STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE 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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, the facility failed to provide the resident with dignity and respect for 1 of 7 residents reviewed (Resident #1). The facility reported a census of 29 residents. Findings include: Resident #1's Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had a [DIAGNOSES REDACTED]. On 6/30/20 at 12:58 PM, the resident reported staff talks about her and hospice gossip. There was one staff member that was not nice to her. The resident said the aide did not change the resident, was not kind to the resident, and was the worst aide. The staff want the resident to move faster than the resident could move. Hospice Progress Note dated 3/26/20 at 10:52 PM stated the resident was upset over several things and utilized a communication board and pictures to indicate the resident felt rushed with cares and no one took the time to take things at a pace that did not cause the resident pain. The resident thought no one understood the resident's disease and treated the resident as an invalid. The care plan dated 3/18/20 informed staff to respect the resident's right to make decisions. On 7/2/20 at 8:45 AM, the Director of Nursing (DON) said the resident reported the staff on day shift not as attentive as the night shift. The DON said on 6/15/20, she educated the staff to make them more aware that the staff needed to assist the resident. The DON stated the resident got upset with staff because the resident felt the staff moved too fast for her. The resident would make a comment that the resident wasn't stupid.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to provide reasonable accommodations to meet the residents' needs to communicate efficiently for one of seven residents reviewed. Resident #1 did not have a call light she could effectively use. The facility reported a census of 29 residents. Findings include: Resident #1's Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of [DATE] showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had a [DIAGNOSES REDACTED]. Interviews: On [DATE] at 11:15 AM, Hospice Staff #1, Registered Nurse (RN), said the resident experienced difficulty speaking and could not move her hand easily. Hospice Staff #1 said the resident had good days and bad days. The bad days started in the last two weeks. The resident has communicated with the staff but had three days where the resident couldn't communicate with the staff. On [DATE] at 12:58 PM, Hospice Staff #2, Certified Nurse Aide (CNA), assisted the resident communicate during the interview using a communication board. Hospice Staff #2 held the resident's hand up above the communication board to prevent the plastic sleeve from sliding. The resident said within the last two weeks, talking is harder to do. The resident reported on the day of the interview communicating seemed more difficult than the day before. Hospice Staff #1 said the prior Hospice Nurse attempted to visit with the facility about a pressure call light. Hospice Staff #1 stated the DON reported that it was not something the facility could do. The resident spelled out that she felt afraid not to have a call light. Observations: On [DATE] at 12:44 PM, observation showed Staff I, Licensed Practical Nurse (LPN), attempt to make the resident comfortable. The resident could not communicate concerns verbally and frequently moaned and tried to indicate something was wrong. Staff I used the communication board in a clear plastic sleeve. The resident attempted to spell out words with difficulty. As the resident tried to spell words, the plastic sleeve slid, causing challenges with spelling words. The increased problems caused increased frustration with the resident as the resident wasn't able to communicate the problem efficiently. Record Review: A care plan problem dated [DATE] identified the resident with a communication problem due to language barrier. The intervention initiated on [DATE] included the resident had a communication paper that the resident could spell out words to tell the resident's wants. An intervention dated [DATE] directed staff to monitor and or document the resident's frustration level and wait 30 seconds before providing the resident with a word. A Health Status Note [DATE] at 10:35 AM showed the resident's hands contracted, and the skin on the palms starting to peel slightly. Staff cleaned the resident's hands cleaned thoroughly, and applied lotion. A Physician Visit Note dated [DATE] revealed the resident could communicate with letters on a communication board. The resident could no longer communicate with the phone or with language. The resident could no longer communicate verbally. The resident required support of the left hand to point out letters to communicate. The resident's left wrist contained contractures and caused pain when the resident attempted to straighten it. The note identified the Physician with difficulty communicating with the resident. On [DATE] at 12:37, the Nurses Note revealed the Interdisciplinary Team (IDT) met to discuss the resident's pain. The resident continued with hospice and received an increase of [MEDICATION NAME] (narcotic). The resident's ability to communicate deceased as well as the patience to do things. On [DATE] at 11:01 AM, the Nurses Note identified the Physician visit/recertification noted the resident remained on an intermediate level of care (ICF) with hospice. The resident showed a progressive decline. Unfortunately, the resident could not communicate her needs adequately. The facility would continue to focus on comfort measures. On [DATE] at 17:06, an Activity Participation Note revealed the Activity staff spent time reading mail to the resident. The resident experienced frustration when staff could not understand what the resident needed. The resident could not use the letter chart to help staff with the resident's concern. The activity staff got a CNA to help the resident. On [DATE] at 4:51 PM, a Social Service Note showed a Digital Audio Monitor purchased on [DATE]. The intention behind the purchase was to add the digital audio monitor to her room to hear the resident better when the resident needed to reach staff and hopefully decrease anxiety level due to call light concerns. On [DATE] at 4:56 PM, the Social Service Note indicated an updated and laminated communication paper board to enable the resident to handle the board and be easier to clean and sanitize. Administration Staff Interview: On [DATE] at 1:55 PM, the Director of Nursing (DON) said the facility attempted to get something more manageable for the resident to use as a call light. There was no pressure pad available through the call light system. The resident can use the call light, but cannot use it easily. The resident frequently used the call light but the DON denied concerns that the resident would go without help. The DON said the resident worked with Speech Therapy in the past and hated to use pictures as the resident could spell out the words. The charge nurse called hospice one day to discuss the use of a baby monitor. Hospice told the nurse that wasn't something they provided. The DON felt the resident could use a baby monitor that the staff could carry, as the resident could still make noise to alert the staff of the need for help. The DON said the facility did not purchase a baby monitor yet for the resident to try. Policy review: The Resident Call System policy dated [DATE] showed that residents unable to use the call system due to decreased physical or mental abilities needed staff to anticipate their needs to the best of abilities.
