| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165585 | A. BUILDING _____ B. WING _____ | 05/15/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER | 2002 CEDAR STREET MUSCATINE, IA 52761 |

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) |
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| F 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff and resident interviews and observations, the facility failed to notify the resident's physician and family member of a change in condition, failed to transfer a resident exhibiting fever and respiratory symptoms to the emergency room according to the physician's orders [REDACTED].#1, #2, #3,#4). The facility reported a census of 67 residents. Findings include: 1. According to the Quarterly Minimum Data ((MDS) dated [DATE] Resident #1 documented with [DIAGNOSES REDACTED]. The resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating intact cognitive ability. The resident required extensive assistance of 2 staff for bed mobility, transfers and required extensive assistance of 1 staff for dressing, toilet use and hygiene, the resident did not walk in her room or hall and used a wheelchair to move about the facility. The MDS revealed the resident did not have a history of rejection of cares or assessments, did not experience shortness of breath and did not utilize supplemental oxygen. Review of Resident #1's Care Plan dated [DATE] identified the resident with [MEDICAL CONDITION] and used an as needed (prn) inhaler and nebulizer and directed the staff to administer the inhaler as ordered and to monitor for side effects and effectiveness. The Care Plan dated [DATE] revealed the resident with an increased risk of potential infection related to the COVID-19 [MEDICAL CONDITION] outbreak and directed the staff to assist with family communication related to visitor restrictions; assess the resident's temperature and assess for signs of respiratory illness and report abnormal findings to the primary care physician for further treatment and care. The Care Plan failed to indicate the resident utilized supplemental oxygen. Review of the Order Recap Report dated [DATE]-[DATE] revealed the resident had the following orders: a. an order for [REDACTED]. an order for [REDACTED]. an order for [REDACTED]. an order for [REDACTED]. An order given on [DATE] by the Medical Director directed staff to exhaust all in house options prior to transferring to the emergency room as long as the resident is stable as per resident and Power of Attorney wishes. f. An order on [DATE] given due to the current decline in the resident's health which could be COVID-19 related, please monitor for decreased oxygen saturation. If the resident's oxygen saturation goes below 90% per current 4 Liters/Nasal Cannula, transfer the resident to a local emergency room (ER), order given by the PCP. Review of the physician's orders [REDACTED].#1 is running a temperature of 101.2 and had a temperature all day. Surveyor inquired what the resident's oxygen saturation status, the nurse stated she did not know as she has not assessed her yet. Staff A and Surveyor went into resident room to measure oxygen saturation. Resident #1 noted to be in bed, with head of bed up, oxygen running at 4 liters per nasal cannula. The resident appeared flushed and Foley catheter draining dark amber urine. Oxygen saturation noted to be 91% on 4 liters of oxygen at this time. During an interview with Staff A, LPN, the staff stated at report; which began at start of her shift at 6:00 p.m. she heard the Primary Care Physician requested the resident be sent to the ER today but indicated it is the Facility Policy to try to keep all the residents in the facility and reported staff obtained a culture for COVID-19 today. Observations at this time, the resident on Station 2 noted in her original room along with a roommate. The resident does not appear to be in any type of isolation as evidenced by no sign posted or isolation equipment noted in or outside the resident room. Staff A entered the resident's room with only a face mask and shield on. Review of Resident #1's temperature, oxygen saturation level and respiratory assessment log revealed the following: a. On [DATE] day shift, Resident #1 had a temperature of 99.3, oxygen saturation of 99% and rubs (abnormal sounds) in her lungs. b. On [DATE] evening shift, the resident had a temperature of 97.3, oxygen saturation of 89% with expiratory wheezes. c. On [DATE] day shift, the resident had temperature of 96.9, oxygen saturation of 84% with diminished lung sounds. d. On [DATE] evening shift, the resident had a temperature of 99.8, oxygen saturation of 79% with diminished lung sounds. e. On [DATE] day shift, the resident had a temperature of 99.3, oxygen saturation of 83% with diminished lung sounds. f. On [DATE] evening shift, the resident had a temperature of 98.6, and oxygen saturation of 78%, the staff failed to assessed the lung sounds. g. On [DATE] day shift, the resident had a temperature of 97.7, oxygen saturation of 86% with diminished lung sounds. h. On [DATE] evening shift, the facility staff failed to assess the resident. i. On [DATE] day shift, the resident had a temperature of 99.5, oxygen saturation of 84% with diminished lung sounds. j. On [DATE] evening shift, the resident had a temperature of 96.7, oxygen saturation of 92% with diminished lung sounds. k. On [DATE] day shift, the resident had a temperature of 101.6, the staff failed to assess the oxygen saturation and lung sounds. l. On [DATE] evening shift, the resident had a temperature of 100.0, oxygen saturation of 90% and diminished lung sounds. m. On [DATE] day shift, the resident had a temperature of 100.2, oxygen saturation of 86% and diminished lung sounds. n. On [DATE] evening shift, the resident had a temperature of 103.1 and 101.7, oxygen saturation of 93% with diminished lung sounds. o. On [DATE] day shift, the resident had a temperature of 100.3, oxygen saturation of 83% and lung sounds not assessed. Review of the Progress Notes dated ,[DATE]-[DATE] revealed the facility failed to notify the physician of condition changes; oxygen saturations ranging from 78%-90% eight times and failed to report to the physician temps ranging from 99.3 -101.6 six times. Review of the Progress Notes dated from ,[DATE]-[DATE] revealed the staff failed to document on Resident #1 on ,[DATE], ,[DATE] and [DATE] even though the resident utilized oxygen, had low oxygen saturation levels and elevated temperatures. Review of a Progress Note written by Staff B, LPN on [DATE] at 1:34 p.m., the Progress Note indicated he received a phone call from Resident #1's Primary Care Physician's (PCP) Nurse directing the staff to send the resident to a local ER due to displaying COVID-19 