STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165426	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL VALLEY REHABILITATION AND NURSING AT PERRY,	**2625 IOWA STREET PERRY, IA 50220**

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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, physician and staff interview, the facility failed provide a safe and orderly discharge for one resident who left the facility against medical advice (AMA) for 1 of 6 residents reviewed (#6). The facility failed to provide discharge instructions for medications (including insulin) or a newly amputated leg to the resident or family member that picked him up from the facility. They did not inquire or ensure that he had medications or supplies needed upon discharge. The record also did not contain information regarding the resident leaving AMA. The facility check on the resident's status until 4 months after he left. The facility reported a census of 24 residents. Findings include: A Minimum Data Set (MDS) for Resident #6 with a completion date of 3/13/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a Brief Interview of Mental Status (BIMS) of 10, moderate cognitive impairment. The MDS documented the resident as independent with bed mobility and personal hygiene, and required limited assist of one staff for transfers, dressing, and toileting. Baseline Care Plan: A Care plan problem with initiation date of 3/6/20, identified skin concerns due to an incision wound from right below knee amputation. Intervention: every day cleanse with soap and water, wrap with gauze and then ace wrap. A Care Plan problem with initiation date of 3/6/20, identified safety concerns due to history of falls. A care plan problem with initiation date of 3/6/20, identified activities of daily living with resident requiring assist with transfers, toileting, grooming/hygiene, and bathing, and use of wheelchair. A Care plan problem with initiation date of 3/6/20, identified medications resident taking to be insulin, anticoagulant (blood thinner), and antibiotic. Review of Nurses Notes: 3/6/20 at 11:00 AM, the resident admitted to the facility after hospitalization for right [MEDICAL CONDITION]. Resident identified as alert and orientated to person, place and time. 3/6/20 at 11:55 AM, the resident signed out to go with his friend to his apartment and returned at 1:30 PM 3/6/20 at 2:45 PM, signed out to leave with friend and returned at 5:30 PM 3/8/20 no time listed, washed and redressed wound, still red and inflamed 3/8/20 no time listed, memory fine and does not make the best choices 3/10/20 2:00 PM -10:00 PM, amputation dressing done twice due to falling off. The resident is able to dress the top half and requires assist with bottom half. 3/10/20 at 10:00 PM - 6:00 AM, stump re-wrapped due to bumping while out with family. No bleeding or sign & symptoms of infection. 3/16/20 no time listed, received fax from doctor noting residents fall 3/16/20 at 10:00 AM, resident left the facility 3/16/20 at 12 noon, rewrapped wound and talked with resident about new rules Review of Social Services Progress notes: 3/12/20 no time listed, advised the resident that he can not receive visitors or leave the building except for necessary doctor appointments. The resident does not think this is fair. 3/13/20 no time listed, after speaking with Corporate, the facility notified the resident that he may leave the building, though it is against recommendations and puts others at risk. 3/16/20 no time listed, due to further concerns with the Coronavirus, informed the resident if he continues to leave the building to go out to eat and shop he will need to eat meals and conduct other activities in his room to keep others safe. The resident voiced that he understood and that he would remain in the facility. Shortly thereafter, the resident told the charge nurse he was leaving the facility AMA (against medical advice). Nurses notes and social service progress notes failed to show documentation regarding the time the resident left the facility AMA, or that he received instruction on his medications and/or treatments to the amputation incision site, or return of medications to pharmacy. Document titled Discharge against Medical Advice signed on 3/16/20; by the resident, Administrator, and DON stated: resident informed that leaving the facility is against medical advice and that he acknowledged that he received information of the possible consequences of his actions. By signing the form, the resident absolved the facility and the residents' primary care provider of all responsibility for any adverse consequence that he might suffer as a result of his discharge against medical advice. Document titled Protocol for AMA discharge date d 8/30/19: Interdisciplinary team will meet with resident if able to coordinate prior to resident leaving the facility Determine if the resident is able to make decisions independently (BIMS over 12) to leave AMA. If there is not a family member/legal guardian or POA requesting the discharge. Notify primary medical provider of AMA discharge, notify family or emergency contact if the resident does not leave with guardian or has an appointed contact person and document who was spoken to in the resident chart. Private pay and Medicaid resident's medications are returned to them on discharge other than controlled substances which will be disposed of per facility protocol. Medications paid for by Medicare are returned to the pharmacy for refund or charges. Educate resident and family of risks when leaving the facility AMA Encourage resident, family to sign the AMA paperwork at the facility If facility feels the resident is a risk to themselves upon discharge the facility will notify Department of Human Services for welfare check Document the AMA discharge in the resident chart Put resident name on the monthly Ombudsman transfer/discharge