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.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the resident's representative for one of seven residents reviewed (Resident #4). The facility reported a census of 29 residents. Findings include: Resident #4's Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 5/14/20 identified the resident with short and long-term memory problems (severe cognitive impairment). The MDS revealed the resident with a significant unplanned weight loss (5 percent (%) in the previous 30 days or 10% over the last six months). The Care Assessment Area (CAA) identified the resident with a poor appetite. Staff encouraged and attempted to help the resident eat. The resident had [DIAGNOSES REDACTED]. Record review: On 5/6/20 at 3:55 PM, the Interdisciplinary Team (IDT) met to discuss the resident's weight, current weight 82.0 pounds (#), down 3.5# since the 4/29/20 IDT meeting. The IDT team identified the resident of advanced age and advancing dementia and they would contact the family to discuss the end of life options. On 5/7/20 at 12:00 PM, the Social Service Note showed the Social Services staff spoke to the resident's representative concerning the resident's weight loss and falls. They discussed Hospice as an option and the resident's representative agreed to start Hospice. The facility sent a facsimile (fax) to the resident's primary Physician and asked for an order for [REDACTED]. The resident's record lacked documentation of notification to the resident's representative related to the weight loss. On 5/21/20 at 9:55 AM, a Social Service Note showed a care plan invitation sent to the Resident's Representative for a care plan scheduled for 6/10/2020 at 10 AM. A care plan dated 5/21/20 revealed the goal as: the resident would continue to make decisions related to the care and daily routine with assistance from the staff, family, and or Hospice. On 5/11/20, the Hospice Note showed the Resident's Representatives weren't close to the resident but did want communication-related to the resident's changes. The Resident's Representatives reported that there wasn't much communication regarding the resident's decline reported from the facility. However, they were happy to have Hospice on board. Interviews: On 6/30/20 at 12:34 PM, the Hospice Staff #3 identified the Resident's Representative upset and requested a conference call due the facility not giving consistent communication. The Resident's Representative remained upset throughout the care conference. The Resident's Representative did not say they were happy with the communication from the facility. The Resident's Representative decided that Hospice would be the primary point of contact for communication. On 7/2/20 at 8:45 AM, the Director of Nursing (DON) identified the Administrator, the Hospice Nurse, and herself as involved in the conference call regarding the Resident's Representative's. During the meeting, everyone agreed to designate Hospice as the primary contact. The DON reported knowing that the facility's notifications as not the best.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to complete a required Significant Change Minimum Data Set (MDS) Assessment for 1 of 1 resident reviewed receiving Hospice Services (Resident #5). The facility reported a census of 29 residents. Findings include: 1. The Minimum Data Set ((MDS) dated [DATE], indicated [DIAGNOSES REDACTED]. According to the MDS, the resident scored six out of fifteen on the Brief Interview for Mental Status (BIMS) indicating severe cognitive deficit. The MDS revealed the resident received hospice care while a resident. Review of the Census tab on 06/29/20 indicated on 12/27/19 the resident admitted to hospice medicaid. A review of the MDS tab lacked a significant change assessment MDS completed after admission to hospice care. During an interview on 07/01/20 at 1300 AM, Director of Nursing stated the facility should complete a significant change assessment when a resident admits to hospice.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to meet professional standards of quality when following Physician order [REDACTED]. Resident #1's Medication Administration Record [REDACTED]. The facility reported a census of 29 residents. Findings include: Resident #1's Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had a [DIAGNOSES REDACTED]. Record review: The Physician order [REDACTED]. On 6/25/20 at 12:18 PM, the Nurses Note showed the hospice staff gave the resident a whirlpool. Upon finishing the whirlpool, the Hospice staff reported removing an outdated pain patch they observed on the resident during the bath. Staff then placed a new [MEDICATION NAME] Patch on the resident. On 6/26/20 at 11:20 AM, the Orders - Administration Note showed a [MEDICATION NAME] Patch 75 mcg patch changed per the nurse's instruction. The previous thirty-day review of tasks shows a weight of 122 pounds (#) on 6/2/20. The task record lacked any further weights for the month of 6/20. The Weight Summary showed the following weights 6/2/20 - 122# 5/21/20 - 124# 4/16/20 - 125.0# 4/2/20 - 125# 3/31/20 - 127.5# 3/19/20 - 127# 3/12/20 - 125# 3/5/20 - 125.5# 2/27/20 - 122.5# 2/20/20 - 121.0# 2/1/20 - 119.5# 1/27/20 - 130# The care plan problem dated 2/24/20 showed the resident had pain related to ALS and a fracture to the left ankle. The intervention dated 2/24/20 said to administer [MEDICATION NAME] as per orders. The Hospice progress note dated 6/25/20 indicated the Interviews: On 6/29/20 at 11:15 AM, the Hospice Staff # 1, Registered Nurse (RN), reported when she assisted the resident in 6/25/20 that she observed a [MEDICATION NAME] Patch dated 6/20/20 on the resident. Hospice Staff #1 said the facility charge nurse reported changing the patch that day but then left the room and then reported changing the patch the day before. Hospice Staff #1 stated that the nurse did change the patch while Hospice Staff #1 was at the facility on 6/25/20. On 7/1/20 at 1:55 PM, the Director of Nursing (DON) reported the [MEDICATION NAME] not signed for 6/23/20 as the order directed. The count was off for two residents. The DON said she validated the date of the patch on the resident due to a lack of documentation on the MAR. Resident #1 was one of the residents who did not have a correct count for the [MEDICATION NAME]es. On 7/1/20 at 1:00 PM, the resident denied noticing an increase in pain the week before. Statement: The statement dated by 7/2/20 by the Administrator and DON noted two of the [MEDICATION NAME] counts were incorrect. Resident #1's narcotic (narc) count sheet showed that the resident should have two patches, and the number of patches in the drawer was three. The Administrator and DON checked Resident #1's patch. The patch was correct with a date of 6/25/20 on the patch. Policies: The Medications - Controlled policy with a revision date of 3/1/14 directed staff to sign out controlled substances at the time of dispensing the medication. Staff should document the medication in the appropriate area of the MAR.