symptoms. The PCP's Nurse stated the resident's oxygen level 85% on 3 liters of oxygen delivered per nasal cannula and a temperature of 101.5. Staff B indicated he would relay the information to the facility Director of Nurses (DON) and Assistant Director of Nurses (ADON). Staff B charted he took all information to the ADON who stated she would take care of it. During an interview with Staff B, LPN on [DATE] at 1:03 p.m., the Staff Nurse stated he was not assigned to Resident #1 on Station 2 but answered the telephone on [DATE]. Staff B stated the PCP's Nurse for Resident #1 wanted him to transfer the resident to the ER but told the PCP's Nurse he did not have the authority to do this but he will give information to the DON/ADON who does have that authority. Staff B stated there is a Facility Policy that all transfer decisions have to go through the DON and ADON. The DON/ADON will then text the Medical Director to get permission for the transfer, he will indicate if they can be transferred even if the resident is not his patient. Staff B relayed transfer info to the ADON at this time and he shared she immediately said NO and told Staff B we are doing everything we can in the building and stated she would take care of this. During an interview with Staff C, ADON/Infection Control Nurse on [DATE] at 1:00 a.m., Staff C stated she tested all residents today for COVID-19, her corporation sent test kits for all residents and she obtained the orders from the Medical Director to test all residents. Staff C stated on [DATE] she received a message from Resident #1 PCP and the PCP's Nurse they wanted to speak to her, Staff C stated they thought I should stop doing COVID testing to speak to them. She indicated she received orders for Resident #1 to discontinue the [MEDICAL CONDITION]/inhalation nebulizer due to the potential spread of the [MEDICAL CONDITION] and initiated hand held puff inhalers in the place of nebulizer treatments. |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 1)<br>Staff C stated Staff B, LPN took a call and reported Resident #1's PCP wanted the resident sent out to the ER as she had symptoms of COVID-19 and is a full code. Staff C, ADON had Staff F, Registered Nurse (RN)/ Agency Nurse complete a COVID assessment on Resident #1 on [DATE]. Staff C reviewed the assessment and decided Resident #1 did not meet the criteria to be transferred for COVID-19. The ADON stated she was on the phone with the facility Medical Director multiple times [DATE], he directed the facility to follow their policy to keep all residents in the facility and not to send out to ER if you can help it. Staff C stated she received a phone call from Resident #1's PCP inquiring why they failed to send Resident #1 to the ER as ordered earlier in the day. Staff C stated when the PCP called I would have thought if she wanted the resident sent to the emergency room she would have said it again, but she didn't. Staff C told the PCP they had 3 nurses assess Resident #1 for COVID and they all felt she did not meet the criteria to transfer to the ER. Staff C again stated the facility Medical Director directed her to treat the resident in the facility. Staff C, ADON said they do not have any COVID-19 in the building and we want to keep it that way and would isolate the residents immediately if they suspected anyone had COVID-19. Staff C did state they have had 2 staff members that recently tested positive for COVID-19 virus.<br>During an interview on [DATE] at 8:41 a.m. with the facilities' Medical Director, the Medical Director stated he does not remember getting a phone call from the facility on [DATE] regarding Resident #1. The Medical Director stated Resident #1 is not my patient and I would never give an order to contradict another physician's orders [REDACTED]. The Medical Director stated this was a general policy they developed as result of the COVID-19, but it did not indicate not to transfer a resident, especially a resident of another physician Review of the hand written COVID-19 Assessment Form dated [DATE] (the form did not include the time of assessment). Staff F, Agency RN indicated the resident requested CPR, had temperatures of 101.6 and 101.5, oxygen saturation level 92% on 3 liters of oxygen, had diminished lung sounds with wheezing, and both yes/no boxes related to shortness of breath checked. The 2nd page of the COVID-19 Assessment Information Form indicated the resident had a temperature with an onset date of [DATE] but no other symptoms noted. During an interview with Staff G, DON on [DATE] at 9:12 a.m., Staff G stated when she came to work on [DATE] she was told they had to place supplemental oxygen on Resident #1 because her oxygen saturation level is low at 88%. Around noon on [DATE] the DON spoke to Resident #1, she denied all complaints of shortness of breath, cough, sore throat but her urine had a strong odor. The Agency Nurse working with Resident #1 called earlier in shift to obtain order for an urinalysis (UA) and change in the resident's nebulizer orders. At approximately 1:00 p.m. the DON spoke to the resident again to inquire how she was feeling. The DON assessed the resident her lungs were clear, oxygen saturation at 90%. The DON stated the resident refused to go to theER on that day and time. The DON stated the nurse working with Resident #1 that day shift stated she felt the symptoms the resident experienced not respiratory related. The DON stated she spoke to the Medical Director on [DATE] between 4:,[DATE]:00 PM, told him resident refusing to go to ER because she didn't feel ill. The DON stated she did not receive any information regarding the PCP contacting the facility to inquire why the resident didn't' go to the ER. The DON stated if the nurses had an order to transfer the resident to the ER they should have transferred her. The DON stated on [DATE] they tested all residents for COVID-19 and at this time they had at least 20 positive cases of COVID-19 and still more results coming in. The DON stated Resident #1 transferred to a localER on [DATE] and then transferred to a larger hospital that same day due to oxygen needs. Review of Resident #1's Progress Notes revealed a note entered by Staff G, DON on [DATE] (late entry) the note stated Resident #1 refused to go to theER on ,[DATE].20. During an interview with Resident #1 on [DATE] at 1:53 p.m., the resident stated she is feeling better. Asked the resident if she told the facility staff that she didn't' want to go to the hospital, the resident stated she could not remember but stated she doubts she said that because she wants all measures done to save her life. During an interview with Staff F, RN/Agency Nurse on [DATE] at 7:39 a.m., Staff F stated she worked on [DATE] and [DATE]- day