resident cohorting with a COVID-19 negative resident moved to a private room on the isolation hall in room [ROOM NUMBER]. The other two COVID-19 positive and negative residents that were cohorting are no longer in the same room as the COVID-19 negative resident transferred to the hospital with a COVID-19 positive diagnosis. b. All staff notified on 7/29/20, via a mass text message, thru the facilities Smart Link system, of the change of policy regarding screening of staff upon entrance for a complete list of COVID-19 signs and symptoms and the requirement for a nurse to take all staff temperatures. Based on the results of the corrective measures taken by the facility lowered the scope and severity of the deficiency from a K level to an E level.