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, and staff interviews, the facility failed to provide the necessary services for incontinence care and bathing for 4 of 7 residents reviewed (Residents #1, #2, #5, and #7). The facility reported a census of 29 residents. Findings include: 1. A Minimum Data Set (MDS) completed for Resident #1 with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had a [DIAGNOSES REDACTED]. The resident was frequently incontinent of bladder and always continent of the bowel. The resident never exhibited a rejection of care in the seven day lookback period, and no change noted in the behaviors since the last assessment. Interviews: On 6/29/20 at 10:10 AM, the Resident's Representative reported the resident did not receive changing of her clothes or incontinence brief. The Director of Nursing (DON) stated she would check to ensure staff changed the resident every two hours. The representative received a report from the Hospice staff that the resident was so wet that the brief stuck to the resident at 11:00 AM. The resident reported no one checked her since 5:00 AM. The resident did not receive any baths except bed baths except when the Hospice would come to the facility. On 6/29/20 at 10:32 AM, Hospice Staff #4, Registered Nurse (RN), said Hospice regularly found the resident incontinent with the brief sticking to the resident's skin. Hospice would usually visit around 11:00 AM and 1:00 PM. Hospice Staff #4 did not notice any concerns with pressure ulcers. Hospice Staff #4 reported Hospice staff provided a majority of the grooming and baths for the resident. On one visit, the resident had bowel movement dried on to the skin. Hospice staff took the resident to the whirlpool, but it needed cleaning first as it appeared staff used the whirlpool area as central supply. Hospice Staff #4 said the resident could respond appropriately and reported no staff in the room to check on the resident since 5:00 AM. On 6/29/20 at 10:41 AM, Hospice Staff #5, Manager of Clinical Services, said it was excessively difficult to contact the facility Administration Staff. Hospice Staff #5 attempted in the past without success in reaching them. On 6/29/20 at 11:15 AM Hospice Staff #2, Certified Nurse Aide (CNA) said the resident is usually completely saturated when she sees the resident at the facility. Today (6/29/20) was the first day Hospice Staff #2 came to the facility and found the

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) resident dry. Hospice Staff #2 reported coming to the facility around 10:30 AM. Hospice Staff #2 had come to the facility for approximately one month. Hospice Staff #1, RN, said the Hospice staff just started to give the resident whirlpools twice a week. The facility only gave the resident bed baths. The resident's skin appeared extremely dry and was flaking off the resident. After the first whirlpool provided by Hospice Staff #2, the whirlpool tub was full of dead skin. Hospice Staff #1 said that if the facility was giving the resident bed baths, it was not enough for the resident. The facility was putting A&D ointment into the resident's hair due to cradle cap. The hospice staff needed dawn dish soap to remove the A&D ointment from the resident's hair. It took approximately seven washes to remove the A&D ointment from the resident's hair. The Hospice staff's biggest concern was the resident's incontinence care. Hospice Staff #1 said there were a couple of times the resident wore two briefs. The resident was incontinent through both briefs onto the bed as there was no underpad beneath the resident. The resident reported the staff changed the resident last at 5:00 AM. The Hospice team attempted to contact the facility. Hospice Staff #1 said the Administrator returned a call stating she did not deal with that. The Hospice staff contacted the Director of Nursing (DON) on 6/12/20 about the concerns. Following the conversation with the DON, Hospice Staff #2 came to the facility and observed the resident wearing two briefs saturated with urine through to the bed. There were no reports to Hospice Staff #1 or Hospice Staff #2 regarding the resident refusing any care. Resident's Interview: On 6/30/20 at 12:58 PM, the resident said recently she received care. The weekends were not good for getting care. The resident said the night shift was good but then wouldn't change the resident at all. The resident said the facility did not give baths as they expected Hospice staff to do them. Up until last week, it wasn't on the Hospice care plans to do. The resident reported not getting a shower for weeks. The staff just washing the resident up and that's why the resident's hair got so bad. The resident heard staff talking about the bath schedule. The resident wasn't on the schedule-the resident reported listening to staff all the time. The resident said her bottom hurt. The resident reported wanting whirlpool baths. During a follow-up interview on 7/1/20 at 1:00 PM, the resident reported it made her feel sad and degraded when the staff didn't change her or bathe her. The resident said that occasionally she would refuse to change her clothes. Observation: On 6/29/20 at 12:44 PM, Staff A, Certified Medication Aide (CMA), and Staff I, Licensed Practical Nurse (LPN), entered the resident's room and explained plan to the resident. The resident utilized the communication board to spell out wet. Staff A removed the incontinent brief. Staff complete incontinence cares on the resident and then washed their hands. Staff I remained in the room to help the resident get comfortable. Observation showed small brownish-red spots on the left side of the resident's sheet. On 6/30/20 at 12:58 PM, Hospice Staff #1 and Hospice Staff #2 assisted the resident with incontinence cares. Observation showed the left side of the resident's sheet to have the same reddish-brown spots in the same place as the observation on 6/29/20. Staff did not offer the resident the bedside commode. Staff Interview: On 7/1/20 at 10:25 AM, Staff A reported not giving the residents baths as they were for the evening shift. Staff A stated Resident #1 received a bed bath in the mornings due to getting sweaty in the night. During a follow-up interview on 7/1/20 at 1:10 PM, Staff A stated that if the residents were sleeping, she would let them sleep. Staff A said she didn't usually go into the room until the nurse went into the room (usually around 6:30 to 7 a m.) because she doesn't want to make them do more work. Staff A stated Resident #1 didn't refuse care, but it did cause pain sometimes to change the resident's clothes. Staff A felt it would help the resident to have more adaptive clothing as it causes the resident so much pain. Staff A said that the resident was very particular with the clothes worn and sometimes did not wish to change them. Staff A wasn't sure if the resident refused to change clothes due to pain. Record review: On 5/15/20 at 5:36 PM, Hospice Staff #4 documented the resident's niece expressed concern as facility staff didn't change the resident for three days. When asked about this, facility staff reported the resident's clothes were never brought to the resident's room. Documentation showed staff received education on hygiene and resident's dignity by Hospice Staff #4. On 5/26/20, the Resident Communication Form revealed staff washed the resident's face, provided oral care, and preformed hair care. Then Hospice Staff #2 repositioned, checked, and changed the resident. On 5/27/20, the Residential Communication Form revealed staff washed the resident's face, provided oral care, and preformed hair care. Then Hospice Staff #2 repositioned, checked, and changed the resident. On 5/28/20, the Residential Communication Form revealed staff washed the resident's face, provided oral care, and preformed hair care. Then Hospice Staff #2 repositioned, checked, and changed the resident. On 5/29/20, the Residential Communication Form revealed staff washed the resident's face. Then Hospice Staff #2 repositioned, checked, and changed the resident. On 5/29/20, Hospice Progress notes showed Hospice Staff #4 documented she cleaned the resident in bed and provided perineal (peri) cares with brief changed. Hospice repositioned the resident in the bed, washed the resident's face washed and provided oral care. On 6/1/20, the Residential Communication Form revealed staff washed the resident's face and hands. Then Hospice Staff #2 repositioned, checked, and changed the resident. Staff D, Certified Medication Aide (CMA), came into the resident's room to see if Hospice Staff #2 needed any assistance. Hospice Staff #2 declined the need for help. On 6/9/20 at 12:38 PM, the Hospice progress note showed the resident received incontinence cares, changing of the resident's gown, teeth brushed, face washed, and a partial bed bath completed. Hospice observed shearing to the resident's buttocks. On 6/12/20 at 1:29 PM, a Hospice progress note showed the resident was incontinent of bladder when they arrived. Hospice Staff #1 assisted Hospice Staff #2 with incontinence cares and repositioning of the resident. On 6/19/20 at 1:44 PM, a Hospice progress note documented the training needs related to the patient's care were medications, side effects, and the dying process reviewed. Hospice provided education to the facility regarding incontinence care and medications. The facility verbalized understanding. On 6/23/20 at 12:46 PM, Hospice Staff #4 documented the resident's hair as greasy due to the use of A&D ointment for cradle cap. Hospice Staff #2 reported the resident wore the same shirt as the day before. The resident said no staff came into the room from the facility before the Hospice Staff arrived that day to provide care. The resident was incontinent of bowel and bladder and taken to the whirlpool room. The resident's hair was shampooed four times without success in removing ointment. The resident had a significant build-up of skin and dirt on their hands and feet that Hospice scrubbed off. The resident was taken back to their room and put back into the bed with clean linens. Hospice returned the resident back to her room and observed the resident's pillows as very dirty, with yellow and brown stains noted. Hospice placed fresh linens and sent the soiled linens to the laundry. Hospice Staff #4 discussed concerns with facility staff. Hospice Staff #2 provided oral care and lotioned the resident. Hospice Staff #2 notified the Manager of Hospice Clinical Services of concerns. On 6/25/20, the Residential Communication Form revealed that the resident received a whirlpool bath with shampoo. They noted the resident with shearing to the coccyx. On 6/25/20, the Client Coordinator Note Report showed the Hospice Nurse, and Hospice Aide took the resident to the whirlpool room. While there, the Hospice staff gave the resident a whirlpool and cleansed the resident's hair. Due to the excessive amount of A&D ointment in the resident's hair, the staff needed to use Dawn dish soap to wash the resident's hair. They washed the resident's hair three times to successfully clean the hair. The resident's coccyx continued with shearing and Hospice applied ointment to the area. Hospice notified the facility of the area to the coccyx and the need for routine incontinence care. The facility staff verbalized understanding. A Grievance Form dated 6/25/20 completed by the facility said the Resident's Representative wished to move the resident to another facility. The Resident's Representative explained the request to move was due to things going downhill since May. The Hospice staff reported that the resident's care was poor. The statement provided from the facility dated 6/25/20 by the Social Services Director documented the call regarding the Resident's Representative's request to change facilities. The Resident's Representative informed the Social Services Director about not being happy with the care provided to the resident. Facility staff did not bathe, change, or check on the resident regularly. The Resident's Representative reported leaving voicemails for the DON and the Administrator about the concerns, without improvement. The Resident's Representative said it was the third strike. The Social Services Director offered to look into this. However, the Resident's Representative declined as wanting to move the resident due to being tired of the situation. The Resident's Representative stressed the frustration of the resident not getting baths. The Social Services Director explained that Hospice was at the facility five days per week. They typically assist or conduct the baths. On 6/29/20 at 11:35 AM, a Hospice progress note completed as a late entry showed the Hospice Manager of Clinical Services called the DON on 6/24/20 regarding concerns the clinical team reported and to schedule a care conference with the team. On 6/29/20 at 11:48 AM, a Hospice progress note showed the aide care plan updated to add a whirlpool bath twice weekly. Hospice staff began giving whirlpool baths on 6/23/20. The bathing task showed that the resident received bath baths on 6/5/20, 6/7/20, 6/8/20, 6/12/20, and 6/17/20. On 6/22/20, the staff documented the resident received a shower. The record shows whirlpools documented for 6/23/20 and 6/25/20. The care plan problem dated 1/30/20 showed the resident had an activities of daily living (ADL) self-care performance deficit related to ALS, impaired balance and musculoskeletal impairment. An intervention dated 1/30/20 showed the resident required assistance with oral care and personal hygiene. Staff should encourage the resident to change clothes daily. An intervention dated