shift. On [DATE] the staff completed COVID-19 swabs on all the residents. Resident #1 had a temperature the day before but didn't complain of a cough on [DATE]. Staff F stated she received a phone call from the PCP's nurse on [DATE] directing her to place Resident #1 in droplet isolation and to move her away from the roommate. Staff F stated she relayed these orders to the ADON who informed her they were only taking orders from the Medical Director. Staff F stated sometime later in the shift she received a phone call from Resident #1's PCP, the PCP was angry because they had give specific orders for Resident #1 to be transferred to the ER. Staff F stated the order came in while she was off grounds for her lunch time and didn't know about it. Staff F spoke to the ADON regarding the phone call from the PCP, the ADON informed Staff F they are not sending anyone out. Staff F stated she charted 3 times in Resident #1's clinical record on [DATE] day shift: a focused assessment, a conversation with Resident #1 regarding her code status with the resident's response and the phone call from the PCP questioning why the resident not transferred to the ER. Staff F informed upon review of those notes, the entries spoken of were not found in the progress notes dated [DATE], she stated again I wrote those three things in the progress notes, I don't know what happened to them. Review of the Progress Notes on [DATE] day shift did not contain any progress notes written by Staff F, RN Agency nurse. During an interview with Staff D, LPN on [DATE] at 1:22 p.m., Staff D stated she worked with Resident #1 on [DATE], the resident had a temperature of 100.2 and required 4 liters of oxygen to keep her oxygen saturation at 93%. Staff D stated the resident did not utilize oxygen prior to running the abnormal temperatures. The nurse stated later in her shift she received orders for a repeat urinalysis, an antibiotic and the PCP stated the resident could possibly be COVID positive and to send to a local ER if the resident's oxygen saturation level goes below 90% on 4 liters of oxygen. Review of a Progress Note dated [DATE] at 5:44 a.m., Staff E, LPN sent a fax to the PCP informing them Resident #1 with a temperature of 101.7 and administered medication to lower the temperature. Review of a Progress Note dated [DATE] at 10:08 a.m. Staff D, LPN indicated Resident #1 with a temperature of 100.3 and an oxygen saturation level of 83% on 4 liters of oxygen and unable to raise the resident's oxygen saturation level. The nurse notified the PCP to inform and transferred the resident to a local emergency room . Review of a [DIAGNOSES REDACTED]-C0V-2 (COVID-19) test results revealed the staff collected the specimen on [DATE] and the lab reported back on [DATE] that Resident #1 tested positive for COVID-19. Review of a fax to Resident #1's PCP dated [DATE] at 7:00 a.m. revealed the resident tested positive for COVID-19 and they gave the resident medication to treat a temperature of 101.7. Review of a typed Condition Report dated [DATE] from Resident #1's PCP. The notes revealed the office's Physician's Assistance (PA)became aware of Resident #1's change of condition on this day, the resident had oxygen saturation of 85 % on 3 liters of oxygen, has a temperature over 101 and is requiring increased oxygen. The PA informed the PCP the resident began showing signs of illness since [DATE] but the record lacked documentation from ,[DATE]-[DATE]. The PA gave an order to transfer the resident to a localER on [DATE] but the staff failed to transfer the resident per order given. The PCP stated as of 5:00 p.m. on [DATE] the staff had not transferred the resident to the ER per orders. The PCP contacted the resident's nurse, the nurse reported the resident is stable and that the ADON and DON did not feel it appropriate to transfer the resident as they felt the resident was stable. The PCP again contacted the facility at 7:30 p.m., another nurse working reported the resident is now on 4 liters of oxygen, temperature 100.0 and oxygen saturation 92%. and 6 other residents are exhibiting increased temperatures. PCP spoke to the ADON who reported the entire building was swabbed for COVID-19 but only 1 resident had a temperature. The ADON reported to PCP the Medical Director has put into place protocols and does not want patients to leave the facility for fear of contracting COVID from an outside exposure and respiratory protocol states only symptoms of shortness of breath, then the patient can leave the facility to go to the ER but only if using accessory muscles for breathing or if low oxygen saturations cannot be corrected with the application of oxygen. The ADON reported to the doctor the DON was responsible for not sending the Resident #1 to the ER as they are following the protocols as outlined by their medical director and felt the resident was stable in the facility and didn't need transferred to the ER. The PCP indicated she reviewed her concerns and feels they have multiple cases of COVID-19 in their building already. During an interview with Resident #1's PCP on [DATE] at 8:50 a.m., the PCP stated her Physician's Assistant contacted the facility regarding 5 residents she was going to do telehealth visits on, the nurse working on the floor asked the PA if she was going to also see three other residents who were ill. The 3 ill residents included Resident #1. The PA and her nurse had the ability to read the resident's electronic Progress Notes and stated Resident #1 had symptoms of COVID 19. The PA called the facility and ordered Resident #1 to be sent to a local emergency room due to low oxygen saturations. The PCP stated she outlined the details of the incident in the Condition Update dated [DATE]. The PCP stated she gave a directive to place Resident #1 into droplet isolation, send to the ER and swab for COVID-19 virus on [DATE], she said they did not follow thru on this order. Review of COVID-19 Testing Conversation dated [DATE] written by the PCP's Office Nurse revealed on [DATE] at 11:40 a.m., she received a report from Staff F, Agency RN at this time, the facility RN reported Resident #1 is running a temperature of 100.2 and had low oxygen saturations since yesterday which required her to be placed on supplemental oxygen. The PCP's Nurse gave orders to the ADON to test for the COVID-19 virus, place the resident in droplet isolation, start [MEDICATION NAME] multi dose inhaler four times daily and discuss the code |