notification list. On 7/27/20 at 2:58 PM, the Administrator stated the resident was unhappy with the facility due to the COVID 19 restrictions of having to be on 14 day isolation if he went out, so he left. On 7/27/20 at 3:00 PM, the Interim Administrator/Social worker (SW) stated the resident left the facility with his cousin with whom he previously lived with and he had a safe place to go where family would be with him. On 7/27/20 at 4:09 PM, the Director of Nursing (DON) stated she was unsure if there was a recapitulation of stay documented, as the resident left the facility AMA. The DON stated she would have to review the residents chart for documentation regarding when the resident left and medications reviewed. The DON stated she did not believe there was a policy for discharging residents. On 7/27/20 at 4:35 PM, the residents Primary Care Provider (PCP) stated the resident had a fresh amputation and needed to stay at the facility. The PCP stated when the facility called him, he stated if the resident left the facility it would be AMA. The PCP stated the resident is very non-compliant and does not follow directions. The PCP stated the resident terminated from his clinic prior to admission to the facility, due to non-compliance, however, he agreed to act as the residents PCP while at the facility. The PCP stated the resident was seen in the emergency room (ER), possibly twice after leaving the facility AMA; where he saw him one of those times. The PCP stated when he saw him in the ER it was due to issues with his amputation site, however, the resident requested to be shipped out to another facility and when that did not occur he left the ER. On 7/28/20 at 8:54 AM, the DON and the Interim Administrator/SW stated they was unaware if Department of Inspections and Appeals or Ombudsmen received notification of resident leaving the facility AMA. On 7/28/20 at 11:39 AM, the DON stated she spoke with the resident about leaving the facility AMA and that if he left they would be unable to assist him. The DON stated she spoke with him while the Charge Nurse changed his dressing in his room. The DON stated the resident stated he would stay and then the resident's cousin showed up at the front door of the facility and the resident came out of his room and said he was leaving. The DON stated she can't believe she did not document on resident leaving the facility, however, stated she barely had time to get the resident to sign the AMA document. On 7/28/20 at 11:45 AM, the Nurse Consultant stated if the facility felt the

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident was unsafe they would have notified Protective services, however, the resident left with his cousin to stay with him. On 7/28/20 at 4:02 PM, the residents' PCP stated he did not know if the resident was safe leaving the facility with his cousin, as he did not know anything about the cousin. The PCP stated from his stand point the resident should not have left the facility, however, he couldn't be stopped. On 7/28/20 at 4:40 PM, the resident stated when he left the facility, he walked out. The resident stated the facility did not review his medications, care of his incision, or discuss the risks or consequences of leaving. The resident stated the facility staff only helped him carry out his belongings. The resident stated he was able to contact his PCP, from previously (prior to admit to the facility on [DATE]) and get his medications. The resident stated he felt like the facility left him to take care of things on his own. The resident stated he was able to get his insulin, as he takes it four times a day (15 units three times day and 40 units at bedtime). The resident stated he had been in the hospital again since he left the facility, however, is now living alone in a trailer in a different town, and getting along good. The resident stated the facility called him just last week to see how he was getting along. 7/28/20 at 5:10 PM, Staff A Registered Nurse (RN) confirmed she worked the day the resident left the facility AMA. Staff A stated the resident was upset that he was no longer able to come and go from the facility unless he went into 14 day quarantine. Staff A stated initially the resident said he was leaving and then he stated he had to discuss it with his friend, so the resident did not leave right away. The RN stated she changed the residents dressing to his incision around noon, however, was unsure of what time the resident left the facility AMA. The RN stated she would have charted in the residents chart when he decided to leave, however, she was unsure of what time he actually left. The RN stated she may not have charted thinking the DON was going to chart when the resident left. On 7/29/20 at 10:45 AM, the Nurse Consultant stated the facility did not follow up with the resident after he left the facility AMA, The Nurse Consultant stated there is no requirement that the facility needs to follow up. The Nurse Consultant stated if the facility felt the resident was unsafe, they would have notified Department of Human Services. The Nurse Consultant stated the resident left with his family and there was no concern with his safety. On 7/29/20 at 10:45 AM, the DON stated she remembered talking with the resident about leaving the facility while the charge nurse was changing the residents dressing. The DON stated the resident was concerned about his [AGE] year old daughter not understanding him having to stay at this facility without being able to go out. The DON stated she was unable to find any supporting documentation by her of when the conversation occurred and when the resident left the facility AMA. The DON stated she discussed with the resident is diabetes, insulin, and his incision. The DON stated she was sure she had convinced him to stay and within 20 minutes his cousin showed up and he came out to say he was leaving.