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) 3/8/20 revealed the resident required the assistance of two for toileting and the resident should use a bedside commode. The care plan directed staff to offer toileting upon rising, before and after meals, at bedtime, and as needed upon request. Administration interviews: On 7/1/20 at 10:54 AM, the DON reported just learning that the resident's hospice provider did not provide baths. This was the DON's first experience with a Hospice provider not providing baths. During a follow-up interview on 7/2/20 at 8:45 AM, the DON reported that on 6/15/20, educating staff to make aware that staff was to help the resident. 2. The MDS completed for Resident #2 with an ARD of 4/2/20 showed the resident had short and long-term memory problems and severely impaired decision making. The resident never or rarely made decisions. The resident required extensive assistance of two staff for toileting and total dependence with two staff for bathing. The resident never experienced a rejection of care in the seven day lookback period. The resident was always incontinent of bowel and bladder. The resident had [DIAGNOSES REDACTED]. Observations: On 6/29/20 at 9:23 AM, observations revealed a slight urine smell near a room in the A Hallway. On 6/29/20 at 12:22 PM, observation showed Staff A and Staff I assist the resident with incontinence cares. Staff remove the brief which was full of urine. Urine went through the resident's brief onto the underpad and on to the sheet. The underpad was placed high up on the resident's hips not altogether preventing the leakage of urine on to the bed. As Staff A positioned the resident away Staff I and observation revealed a large area of redness to the resident's right ischium bone. Staff A offered to change the resident's shirt and the resident shook head to decline. Record review: The bathing task record showed bed baths completed on 6/1/20 and 6/4/20. The documentation showed the resident refused a bath on 6/3/20 and 6/17/20. The record lacks any further documentation related to baths. A care plan problem dated 3/12/20 showed the resident had an ADL self-care performance deficit related to [MEDICAL CONDITION] (weakness), impaired balance, limited Mobility, and a stroke. An intervention dated 3/12/20 showed that the resident is totally dependent on two staff to provide a shower at least twice a week and as necessary. Interviews: On 7/1/20 at 10:25 AM, Staff A reported not giving the residents baths as they do them on the evening shift. During a follow-up interview on 7/1/20 at 1:10 PM, Staff A stated that if the residents were sleeping, she would let them sleep. Staff A said she didn't usually go into the room until the nurse entered the room (usually around 6:30 - 7:00 AM) because she didn't want to make them do more work. Staff A said she often returns in about an hour. She stated the resident doesn't make much noise unless he wants repositioning or incontinent care. On 7/1/20 at 1:55 PM, the DON said staff needed to document baths in the electronic health record whether given or refused. During a follow-up interview on 7/2/20 at 10:15 AM, the DON said staff needed to change linens if they are dirty with whatever, feces, or urine. 3. A Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 5/31/20 for Resident #5 shows a Brief Interview Status Score (BIMS) of 6 (severe cognitive impairment). MDS showed Resident #5 with [DIAGNOSES REDACTED]. The MDS revealed the resident required extensive assistance with all activities of daily living (ADL'S) Review of bath schedules for hall A revealed the bath schedule did not contain Resident #5's name. Review of the bathing task staff sign off documentation revealed no bathes completed for the prior thirty day look back period. On 7/1/20 at 7:40 AM Staff A stated the facility did not have a designated bath aid responsible for completing baths as scheduled. Staff A stated when staff completes a bath, staff documents in Point Click Care (PCC). On 7/1/20 at 10:20 AM Staff A revealed Hospice gives Resident #5 a bath, but then stated no the resident is on the bath schedule for Tuesdays and Fridays. Staff A stated she did not know why a bath is not documented and could not state when Resident #5 had their last bath. 4. A MDS with ARD of 5/13/20 for Resident #7 revealed a BIMS of 13 (no cognitive impairment). The MDS showed Resident #7 to have a [DIAGNOSES REDACTED]. The MDS revealed the resident required one person physical assistance with bathing and independent with ambulation A Bath schedule sheet for Hall C revealed the resident scheduled for a bath on Monday and Thursdays. Review of bathing task staff sign off documentation revealed no baths completed for a thirty day look back period. On 7/1/20 at 9:15 AM the resident stated he preferred a sponge bath and he required staff to assist with this activity due to receiving continuous oxygen. The resident identified not receiving a bed bath for awhile and no staff have asked if he wanted one or if he completed a bath on his own. A care plan contained an intervention of encourage resident to bath dated 8/16/19. On 7/1/20 at 10:20 AM Staff A stated the resident gave his own bed bath. Staff only provides towels and staff is to ask the resident if he had completed his bath and document in PCC. Review of the facility bath/shower policy dated 3/1/14 revealed residents have the opportunity to bathe at least weekly or as resident request or as needed. On 7/1/20 at 2:00 PM the DON stated she expects residents to bathe one to two times a week and if refused it staff should document that. The DON expected Hospice to help bathe residents but knows the facility should not rely on hospice for all the bathing.