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| F 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 2)<br>status and there patient's preference for intubation. At 1:39 p.m. the PCP's Nurse received an update report, the resident's temperature is 101.6, oxygen saturation is 75% on 2 liters of oxygen, when oxygen increased to 3 liters the oxygen saturation went to 85%. The PCP gave an order to transfer the resident to the ER to be evaluate due to Resident #1's high temperature and low oxygen levels. The order to transfer given to Staff B and he read back the order to her, which indicated he understood the order. The PCP directed staff to utilize an ambulance for the transfer and inform the ambulance staff the resident has symptoms of COVID-19. The PCP called the local ER to make them aware of the resident coming to the ER and COVID status. Review of the Conversation Notes revealed the PCP's Nurse called multiple times yesterday ([DATE]) to see why the patient not sent out to the ER, but did not receive a response. At 5:30 p.m. the Staff C, ADON replied to the PCP's Nurse that is was out of her hands and that this is for the DON. During an interview with the PCP's Nurse on [DATE] at 10:09 a.m., revealed she called the facility to only get vitals on the 5 residents she would be seeing for telehealth on [DATE]. She was asked if she was going to see the additional 3 ill residents which included Resident #1. She stated she could electronically view the vitals and Progress Notes and discovered the resident began to have symptoms on [DATE] but the staff failed to document anymore until [DATE]. The staff informed the PCP's Nurse Resident #1 had an elevated temperature, oxygen saturation of 75% on 4 liters of oxygen, and the resident did not utilize supplemental oxygen prior to this illness. The PCP's Nurse ordered the resident to be tested for COVID-19 and to place the resident in droplet isolation as she has symptoms of COVID- 19. The PCP's Nurse stated she called the facility throughout the day to inquire why the staff did not send the resident to the ER. The PCP's Nurse gave orders for the resident to be placed in droplet isolation and to have a COVID swab completed at a local lab. These orders were not followed. Review of the emergency room records for Resident #1 on [DATE] revealed the staff transferred the resident to the ER for COVID-19 symptoms and low oxygen levels. The resident tested positive for COVID and she is a resident at a local nursing home facility where there is a concern for a COVID outbreak. The resident complained of difficulty breathing and reports having a cough when arriving to the ER. An x-ray report dated [DATE] revealed patchy airspace opacities at the left base, which may represent atelectasis or developing pneumonia and lab reports consistent with a [MEDICAL CONDITION] infection. The resident required 5 liters of oxygen and had to be transferred to a larger hospital with a [DIAGNOSES REDACTED]. Review of a Progress Note dated [DATE] revealed the resident returned to the facility. Review of a COVID-19 Policy and Procedure dated [DATE] indicated the purpose of the policy is to identify and isolate symptomatic residents and prevent the potential contamination of facility population with Novel Coronavirus. The Policy directs the staff to assess the residents every shift for abnormal vital signs and noted respiratory symptoms. Should residents exhibit any of the following symptoms the facility shall initiate droplet isolation precautions for symptomatic residents and roommates if applicable. For symptoms which included: 1. A fever greater than 100.4. 2. A sore throat. 3. A cough. 4. Decreased oxygen saturation levels. 5. Difficulty breathing or painful respirations. 6. Fatigue, body aches, headache or any other flu-like symptoms. The Policy also directed nursing staff on th following: a. The facility shall notify the primary medical provider or their designee of symptoms. b. Residents will be placed into droplet isolation along with their roommate. c. Follow up testing shall occur per the order of the primary care physician. d. Residents and room mate will remain in droplet isolation precautions until tests are return with definitive diagnosis. e. Should the resident require transfer to hospital and is hospitalized the roommate will continue droplet isolation requisitions until tests are confirmed or 14 day isolation period has been completed with no noted symptoms of illness. Review of an undated Physician Notification Policy directed the staff to respond in an appropriate and timely manner to acute changes in a resident's condition as indicated by the nursing staff and to ensure continuity of care. The Policy identified the types of conditions to notify the physician; altered mental status, chest pain, diarrhea, shortness of breath and vital sign changes. The policy described emergency situations as: chest pain, shortness of breath, vital signs as temperature over 101 and oxygen saturation below 90%. 2. According to the Minimum Data Set ((MDS) dated [DATE] Resident #2 documented with [DIAGNOSES REDACTED]. The MDS revealed the resident had a Brief Interview for Mental Status (MDS) score of 11 which meant the resident had intact cognitive ability. Resident #2 required limited assistance of 1 staff for transfers, walking in room, and needed extensive assistance of 1 staff for dressing, toilet use and personal hygiene. The resident noted to be continent of bowel and bladder, had shortness of breath with exertion and laying flat and received supplemental oxygen therapy. Review of the undated Care Plan revealed the resident with a risk for falls due to non compliance with requesting assistance with transfers and not wearing oxygen as ordered. The Care Plan failed to inform staff how oxygen is administered and the amount prescribed. Review of Resident #2's Progress Notes revealed the following: a. On [DATE] at 1:22 p.m., the staff noted a bruise on the resident's left shin and contacted the resident's physician. Oxygen saturation level noted as 91% on room air. b. On [DATE] at 6:09 a.m., the staff documented Resident #2 did not feel well, had a temperature of 99.2, oxygen saturation 90% on 1 liter of oxygen via nasal cannula and incontinent of urine. The staff contacted the Primary Care Physician (PCP) regarding the urinary incontinence and increased weakness. The PCP ordered an urinalysis and an antibiotic. c. On [DATE] at 2:00 a.m., there resident had a temperature of 100.2. d. On ,[DATE]/.20 at 6:00 a.m., the nurse documented the resident utilized oxygen all night via face mask due to mouth breathing. e. On [DATE] at 12:25 p.m., noted upon entering the resident's room, the resident sat at side of bed, shaking, covered in a blanket. The resident's temperature 102.5, oxygen saturation level 82% on 3 liters of oxygen, unable to obtain a blood pressure due to the resident's constant involuntary movement. The resident reports chest discomfort which just started. The floor nurse notified Staff C, ADON per new facility policy. The