F 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy, and interviews the facility failed to allow a resident to return to the facility following acute hospitalization and involuntarily discharged the resident without proper notification for 1 of 6 residents reviewed (#5). The facility reported a census of 24 residents. Findings include: A Minimum Data Set (MDS) for Resident #5 with a completion date of [DATE], documented the resident discharged the facility on [DATE] to an acute care hospital with return anticipated. Listed [DIAGNOSES REDACTED]. The resident's payer source was private pay. Care Plan: A Care plan problem with initiation date of [DATE], identified the resident as having pain related to [MEDICAL CONDITION] arthritis and receiving routine pain medications. The resident will frequently verbalized she needed more medications, opioid (pain reliever) dependence, history of over sedation, and history of headaches. Interventions included: medications as ordered, medicate with caution due to history of opioid dependence, document complaints of pain, contact the residents Pain clinic for medications as needed, and document effectiveness of pain medications. A Care plan problem with initiation date of [DATE], identified the resident at risk for side effects related to the resident receiving antipsychotic (a class of medication used to manage delusion, hallucinations, paranoia, and [MEDICAL CONDITION]), antidepressant (used to treat depression), and antianxiety (used to treat anxiety) medications. The resident had a history of [REDACTED]. Interventions included: medications are ordered and notify physician if side effects noted to medications. A Care plan problem with initiation date of [DATE], identified the resident with a history of mental health issues related to [DIAGNOSES REDACTED]. The resident complained of feeling anxious at all times, becomes irritated easily, and rude to staff and others. The resident was attention seeking and wanted her requests met immediately. The resident would frequently express the need for additional pain, antianxiety, and antipsychotic medications. Interventions included: medications as ordered, provide reassurance and support when irritated or anxious, allow the resident to vent feelings and emotions, take times to listen and establish trusting relationship, encourage diversional activities (lap top, watching television, and visiting), encourage the resident to take deep breaths to calm when she is anxious and overwhelmed, observe and report changes in mood/behavior, when the resident becomes irritated/rude she feels she is being ignored or not getting enough attention, include her in conversations and promote socialization, provide mental health services, acknowledge the residents current situation, encourage the resident to verbalize concerns and fears, clarify misconceptions, and explore with the resident past effective/in-effective coping mechanisms. Review of Nurses notes: [DATE] at 3:15 PM, residents oxygen saturation was 87% (O2 sat, level of oxygen in the blood with normal being ,[DATE]%), lung sounds revealed crackles, blood pressure ,[DATE], pulse 83, temperature 98.4 degrees Fahrenheit, respirations 18. Doctor on call notified and order received to initiate oxygen and transport the resident to the hospital. [DATE] at 4:20 PM, the resident left the facility with Emergency Medical Services (EMS) and 2 male attendants to take to the emergency room . [DATE] at 3:30 PM, late entry, after oxygen in place for half hour, O2 sat was at 92% and the resident felt concerned about issues with breathing. [DATE] at 4:00 AM, the resident remains in ER at the hospital and the residents' primary care provider (PCP) updated. [DATE] no time listed, the resident admitted to the hospital. The resident tested negative for COVID 19 and received treatment for [REDACTED]. The residents' belongings packed up and placed in storage. Nurses notes contained no documentation of follow up with the resident, the residents representative (Guardian), or with the hospital after the resident admitted to the hospital on [DATE]. Social Service progress notes failed to provide documentation of follow up with the resident, the residents' representative, or with the hospital after the resident admitted to the hospital on [DATE]. Behavior Sheets dated [DATE], for the month of [DATE]; included behaviors, interventions, outcome, and side effects. Behaviors being documented included: Refusal of cares - occurred during the day shift and night shift with the intervention of re-approach, educate, redirect, and one to one being provided. The intervention outcome varied from no change to worse. Medication seeking - occurred throughout the day with the interventions of re-direct, one to one, and education being provided. The intervention outcome varied from no change to worse. Rude to staff - occurred