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to assess a resident's weight accurately, and appropriately intervene for one of seven residents reviewed (Resident #4). The facility reported a census of 29 residents. Findings include: Resident #4's Minimum Data Set (MDS) completed with an Assessment Reference Date of 5/14/20 identified the resident with short and long-term memory problems and severely impaired decision making. The MDS showed a weight loss of 5% or more in the last month or loss of 10% or more over the previous six months, without a prescribed weight-loss regimen. The resident required extensive physical assistance of one staff with eating. The resident had [DIAGNOSES REDACTED]. The CAA completed for the 5/14/20 MDS showed a body mass index (BMI) too low as indicated by a BMI of 13.9348. The resident's Weight Summary showed the following weights 6/1/20 - 67.0 pounds (#) 5/25/20 - 68.0# 5/18/20 - 68.5# 5/11/20 - 83.0# 5/7/20 - 82.0# 5/4/20 - 82.0# 4/27/20 - 85.5# 4/20/20 - 87.5# 4/13/20 - 89.2# 4/8/20 - 88.5# 3/2/20 - 101.2# 2/1/20 - 100.2# The resident's weight on 3/2/20 showed 101.2#, and on 4/8/20, the resident's weight was 88.5#, indicating a weight loss of 12.7# or a loss of 12.55% in 30 days. The resident's weight on 5/11/20 showed 83.0#, and on 5/18/20, the resident's weight was 68.5#, indicating a weight loss of 12.5# or a loss of 17.47% in seven days. A care plan problem dated 10/15/19 showed the resident at nutritional risk due to having a history of dementia, malnutrition, and [MEDICAL CONDITION]. The intervention dated 10/15/19 identified the resident with a history of malnutrition but eating well and with weight stable. No nutritional interventions put in place at the time. The Registered Dietitian (RD) will continue to monitor intakes and weight and put interventions in place as appropriate. On 4/14/20 at 6:11 PM, the Dietary Note showed the resident current weight 89.2#, down 12# (13.5%) in one month and down 7.8# (8.7%) in six months. Intakes varied from 25-100% of meals, and the resident occasionally refused meals. Staff implemented chocolate shakes to help meet nutritional needs. If the resident did not tolerate shakes, 4 ounces of 2Cal (high calorie drink) four times a day recommended to provide approximately 950 calories and 40 grams of protein per day to help meet nutritional needs. Recommend staff encourage intakes at meals as able-RD to monitor intakes and weight. The RD would follow up quarterly or as needed. On 4/29/20 at 3:29 PM, a Nurses Note documented the Interdisciplinary Team (IDT) team met to discuss the resident's weight. The resident's current weight at 85.5#, down 2.0#. The resident did not eat breakfast and picked at other meals and drank half of her shakes. The resident liked to eat chocolate and the facility should ensure the availability of snacks. On 5/6/20 at 3:55 PM, a Nurses Note documented the IDT team met to discuss the resident's weight, current weight 82.0, down 3.5# since the 4/29/20 IDT meeting. The resident was of advanced age with advancing dementia and the facility was to contact the family to discuss the end of life options. On 5/7/20 at 4:11 PM, a progress note completed as a late entry showed the facility received a signed order for a Hospice evaluation due to weight loss and advanced dementia. The facility notified the chosen Hospice agency of the order. The resident's record lacked documentation of notification to the Physician for the weight loss noted on 4/8/20 until 5/7/20. The resident's chart lacked documentation related to the Physician's notification regarding the weight loss on 5/18/20. On 6/10/20 at 10:09 AM, the Care Plan Conference Note lacked documentation related to dietary. On 7/2/20 at 10:15 AM, the Director of Nursing reported that the IDT meetings were charted in the resident's record once completed. The IDT consisted of facility department heads. If there wasn't an IDT meeting documented, there was no meeting. The facility did not have a Registered Dietitian (RD) for approximately one month. The RD should see residents monthly and as needed. The decision for supplementation was based on the individual.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to assure that there was sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs by answering residents calls

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	165149	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE 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.

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) lights in a timely manner for three (Resident # 6, #7, and # 1) out of six residents reviewed. The facility reported a census of twenty nine residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date (ARD) of 6/23/20 for Resident #6 revealed a BIMS of 15 (no cognitive impairment). The MDS revealed Resident #6 had [DIAGNOSES REDACTED]. The MDS shows Resident to need extensive assistance with all ADL's except for eating. Call light report for 6/24/20 thru 6/30/20 shows Resident waited 27:47 minutes on 6/24/20, 15:41 minutes on 6/27/20, 17:00 minutes on 6/28/20, 15:15 minutes on 6/29/20, 20:06 minutes on 6/29/20, 20:30 minutes on 6/30/20, 18:20 minutes on 6/30/20, and 15:36 minutes on 6/30/20. On 06/30/20 at 1:25 PM the resident identified two episodes of bowel incontinence due to having to wait for staff to answer the call light. The resident stated that she had never been incontinent of bowel before. 2. The MDS with ARD of 5/13/20 for Resident #7 revealed a BIMS of 13. The MDS identified the resident with [DIAGNOSES REDACTED]. The MDS revealed the resident required one person physical assistance with bathing and independent with ambulation. The resident used oxygen continuously. Call light report for 6/24/20 thru 6/30/20 revealed the resident waited 15:24 minutes on 6/27/20, 18:58 minutes on 6/28/20, 40:17 minutes on 6/29/20, 22:37 minutes on 6/29/20, and 19:56 minutes on 6/30/20. On 7/1/20 at 9:30 AM the resident stated sometimes it takes staff a long time to answer the call light, and it has been worsen since they moved a lot of residents off of hall C which the resident currently lives on. The resident stated he times the staff to see how long it takes them and looks at the digital clock across from where he is seated. He begins timing it when he activates the call light. The resident stated he fell about six months ago as he got tangled up in the oxygen tubing. The resident stated he pushed the call light when he was on the floor but nobody came so he got up without assistance. Staff came to room and asked what was needed and the resident told them about the fall. The resident stated staff looked him over and determined there no injury occurred. The resident was upset about staff not answering his call light timely and went to the Director of Nursing (DON) to make a complaint and was told it was due to a facility staff shortage. The resident stated he complained to the Certified Nurses Aid (CNA) about how long it took her to answer his light and CNA stated that it was only 10 minutes and the resident informed the CNA it was 30 minutes as he was timing the response. A post fall review dated 12/10/19 revealed the resident fell and identified the cause as the resident tripped over his oxygen tubing. The intervention following the incident was for staff to assist the resident with keeping oxygen tubing out of his walk way. The resident needs to ask for help in keeping tubing picked up and use