ADON advised the staff nurse to await a call back, as she would authorize and obtain an order for [REDACTED]. g. On [DATE] at 1:20 p.m., Staff C, ADON at resident bedside, informed the resident of the new orders. The residents temperature at this time 99.4 and oxygen saturation 88% on 3 liters of oxygen per nasal cannula. Staff C reported gave Medical Director an update and he directed Staff C to continue with prior plan and try to avoid sending the resident to the ER and continue to treat the resident in house. Staff C notified the Charge Nurse of interventions in place and completed orders. h. On [DATE] at 4:00 p.m., the resident had a temperature of 103.6 and oxygen saturation of 80% on 2 liters of oxygen per nasal cannula. The staff nurse made the Director of Nurses aware. i. On [DATE] at 5:37 p.m., the resident remains restless, removing his oxygen, temperature 102.9 and oxygen saturation 86% on 3 liters of oxygen. j. On [DATE] at 7:50 p.m., the resident had a temperature of 104.5, oxygen saturation 86% on ,[DATE] liters of oxygen, stated he cannot breath and a cough noted. Staff provided 1:1 with resident as he attempted to pull out Foley catheter and frequently removed his oxygen. The Staff Nurse contacted the management, the management advised the nurse to apply resident's [MEDICAL CONDITION] and to monitor. Staff C, ADON will notify the Medical Director and family. k. On [DATE] at 8:05 p.m., the nurse notifies the family, family refused to allow transfer to the emergency room , family indicated resident only has urinary tract infection does not need to go to the ER. l. On [DATE] at 11:51 p.m., the resident has a temperature of 104.5. m. On [DATE] at 2:04 a.m., Staff C, ADON obtained an order for [REDACTED]. On [DATE] at 2:10 a.m., the resident had a green, bile emesis and Staff Nurse administered [MEDICATION NAME]. The resident's oxygen saturation level ,[DATE]% on 3 liters of oxygen and temperature 102.5. n. On [DATE] at 3:56 p.m., the resident has a temperature of 104.5. o. On [DATE], the resident has temperature of 100.3 at 3:30 a.m. and at 3:01 p.m. a temperature of 99.0. p. On [DATE], the staff obtained a nasal swab for COVID-19 ordered by the Medical Director due to heavy virus activity in the community. The DON documented at 5:05 p.m., the resident is asymptomatic and will monitor vital signs and respiratory assessments twice daily as a proactive measure. q. On [DATE], the resident had a temperature of 99.6 at 6:52 a.m. and at 9:43 a.m. temperature of 100.5. r. On [DATE], the resident appeared more confused at 1:43 a.m. and at 5:00 a.m. the nurse documented the resident ran a low grade fever all night, confusion continues and the resident had complaints of body aches and pains. s. On [DATE], the staff reported to the PCP the resident had a temperature of 101.0 and oxygen saturation level of 85% on 4 liters of oxygen. At 10:48 a.m. the staff received an order from the PCP to transfer the resident to the ER for COVID-19 and low oxygen saturation levels. Observation on [DATE] at 11:28 a.m., Resident #2 in bed, the Staff Nurse called 911 to transfer the resident to a local the ER. The resident is observed in bed, oxygen on via a non-re-breather mask, the Foley catheter is draining dark colored urine. The nurse gave a verbal report to Emergency Medical Staff (EMS) personnel, the resident is COVID-19 positive, oxygen saturation is 85% on 4 liters of oxygen and unable to be stabilized. The resident has been running temperatures. The resident left the facility via ambulance at 11:32 a.m. Review of local the ER notes dated [DATE] at 12:30 p.m., revealed Resident #2 arrived to the ER from a local nursing home for ongoing shortness of breath. The resident tested positive today for COVID-19. Today experienced low oxygen saturations into the 70% range and transferred to the ER. The resident stated he had difficulty breathing and has a cough. Upon arrival he had oxygen saturation of 78% on room air and placed on 6 liters of oxygen per nasal cannula then placed on 15 liters with non re-breather mask. Review of [DIAGNOSES REDACTED]-C |

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| | **165585** | A. BUILDING _____ B. WING _____ | **05/15/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER** | **2002 CEDAR STREET MUSCATINE, IA 52761** |

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) |
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| F 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 3) |
| F 0695<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff and resident interviews and observations the facility failed to obtain orders for the use of non-rebreather [MED]gen masks for 4 of 8 open sampled residents (Resident #2, #3, #7, #8). The facility reported a census of 67 residents. Findings include: 1. According to the Minimum Data Set ((MDS) dated [DATE] Resident #2 documented with [DIAGNOSES REDACTED]. The MDS revealed the resident had a Brief Interview for Mental Status (MDS) score of 11 which meant the resident with intact cognitive ability. Resident #2 required limited assistance of 1 staff for transfers, walking in room, and needed extensive assistance of 1 staff for dressing, toilet use and personal hygiene. The resident noted to be continent of bowel and bladder, had shortness of breath with exertion and laying flat and received supplemental [MED]gen therapy. Review of the undated Care Plan revealed the resident had a risk for falls due to non compliance with requesting assistance with transfers and not wearing [MED]gen as ordered. The Care Plan failed to inform staff how [MED]gen is administered and the amount prescribed. Observation on 4/30/20 at 11:28 a.m., Resident #2 in bed, the staff nurse called 911 to transfer the resident to a local emergency room (ER). The resident observed in bed, [MED]gen administered via a non-re-breather mask, the Foley catheter is draining dark colored urine. The nurse gave a verbal report to the Emergency Medical Staff (EMS) personnel, the resident is COVID-19 positive, [MED]gen saturation is 85% on 4 liters of [MED]gen, unable to be stabilized and running elevate temperatures. The resident left the facility via ambulance at 11:32 a.m. Review of the the physician's orders [REDACTED]. noted upon arrival the staff placed a non rebreather mask with [MED]gen running at 15 liters on the resident. 