during the night shift with the intervention of re-direct and one to one with an outcome of no change to worse. [MEDICAL CONDITION] - not documentation on behavior sheet of occurrence Demanding - occurred during the evening and night shift with the interventions of redirect and one to one. The intervention outcomes were effective one time, otherwise no change. Attention seeking - occurred throughout the day with the interventions of redirect and one to one, with no change in behavior. False allegations - occurred 3 times during the month of May, one time on each shift. Interventions included redirect and one to one, with behavior being unchanged. Review of document titled Instructions for Bed Hold Notice undated, instructed: Use enclosed forms when any resident is out of the facility overnight. This means for hospitalization , visit with family or any other situation where the resident will return to the facility by/at midnight. Use for private pay and Medicare (treated same way as private pay) and for those on Medicaid and Hospice. If either the resident capable or the resident representative is present, have them complete and sign second sheet. The original is kept in the facility and copy made for the resident or resident representative if one is requested. If the resident is not capable of completing the form and the resident representative is not present, notify either the business office manager or the administrator that the resident was or will be out overnight, and they will send out the second page to be completed and returned. Review of document titled Bed Hold Notice dated [DATE]: Residents who stay is paid by Medicaid will be offered a bed hold benefit at no cost, which will reserve the room upon hospitalization for a maximum of ten (10) days in a calendar month. Should these days expire, and hospitalization is still required, resident or representative may choose to request that Pearl Valley Rehabilitation and Nursing extend the bed hold beyond 10 days to reserve the bed. However, to hold the bed after the 10 day period, resident/representative uses their own income to pay for the bed hold. If resident does not hold the bed following the bed hold benefit (hospitalization , therapeutic leave, or vacation), and resident wishes to return to the facility, resident

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F 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) can return to the facility to previous room, if available, or immediately upon the first availability of a bed in a semi-private room: 1. Require the services provided by the facility; and 2. Are eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. Medicare insurance does not offer bed hold coverage. Therefore, Medicare and Private Pay residents may choose to hold the room at the current room and board rates until the residents return to the facility. Residents receive this letter because of admission to the hospital. According to Pearl Valley Rehabilitation and Nursing's bed hold policy, verification of room reservation must be made within a 24-hour period from the time the resident is admitted to the hospital, or bed will be relinquished. Bed hold fees are due prior to return to the facility. If resident/representative has any questions, please feel free to contact facility. The residents' guardian signed the Bed Hold Notice, requesting the bed to be held on [DATE]. Review of document titled Iowa Ombudsman (public advocate in charge of representing the interests of residents in Long Term Care facilities by investigating and addressing complaints) discharge notification documented Resident #5, had a discharge/transfer date of [DATE] for hospitalization , with return anticipated, and was voluntary. No further notification to the Ombudsman that the resident was not returning to the facility. Review of document titled hospitalized or deceased Residents Policy and Procedures dated [DATE]: When a resident is admitted into the hospital the Director of Nursing (DON), Assistant Director of Nursing (ADON)/designee, Administrator, or Social Worker shall call for status updates daily and potential discharge back to the facility. If the facility has concerns regarding medical complexity, behavioral concern or any threat to self or others the DON or designee must complete an onsite visit of the resident in hospital setting to determine the facilities capability of caring for the resident. If the facility does not feel that they can meet the clinical needs of the resident they may determine the need for emergency/involuntary discharge. If the emergency/involuntary discharge will be taking place please refer to the involuntary/emergency discharge protocols. Review of document titled Emergency/Involuntary Discharge or Transfer Policy undated: In the case of an emergency involuntary transfer or discharge, the resident must be given a written