his call button. On 7/1/20 at 2:00 PM the DON stated she expects to answer call lights within fifteen minutes. The DON stated she did not do call light audits but looked at the call light report every once in a while. She stated she heard complaints from residents in Hall C and looked into them and there was nothing of concern to her. 3. A MDS completed for Resident #1 with an ARD of 3/25/20 showed a BIMS score of 14, indicating intact cognition. The resident had [DIAGNOSES REDACTED]. Interviews: On 6/30/20 at 12:58 PM, the resident said that when the resident was able to push the call light, the staff didn't come to answer the call light. Care Plan: A care plan problem dated 1/30/20 showed the resident with an activities of daily (ADL) self-care performance deficit related to ALS, impaired balance, and musculoskeletal impairment. An intervention dated 1/30/20 said to encourage the resident to use the bell to call for assistance. The review of the call light log showed response times greater than fifteen minutes occurred seven times in from 6/23/20 - 6/30/20. 6/27/20 at 11:21 AM - 20 minutes and 6 seconds 6/27/20 at 11:56 AM - 27 minutes and 36 seconds 6/27/20 at 12:49 PM - 16 minutes and 51 seconds 6/28/20 at 10:52 AM - 21 minutes and 20 seconds 6/29/20 at 7:52 PM - 18 minutes and 19 seconds 6/29/20 at 8:22 PM - 24 minutes and 40 seconds 6/29/20 at 10:14 PM - 18 minutes and 35 seconds On 7/1/20 at 10:25 AM, Staff A, Certified Medication Aide (CMA), reported never having issues with something terrible happening due to call light response times. Staff A reported not having trouble with call lights, but the facility was busy. Staff A said it was hard with staffing at the time. Staff A reported that it was not always like that. On 7/1/20 at 1:55 PM, the DON said she expected staff to answer the call lights in fifteen minutes or less. The DON believed there were times that the response time was greater than fifteen minutes. One of the Department Heads reviewed the call light log. From there concerns are brought to the DON, the DON then reviews it. Occasionally there are times the call light log isn't an accurate response, as sometimes staff forgot to turn off the call light. A couple of residents from the A hall were upset there wasn't staff available to help. The residents in hall C were either independent or an assist of one. Policy review: The Resident Call System policy dated 4/1/18 stated that all staff responded promptly when the call system was activated.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to account for Narcotic Medications for one of one resident reviewed (Resident #1). The facility reported a census of 29 residents. Findings include: A Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had [DIAGNOSES REDACTED]. The resident used opioids for seven of the previous seven days in the lookback period. Interviews: On 6/29/20 at 11:15 AM, Hospice Staff # 1, Registered Nurse (RN), reported on 6/25/20 she observed a [MEDICATION NAME] (narcotic) patch dated 6/20/20 on the resident. Hospice Staff #1 said the nurse reported changing the patch that day but then left the room and later said she changed the patch the day before. Hospice Staff #1 stated the nurse did change the patch while Hospice Staff #1 was at the facility on 6/25/20. On 7/1/20 at 1:00 PM, the resident denied noticing an increase in pain the week before. On 7/2/20 at 9:51 AM, Staff D, Certified Medication Aide (CMA), said the staff gave the resident the medication and then they sign off on the Medication Administration Record [REDACTED]. The staff counts the narcotics at a shift change, with one staff counting the medications and one staff checking the book. Staff D wasn't aware of any issues with the count being wrong. Staff D showed that eight residents used narcotic medications in the A hall. Observations: On 7/1/20 at 1:35 PM, observation showed the resident with a [MEDICATION NAME] on the left upper arm dated 6/28/20. Chart review: A Physician order [REDACTED]. Patch. On 6/25/20 at 12:18 PM, Nurses Notes revealed hospice staff gave the resident a whirlpool. Upon finishing the whirlpool, Hospice staff reported removed an outdated pain patch noted on the resident during the bath. Staff placed a new pain patch on the resident. On 6/25/20 the Client Coordination Note Report showed the Hospice Nurse observed a patch dated 6/20/20. The Hospice Nurse reported this to the facility nurse. The facility Nurse reported the patch was changed that day just before removing and applying a new patch. On 6/26/20 at 11:20 AM, the Orders - Administration Note showed a [MEDICATION NAME] Patch 75 mcg patch changed per the nurse's instruction. A care plan problem dated 2/24/20 showed the resident had pain related to ALS and a fracture to the left ankle. The intervention dated 2/24/20 said to administer [MEDICATION NAME] as per orders. The Verification of Controlled Substance Count sheet for 6/15/20 - 6/26/20 showed missing signatures for the on-coming caregiver for 6/26/20 at 6:00 AM. The narcotic (narc) count showed missing signatures of off-going caregiver for 6/15/20, 6/20/20, and 6/24/20. The Controlled Substance Record dated 6/23/20 showed documentation of two patches signed by the Administrator and DON. There was no documentation related to the patch documented as given on 6/25/20 per the progress note. The chart and narcotic count sheets lacked documentation of a patch placement for 6/28/20. Facility statement: The statement dated by 7/2/20 by the Administrator and the Director of Nursing (DON) noted two of the [MEDICATION NAME] counts were incorrect. Resident #1's narcotic count sheet showed the resident should have two patches, and the number of patches in the drawer was three. The Administrator and DON checked Resident #1's patch. The patch was correct with a date of 6/25/20 on the patch. DON interview: On 7/1/20 at 1:55 PM, the DON reported the [MEDICATION NAME] not signed for the 6/23/20. The count was off for two residents. The DON said she validated the date of the patch on the resident due to a lack of documentation on the MAR. Resident #1 was one of the residents who did not have a correct count for the [MEDICATION NAME]es. Policy review: The Medications - Controlled policy with a revision date of 3/1/14 showed Scheduled II or higher controlled substances are signed out upon dispensing of the medication. A count of controlled drugs is maintained by nurses of the off-going and on-coming shifts. Any irregularities are to be reported to the Director of Nursing. The controlled documentation procedure stated that a separate controlled substance administration control record is kept on all scheduled II drugs. It contains the amount verifiable by inventory.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility did not wear appropriate personal protective equipment