2. According to the Minimum Data Set ((MDS) dated [DATE] Resident #3 documented with [DIAGNOSES REDACTED]. The resident had a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident with intact cognitive ability. The resident required limited assistance 2 staff for bed mobility and extensive assistance of 2 staff for transfers and extensive assistance of 1 staff for moving about the facility, dressing, toilet use and personal hygiene. The resident utilized a wheelchair for mobility and did not utilize supplemental [MED]gen therapy. Review of the undated Care Plan revealed a focus area that stated the resident is at risk for COVID-19 [MEDICAL CONDITION] outbreak and directed staff to assist the resident with communication with family, assess the resident's temperature, monitor for signs of respiratory illness and report abnormal findings to the primary care provider for further treatment and care. Review of the April Medication/Treatment Administration record failed to indicate the resident utilized [MED]gen in April 2020. Review of the physician's orders [REDACTED]. Staff H, Nurse Consultant failed to write the order she received on 5/1/20 from the PCP until 5/5/20. Review of the Station 2 temperature logs for Resident #3 revealed the following abnormal findings: a. On 4/28/20 day shift, the resident had a temperature of 101.4 and [MED]gen saturations of 88%, failed to identify the amount of [MED]gen needed, 4/28/20 evening shift, (6 p.m. to the next am at 6 a.m.) the resident had a temperature of 99.5 and [MED]gen saturations of 90%. b. On 4/29/20 day shift, the resident had a temperature of 100.8 with a dry cough. c. On 4/30/20 day shift, the resident had a temperature of 102.0, [MED]gen saturation of 83-86%, staff indicted they increased the [MED]gen to 4 liters at 2:00 p.m. and the [MED]gen saturation rose to 93% on 4 liters of [MED]gen. d. On 5/1/20 evening shift, the resident had an [MED]gen saturation of 85% and blood pressure of 90/57. e. On 5/2/20 the resident had an [MED]gen saturation of 98% on 3.5 liters of [MED]gen. Review of the Progress Notes revealed the staff failed to follow the orders of 5/1/20 and failed to contact the resident's physician with the use of [MED]gen over 4 liters to maintain [MED]gen saturation on 5/1/20 and 5/2/20. Review of physician's orders [REDACTED]. EMS increased the resident's [MED]gen to 10 liters with the non rebreather mask and the resident's [MED]gen saturation level rose to 96%. 3. According to the Minimum Data Set ((MDS) dated [DATE] Resident #7 documented with [DIAGNOSES REDACTED]. Review of the Care Plan failed to reveal the resident used supplemental [MED]gen therapy. Review of a Progress Note dated 4/28/20 indicated the staff completed a COVID-19 nasal swab and noted the resident does not have symptoms. The notes revealed the staff will monitor vital signs and respiratory status twice daily. On 5/6/20 at 2:02 p.m., the nurse noted a drop in the resident's [MED]gen saturation level to 78%, the supplemental [MED]gen increased to 4 liters, the staff place a non rebreather mask on the resident at this time. On 5/6/20 at 1:53 p.m., staff called 911 for continued low [MED]gen saturation levels and unresponsiveness. EMS took the resident to a local hospital then subsequently transferred to a larger hospital and placed on a ventilator. Review of a local ambulance run report dated 5/6/20 at 2:26 p.m., EMS indicated the staff reported placing a non-rebreather mask on the resident then bumped the [MED]gen up to 4 liters. Resident currently had an [MED]gen saturation level of 72%. Review of the Order Recap Sheet dated 4/28-5/5/20 revealed the resident did not have an order for [REDACTED].#8 documented with [DIAGNOSES REDACTED]. The staff required limited assistance of 1 staff for transfers, walking, dressing and extensive assistance of 1 staff for toilet use and personal hygiene. The MDS revealed the resident had a BIMS score of 12 which indicated intact cognitive ability. Review of the Care Plan failed to indicate the resident used supplemental [MED]gen therapy. Review of a local ambulance run report dated 5/4/20 at 9:36 p.m., the EMS stated when they arrived to the facility, the resident had on a non rebreather [MED]gen mask with 1 liter of [MED]gen running. Review of the Order Recap Summary dated 4/7-5/31/20 failed to include an order for [REDACTED]. Staff H stated we do have an order into our supplier for more but they are on backorder. Staff H along with the Administrator stated there were only 2 residents that utilized the non-rebreather mask because they both developed a low [MED]gen saturation level and needed a high level of [MED]gen. During an interview with Staff C, Assistant Director of Nursing (ADON) on 5/14/20 at 3:07 p.m., the staff stated they recently had 2 residents who used the non-rebreather masks. Staff C indicated the staff should have an order before applying the masks and said the amount of [MED]gen you would us with the non-rebreather is according to the physician's orders [REDACTED]. [REDACTED]. During an interview with Staff A, LPN on 5/15/20 at 2:05 p.m., Staff A stated she has used a non-rebreather on residents at the facility, she didn't know if it required a physician's orders [REDACTED]. Review of an Administration of Oxygen Therapy Policy dated 5/12/19 and an Oxygen Use During COVID-19 Activity Period Policy dated 4/2/20 failed to address the use of a non-rebreather mask. |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff and resident interviews and observations the facility failed to implement effective infection control measures in attempts to mitigate the transmission of the COVID-19 virus amongst their residents and failed to follow physician's orders [REDACTED].#1, #2, #3). The facility reported a census of 67. Findings include: 1. According to the Quarterly Minimum Data ((MDS) dated [DATE] Resident #1 documented with [DIAGNOSES REDACTED]. The resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated intact cognitive ability. Review of Resident #1's Care Plan dated 3/26/20 revealed the resident with an increased risk of potential infection related to the COVID-19 [MEDICAL CONDITION] outbreak and directed the staff to assist with family communication related to visitor restrictions; assess the resident's temperature and assess for signs of respiratory illness and report abnormal findings to my primary care physician for further treatment and care. Review of the Order Recap Report dated 3/1/20-5/4/20 revealed the resident had the following orders: a. an order for [REDACTED]. On order on 4/29/20 due to the current decline in the resident's health which could be COVID-19 related, please monitor for decreased oxygen saturation. If the resident's oxygen saturation goes below 90% per current 4 Liters/nasal cannula transfer the resident to a local emergency room (ER), order given by the Primary Care Physician (PCP). Observation on 4/29/20 at 12:48 a.m. revealed Staff A, Registered Nurse (RN), at Station 2 Nursing Station, Staff A stated Resident #1 is running a temperature of 101.2 and had a temperature all day. Surveyor inquired what the resident's oxygen saturation