notice prior to or within 48 hours following the transfer or discharge A copy of the emergency transfer or discharge notice shall also be transmitted to the: 1. Department 2. Resident's responsible party 3. Resident's primary care provider 4. Person or agency responsible for the resident's placement, maintenance, and care in the facility 5. Department on Aging's office of the Long Term Care Ombudsman This notice shall indicate that copies have been transmitted to the required parties by using the abbreviation cc: and listing the names of all parties whom copies were sent A copy of the Emergency involuntary transfer/discharge shall be maintained in the resident record. Review of hospital documentation by the Social Service Department: [DATE] at 2:55 PM, spoke with Marketer at Pearl Valley and faxed updated resident information [DATE] at 12:57 PM, updated Marketer at Pearl Valley [DATE] at 12:45 PM, resident ready for discharge, Marketer at Pearl Valley stated she would send the residents information to the Perry Facility to determine if they will accept the resident back [DATE] at 4:25 PM, spoke with Marketer at Pearl Valley and the MDS Coordinator at Perry Facility several times over the past few days, and attempted to get them information that needed to reassess the resident for return to the facility. The facility declined to accept the resident back due to her drug seeking behavior and mental health diagnosis. [DATE] at 5:20 PM, the residents' representative informed the hospital Social Worker that she paid to hold the residents bed at the facility and the facility now refused to allow the resident to return. On [DATE] at 2:51 PM the Administrator stated once Resident #5, transferred to the hospital and they received notification there was a plan for her to return to the facility, the nursing department did not feel they could meet the resident's needs anymore due to medication increases while at the hospital. The Administrator stated once the facility reviewed the hospital documentation and the resident resumed benzodiazepines, they did not feel they could meet her needs. The Administrator stated they had direction from the resident's previous hospital stay that the resident should not resume benzodiazepines. The Administrator stated the resident's guardian agreed to pay privately for the bed hold when the resident transferred to the hospital, and requested the return of bed hold funds since the resident did not return to the facility. The Administrator stated she did not speak with the resident's guardian about the resident not being able to return to the facility, that the Interim Administrator/Social Worker (SW) spoke with her. On [DATE] at 3:00 PM, the Interim Administrator/SW stated she thought she spoke with Resident #5's guardian, however, would have to check her documentation. On [DATE] at 3:04 PM, the Director of Nursing (DON) stated the resident transferred to the hospital on [DATE] with respiratory issues. The DON stated the hospital provided updates, however, the resident had been out longer than 10 days and the facility did not have to accept the resident back to the facility. The DON stated the resident was not to resume Benzodiazepines per previous hospitalization , however, the resident resumed [MEDICATION NAME] (benzodiazepine) and due to this the facility did not feel they could meet her needs any longer. The DON stated she was unsure if the facility spoke to the residents' representative about the resident not returning to the facility. The DON stated possibly the Administrator spoke with the residents' representative, as she was able to get her bed hold money reimbursed. On [DATE] at 3:18 PM, the Social Worker (SW) from the hospital stated the facility informed her that they were no longer able to meet the residents' needs when they were called about the resident being ready for discharge. The SW stated they informed her throughout the hospitalization that they were indeed going to take the resident back and when she called they wanted to review the residents' records. The SW stated she informed the residents' representative that the facility would not accept her return, and the guardian was not aware. On [DATE] at 3:27 PM, the residents' representative (Guardian) confirmed the resident went to the hospital on [DATE] and on [DATE] she received a call from the facility regarding paying for a bed hold. The residents' representative stated she had paid for an entire month to hold the bed (30 days). The residents' representative stated the facility did not inform her that they were unable to meet the residents' needs or that she would not be returning to their facility, the SW at the hospital called her. The representative stated she insisted a full refund from the facility. The representative stated she had called the Department of Aging regarding the resident being involuntarily discharged , and was informed she needed to call the Ombudsman, which she did. On [DATE] at 8:54 AM, the Interim Administrator stated she was unaware of any notification to the Department of Inspections and Appeals (DIA) or Ombudsmen regarding notification of involuntary discharge for Resident #5. On [DATE] at 8:55 AM, the DON stated she was not aware of any notification to DIA or Ombudsmen regarding involuntary discharge of Resident #5. On [DATE] at 11:25 AM, the Nurse Consultant stated the facility did not involuntary discharge Resident #5 and stated after the facility reviewed the residents progress notes from the hospital they did not feel they could meet her needs. The Nurse Consultant stated the resident had drug seeking behaviors and resumed [MEDICATION NAME] while in the hospital. The Nurse Consultant stated the facility held the residents bed beyond 10 days as a courtesy due to resident being private pay, they were not required to hold her bed. The Nurse Consultant confirmed the resident's representative had paid for the resident's bed to be held for 30 days. The Nurse Consultant stated they had attempted to place the resident in other sister facilities and the the residents' representative was okay with whatever. On [DATE] at 4:02 PM, the resident's primary care provider (PCP) stated he saw the resident at the facility a couple of times. The PCP stated while resident previously hospitalized (prior to original admit on [DATE]) she was weaned off her addictive medications (benzodiazepines) and the resident did well while she was off of them. The PCP stated while the resident was in the hospital (from [DATE] admit) the hospital psychiatric department saw her and resumed [MEDICATION NAME] every 4 hours as needed, however, she received it regularly. The PCP stated he felt concerned about the resident returning with the [MEDICATION NAME]. The PCP stated he was unsure of the environment to the facility that the resident was discharged to. On [DATE] at 9:01 AM, the hospital SW stated several specialists saw the resident while she was in the hospital, however, reviewed doctor's notes and could not find any documentation regarding the resident having drug seeking behavior. The resident went to another SNF/NF facility for care after hospitalization due to Pearl Valley refusing to take the resident back. On [DATE] at 10:45 AM, the Nurse Consultant stated the facility did not involuntary discharge Resident #5, they just refused to take her back after the 10 day bed hold. The Nurse Consultant stated the SW from the hospital only had contact with the Corporate Marketer. On [DATE] at 8:30 AM, the hospital SW stated the resident did not have any new mental health [DIAGNOSES REDACTED].
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and staff interview the facility failed to implement transmission based precautions for a resident with acute respiratory symptoms for 1 of 6 residents reviewed (#3). The facility reported a census of 24 residents. Findings Include: A Minimum Data Set (MDS), with a completion date of 5/29/20, for Resident #3, listed [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS), documented 7 out of 15 indicating severe cognitive impairment. The MDS documented the resident as requiring limited assist of one staff for bed mobility. Extensive assist of one staff for transfers, dressing, toileting, and personal hygiene. Nurses Notes: 7/15/20 at 10:00 AM, the resident complained of occasional nonproductive cough, lungs clear to auscultation, fluids encouraged, temperature 97.7

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) degrees Fahrenheit, respirations 16, oxygen saturation 93% on room air (O2 sat, level of oxygen in the blood with normal being 95-100%), will continue to monitor 7/16/20 at 4:00 AM, the resident rested quietly overnight with no complaints voiced. The residents roommate reported Resident #3 coughed intermittently overnight. Resident #3, denied feeling ill, however, noted to have nasal congestion. Lung sounds clear, denied shortness of breath, and denied difficulty breathing. 7/16/20 at 4:00 PM, the resident had occasional nonproductive cough, lung sounds clear, fluids encouraged and taken freely 7/17/20 at 4:00 AM, the resident rested quietly in bed, voiced no complaints. Nasal congestion and occasional non-productive cough noted. 7/17/20 at 6:00 AM - 6:00 PM, little cough noted today. 7/18/20 at 2:00 AM, the resident rested quietly in bed overnight. The resident continued to have occasional nonproductive cough and nasal congestion. The resident denied complaints of shortness of breath of difficulty breathing, lung sounds clear, and fluids encouraged. 7/18/20 at 6:00 AM - 2:00 PM, the resident had a minor cough, increased while getting out of bed, and lung sounds clear 7/18/20 at 2:00 PM-10:00 PM, no cough noted 7/19/20 at 4:00 AM, the resident rested quietly in bed overnight, continued to have nasal congestion and occasional nonproductive cough. Cough noted while laying down in bed. The resident denied complaints of shortness of breath, difficulty breathing, or shortness of breath. 