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) (PPE) as indicated by the Iowa Department of Public Health for the prevention of Novel Coronavirus 2019 (COVID-19) throughout the facility. The facility reported a census of 29 residents. Findings include: 1. On 6/29/20 at 9:21 AM observation revealed two therapists working with a resident. The therapists failed to wear face shields or goggles. They did wear face masks. 2. A Minimum Data Set (MDS) completed for Resident #2 with an Assessment Reference Date (ARD) of 4/2/20 showed the resident had short and long-term memory problems and severely impaired daily decision making. The resident never or rarely made decisions. The resident required extensive assistance of two staff for toileting and total dependence with two staff for bathing. The resident never experienced a rejection of care in the seven day lookback period. The resident was always incontinent of bowel and bladder. The resident had [DIAGNOSES REDACTED]. Observation: On 6/29/20 at 12:06 PM, observation showed Staff A, Certified Medication Aide (CMA), and Staff I, Licensed Practical Nurse (LPN), completed incontinence cares for the resident. Neither staff wore a face shield or goggles. During the resident's care, Staff A's face mask fell below the staff's nose showing the top of the staff's mouth. Staff A did not reposition the mask until outside of the resident's room at 12:37 PM. A care plan problem dated 3/17/20 identified the resident at risk for COVID-19 infection with signs and symptoms. The intervention dated 3/17/20 directed staff to follow facility protocol for COVID-19 screening and or precautions. 3. The MDS completed for Resident #3 with an ARD of 6/3/20 showed the resident no memory concerns. The resident could make independent decisions consistently and reliably. The resident had the [DIAGNOSES REDACTED]. Observation: On 6/29/20 at 12:38 PM, observation showed Staff A and Staff I provide cares to the resident. Neither staff wore the required face shield or goggles during the cares provided. Staff A's mask fell , exposing her nose and a portion of her mouth. Chart review: A care plan problem dated 3/17/20 identified the resident at risk for COVID-19 infection with signs and symptoms. The intervention dated 3/17/20 said to follow facility protocol for COVID-19 screening and or precautions. On 5/28/20 at 10:24 AM, a Nurses Note revealed the resident tested positive for the COVID-19 virus. The resident's family notified of results and stated understanding. The resident's primary Physician advised of the results. On 6/1/20 at 11:25 AM, a Nurses Note showed the Interdisciplinary Team (IDT) met to discuss the resident's COVID-19 status. The resident reported positive on 5/27/20 and was in isolation. The resident said shortness of breath, respiratory rate elevated at 24 on the 14th, and oxygen saturation was greater than 90%. The resident continued on isolation and hospice for [MEDICAL CONDITION]. The resident's record showed the resident was on droplet precautions from 5/27/20 - 6/22/20 with a private room, and the door closed. On 6/23/20 at 9:54 PM, the Daily Screener showed the daily screen completed with the following findings: - Vitals - Most Recent Temperature: T 97.1 - 6/23/2020 12:55 PM Route: Tympanic Most Recent O2 Saturation: O2 96.0 % - 6/23/2020 12:55 Method: Oxygen via Nasal Cannula - Observation Details - Current Symptoms: None of the Above / Unknown Interventions Completed: Proper PPE Applied / Utilized 4. A MDS completed with an ARD of 3/25/20 showed a BIMS score of 14, indicating intact cognition. The resident had [DIAGNOSES REDACTED]. Observation: On 6/29/20 at 12:43 PM, observation showed Staff A and Staff I provide incontinence cares for the resident. Neither staff wore a face shield or goggles during care. Chart review: A care plan problem dated 3/17/20 identified the resident at risk for COVID-19 infection with signs and symptoms. The intervention dated 3/17/20 said to follow facility protocol for COVID-19 screening and or precautions. Staff interviews: On 7/1/20, Staff A said staff wore goggles or face shields when the facility had COVID-19, it was a sweat show then. Now the staff only wear the face shield or goggles for the rooms that need them but not every room. DON interview: On 7/1/20 at 1:10 PM, the Director of Nursing (DON) said staff should wear full PPE for isolation rooms as posted on the door. The DON said she believed all should have full PPE. Staff should use face protection for direct patient contact. Staff wore full PPE for COVID-19 but now just wears masks. 5. A MDS completed for Resident #6 with an ARD of 6/23/20 showed a BIMS score of 15, indicating intact cognition. Resident had [DIAGNOSES REDACTED]. Review of hospital discharge notes revealed the resident tested positive for Covid on 5/4/20 and 6/9/20 with no follow-up testing showing negative results. The resident admitted to the facility on [DATE]. Observation on 6/30/20 at 1:25 PM showed the resident located on Hall C with droplet precaution signs posted on door of the resident's room which directed staff to wear facemask, face shield, gloves, and gown when entering room. Observation showed an isolation cart at doorway and two gowns hanging on hooks outside of room with two face shields hanging on hooks outside of room. Observation on 6/30/20 at 1:55 PM showed Staff G standing in the resident's room in front of the resident who sat in a recliner. Staff G was within arm's length of the resident. Staff G wore a face shield and face mask and gloves. Observation on 6/30/20 at 2:10 PM showed Staff G remove her gloves and wash her hands in the reisdent's room bathroom. Staff G then exited the resident room walking down hallway about 100 feet and stated, I almost ran off with this (referring to face shield). Staff G removed the face shield and returned it to the hook outside of the resident's room without sanitizing the face shield. Observation on 6/30/20 at 2:40 PM showed Staff H standing in the resident's room in front of the resident who sat in a recliner. Staff H was within reach of Resident. Staff H removed his /her gown and placed it on the hook outside of the resident's room and then went back into resident's room with no gown or gloves and closed the door. On 6/30/20 at 2:42 PM Staff H exited the resident's room wearing a facemask and walked down the hall. Staff H did not sanitize her hands. On 7/1/20 at 2:00 PM the Director of Nursing stated she expected all staff to follow the proper precautions for infection control. Document review of COVID-19 new admission plan stated staff should wear N95 or higher or facemask if not available along with eye protection, gloves, and gown when caring for residents.