status, the nurse stated she did not know as she has not assessed her yet. Staff A and Surveyor went into resident room to measure oxygen saturation. The resident in bed next to window. Staff A reported Resident #1 tested for COVID-19 today. Observations at this time, the resident on Station 2 in her original room along with a roommate. The resident does not appear to be in any type of isolation as evidenced by no sign or isolation equipment noted in or outside the resident room. Staff A entered the resident's room with only a face mask and shield on. Review of Resident #1's temperature, oxygen saturation level and respiratory assessment log revealed the following: a. On 4/23/20 day shift, Resident #1 had a temperature of 99.3, oxygen saturation of 99% and rubs in her lungs. b. On 4/23/20 evening shift, the resident had a temperature of 97.3, oxygen saturation of 89% with expiratory wheezes. c. On 4/24/20 day shift, the resident had temperature of 96.9, oxygen saturation of 84% with diminished lung sounds. d. On 4/24/20 evening shift, the resident had a temperature of 99.8, oxygen saturation of 79% with diminished lung sounds. e. On 4/25/20 day shift, the resident had a temperature of 99.3, oxygen saturation of 83% with diminished lung sounds. f. On 4/25/20 evening shift, the resident had a temperature of 98.6, and oxygen saturation of 78%, the staff failed to assessed the lung sounds. g. On 4/26/20 day shift, the resident had a temperature of 97.7, oxygen saturation of 86% with diminished lung sounds. h. On 2/26/20 evening shift, the facility staff failed to assess the resident. i. On 4/27/20 day shift, the |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 4)<br>resident had a temperature of 99.5, oxygen saturation of 84% with diminished lung sounds. j. On 4/27/20 evening shift, the resident had a temperature of 96.7, oxygen saturation of 92% with diminished lung sounds. k. On 4/28/20 day shift, the resident had a temperature of 101.6, the staff failed to assess the oxygen saturation and lung sounds. l. On 4/28/20 evening shift, the resident had a temperature of 100.0, oxygen saturation of 90% and diminished lung sounds. m. On 4/29/20 day shift, the resident had a temperature of 100.2, oxygen saturation of 86% and diminished lung sounds. n. On 4/29/20 evening shift, the resident had a temperature of 103.1 and 101.7, oxygen saturation of 93% with diminished lung sounds. o. On 4/30/20 day shift, the resident had a temperature of 100.3, oxygen saturation of 83% and lung sounds not assessed. During an interview with Staff C, Assistant Director Of Nursing (ADON)/Infection Control Nurse on 4/29/20 at 1:00 a.m., Staff C stated she tested all residents yesterday for COVID-19, her corporation sent test kits for all residents and she obtained the orders from the Medical Director to test all residents. Staff C stated Staff B, Licensed Practical Nurse took a call and reported Resident #1's PCP ordered the resident sent out to the ER as she had symptoms of COVID-19 and is a full code. Staff C, ADON had Staff F, RN/ Agency Nurse complete a COVID assessment on 4/28/20. Staff C reviewed and decided Resident #1 did not meet the criteria to be transferred to the ER for COVID-19. The ADON stated she was on the phone with the facility Medical Director on 4/28/20, he directed the facility to follow their policy to keep all residents in the facility and not to send out to the ER if you can help it. Staff C told the PCP they had 3 nurses assess Resident #1 for COVID and they all felt she did not meet the criteria to transfer to the ER. Staff C again stated the facility Medical Director directed her to treat the resident in the facility. Staff C, ADON said they do not have any COVID-19 in the building and we want to keep it that way and if we did we would isolate the residents immediately if they suspected anyone had COVID-19. Staff C did state they have had 2 staff members that recently tested positive for COVID-19 virus. During an interview with Staff G, Director Of Nursing (DON) on 5/4/20 at 9:12 a.m., Staff G stated when she came to work on 4/28/20 she was told they had to place supplemental oxygen on Resident #1 because her oxygen saturation level is low at 88%. DON stated the nurse working with Resident #1 that day shift 4/28/20 stated she felt the symptoms the resident experienced is not respiratory related. DON stated on 4/28/20 they tested all residents for COVID-19 and at this time they had at least 20 positive cases of COVID-19 and still more results coming in. The DON stated Resident #1 transferred to a localER on [DATE] and then transferred to a larger hospital that same day due to oxygen needs. During an interview with Staff F, RN/Agency Nurse on 5/7/20 at 7:39 a.m., Staff F stated she worked on 4/27/20 and 4/28/20 day shift. On 4/28/20 the staff completed COVID-19 swabs on all the residents. Resident #1 had a temperature the day before but didn't complain of a cough on 4/28/20. Staff F stated she received a phone call on 4/28/20 from the PCP's Nurse directing her to place Resident #1 in droplet isolation and to move her away from the roommate. Staff F stated she relayed these orders to the ADON who informed her they were only taking orders from the Medical Director. Review of a [DIAGNOSES REDACTED]-C0V-2 (COVID-19) test results
revealed the staff collected the specimen on 4/28/20 and the lab reported back on 4/29/20 that Resident #1 tested positive for COVID-19. During an interview with Resident #1's PCP on 4/29/20 at 8:50 a.m., the PCP stated her Physician's Assistant (PA) contacted the facility regarding 5 residents she was going to do telehealth visit on, the nurse working on the floor asked the PA if she was going to also see three other residents who were ill. The 3 ill residents included Resident #1. The PA and her Nurse had the ability to read the resident's Progress Notes electronically and stated Resident #1 had symptoms of COVID-19. The PA called the facility and ordered Resident #1 to be sent to a local ER due to low oxygen saturations. The PCP stated she outlined the details of the incident in the Condition Update dated 4/28/20. The PCP stated she gave a directive to place Resident #1 into droplet isolation and to swab for COVID-19 virus on 4/28/20, she said they did not follow thru on this order. 2. According to the Minimum Data Set ((MDS) dated [DATE] Resident #2 documented with [DIAGNOSES REDACTED]. The MDS revealed the resident had a Brief Interview for Mental Status (MDS) score of 11 which meant