7/19/20 at 6:00 AM - 2:00 PM, the resident remained on checks for cough, appeared to have nasal drainage. 7/19/20 at 2:00 PM - 10:00 PM, no cough noted this shift 7/20/20 at 2:00 AM, the resident had no further congestion or cough and voiced feeling okay Document titled COVID 19 daily assessment contained: Temperature, respirations, O2 sat, oxygen if used, loss of taste/smell, nausea/vomiting/diarrhea, abdominal pain with breathing, ear pain or headache, nasal congestion/drainage, lethargy or increased weakness, pain, chills/shaking, cough, and history of low O2 sat or respiratory [DIAGNOSES REDACTED]. COVID 19 daily assessments then completed every 4 hours starting 7/15/20, at 12 N and continued every 4 hours until 7/19/20 at 12 midnight. On 7/15/20, documented the resident with occasional nonproductive cough every 4 hours. On 7/16/20, documented the resident had nasal congestion and dry cough every 4 hours. 7/17/20 at 4:00 AM, 8:00 AM, 8:00 PM, and 12 midnight documentation identified the resident with nasal congestion and occasional dry cough. On 7/18/20 at 4:00 AM and 12 midnight documented the resident had nasal congestion and occasional dry cough. On 7/19/20 at 4:00 AM, documented the resident had congested cough and occasional dry cough. Document titled COVID 19 Policy and Procedure dated 3/1/20, the purpose of this policy is to identify and isolate symptomatic residents and prevent the potential contamination of the facility population with Novel Coronavirus. The residents will be assessed every shift for elevated temperature and noted change in condition. Should residents exhibit any of the following symptoms the facility shall initiate droplet isolation precautions for symptomatic residents and roommates if applicable. Fever greater than 100.4 degrees Fahrenheit Sore throat Cough Decreased oxygen saturation Difficulty breathing or pain respirations Fatigue, body aches, headache, or any other flu like symptoms Faculty shall notify primary medical provider or their designee of symptoms Residents will be placed into droplet isolation along with their roommate Follow up testing shall occur per the order of the primary medical provider Residents and roommate will remain on droplet isolation precautions until test results are returned with definitive [DIAGNOSES REDACTED]. started on every 4 hour assessments and will be placed in droplet isolation until symptoms resolve per the Iowa Department of Public Health (IDPH) and Centers for Disease Control (CDC) recommendations The residents primary care provider will be notified and will determine follow up criteria for testing and further isolation requirements The residents will be removed from isolation per the clearance criteria of the IDPH and CDC recommendations Facility may initiate increased assessments for any resident with symptoms that are a change from baseline which will be determined by the Director of Nursing (DON) or designee Implementation of further isolation shall be determined by the DON or designee for symptoms that do not meet other physician determined causes (elevated temperature, productive cough, sore throat, new persistent cough) On 7/28/20 at 1:34 PM, Staff B Licensed Practical Nurse (LPN) stated if a resident had a cough, fever, or difficulty breathing she would notify the residents' primary care provider, increase COVID assessment to every 4 hours, place the resident on droplet isolation and test for COVID as directed. On 7/28/20 at 1:50 PM, the Director of Nursing (DON) stated Resident #5 was not placed in isolation due the residents' history of occasional cough, no elevated temperature, and no low O2 saturations. The DON stated the facility assessed the resident every 4 hours and the symptoms resolved on their own. On 7/29/20 at 10:45 AM, the DON confirmed Resident #5 was not in a private room and was not placed on droplet precautions at the time his symptoms were noted. The DON confirmed that Resident #2 was tested for COVID, after being placed on isolation and had documented symptoms of occasional dry cough, nasal congestion, and sore throat. On 7/29/20 at 10:45 AM, the Nurse Consultant stated several residents were experiencing sinus issues at that time. The Nurse Consultant stated Resident #5 never had elevated temperature or low O2 saturations. On 7/29/20 at 3:50 PM, the DON stated the Resident #5 had allergy symptoms and COVID assessment increased to every 4 hours to be proactive. The DON stated she did not feel the symptoms were COVID related and would not expect the resident to be placed in isolation. The DON stated the residents vital signs were normal, lungs clear, and the resident had no difficulty breathing.