the resident had intact cognitive ability. Review of Resident #2's Care Plan failed to include the resident had an increased risk for potential infections related to the COVID-19 [MEDICAL CONDITION] outbreak. Review of the Progress Notes revealed the following: a. On 4/25/20 at 12:25 p.m., noted upon entering the resident's room, the resident sat at the side of bed, shaking, covered in a blanket. The resident's temperature 102.5, oxygen saturation level 82% on 3 liters of oxygen, unable to obtain a blood pressure due to the resident's constant involuntary movement. The resident reports chest discomfort which just started. The Floor Nurse notified Staff C, ADON per new facility policy. The ADON advised the Staff Nurse to await a call back, as she would authorize and obtain an order for [REDACTED]. The DON documented at 5:05 p.m., the resident is asymptomatic and will monitor vital signs and respiratory assessments twice daily as a proactive measure. c On 4/30/20, the resident appeared more confused at 1:43 a.m. and at 5:00 a.m. the nurse documented the resident ran a low grade fever all night, confusion continues and the resident had complaints of body aches and pains. d. On 4/30/20, the staff reported to the PCP the resident had a temperature of 101.0 and oxygen saturation level of 85% on 4 liters of oxygen. At 10:48 a.m. the staff received an order from the PCP to transfer the resident to the ER for COVID-19 and low oxygen saturation levels. Observation on 4/30/20 at 11:28 a.m., Resident #2 in bed, the Staff Nurse called 911 to transfer the resident to a local ER. The resident is observed in bed, oxygen on at 4 liters via a non-rebreather mask, the Foley catheter is draining dark colored urine. The nurse gave a verbal report to the Emergency Medical Staff (EMS) personnel, the resident is COVID-19 positive, oxygen saturation is 85% on 4 liters of oxygen and unable to be stabilize. The resident has been running temperatures. The resident left the facility via ambulance at 11:32 a.m. Review of [DIAGNOSES REDACTED]-CoV-2 (COVID-19) test result revealed the specimen obtained on 4/28/29 returned positive on 4/29/20. During an interview with Staff F-RN/Agency nurse on 5/7/20 at 7:39 a.m. Staff F stated she worked on 4/27/20 and 4/28/20 day shift. On 4/28/20 the staff completed COVID-19 swabs on all the residents. Staff F stated she received a phone call from the PCP's Nurse directing her to place Resident #2 in droplet isolation and to move him away from the roommate. Staff F stated she relayed these orders to the ADON who informed her they were only taking orders from the Medical Director. 3. According to the Minimum Data Set ((MDS) dated [DATE] Resident #3 documented with [DIAGNOSES REDACTED]. The resident had a Brief Interview
of Mental Status (BIMS) score of 15 which indicated the resident had intact cognitive ability. Review of Resident #3's undated Care Plan revealed a focus area that stated the resident is at risk for COVID-19 [MEDICAL CONDITION] outbreak and directed staff to assist the resident with communication with family, assess the resident's temperature, monitor for signs of respiratory illness and report abnormal findings to the primary care provider for further treatment and care. During an interview with the PCP's Nurse on 4/29/20 at 10:09 a.m., the nurse stated the staff told her Resident #3 has a high temperature, low oxygen saturations and a cough. The PCP ordered the resident to be placed in droplet isolation on 4/28/20 as he is showing signs of COVID-19. During an interview with Staff F-RN/Agency Nurse on 5/7/20 at 7:39 a.m. Staff F stated she worked on 4/27/20 and 4/28/20 day shift. On 4/28/20 the staff completed COVID-19 swabs on all the residents. Staff F stated she received a phone call from the PCP's Nurse directing her to place Resident #3 in droplet isolation and to move him away from the roommate. Staff F stated she relayed these orders to the ADON who informed her they were only taking orders from the Medical Director. During an interview on 4/29/20 at 1:00 a.m. with Staff C, ADON/Infection Control Nurse stated we currently do not have any COVID-19 positive residents. The staff indicated the facility has strict guidelines on transferring a resident out to the ER from the Medical Director. The Medical Director said we can do as much in the facility as they can do at the hospital like managing temperatures and giving fluids. Staff C stated if she suspected a resident had COVID-19 she would place them immediately in droplet isolation. We have designated the 100 Hall as our COVID Unit if needed. Staff C stated they currently did not have any residents with COVID symptoms and does not have any residents in droplet isolation. Staff C stated yesterday on 4/28/20 they completed COVID-19 swab test on all their residents per order of the Medical Director. During an interview with Staff A, Licensed Practical Nurse (LPN) on 4/28/20 at 10:50 p.m. the staff stated the DON and ADON tested all residents for COVID-19 but we currently do not have any symptomatic residents in the building. We have 3 residents who are ill with temperatures but the temperatures are from a urinary tract infection. Observation on 4/30/30 at 9:00 a.m., revealed staff walking about Station 1 and Station 2 with only shields and masks on, the staff did not have on gloves or gowns at this time. Staff I, Certified Nurse Aide (CNA) working on Station 2 asked should I have more than my mask and shield on we are getting a lot of COVID positive residents and most of them are down here. Staff I asked what the nurse directed her to do, she stated nothing different than before. Observation on 4/30/20 at 9:30 a.m., on Station 2 revealed a yellow isolation gown hanging on the cloth room divider and a red isolation tag on the door. Staff I stated she has to walk into the room without a gown on, only mask and face shield to put on the isolation gown. The staff stated the resident in Bed A is positive for COVID-19 and Bed B is negative for COVID-19. During an interview on 4/30/20 at 10:30 a.m., Staff J, CNA and Staff K, CNA noted at the end of Station 1 south exit door. The staff were asked what re-education they received this morning regarding the wearing of Personal Protection Equipment (PPE) and precautions for residents now that they have COVID positive residents. Both Staff J and K indicated |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 5)<br>they have not received any education on what to do now that they have residents positive for COVID-19. Both staff said so far today they have only been wearing their shields and masks. During an interview with Staff H, Nurse Consultant on 4/30/20 at 12:30 p.m., Staff H did not respond to the question why the staff did not have on gowns at Station 2 this am with know COVID-19 positive residents, she stated we have plenty of PPE. During an interview with Staff H, Nurse Consultant on 4/30/20 at 2:00 p.m., Staff H stated we will make Station 2 the designated COVID-19 unit, they have 44 or 45 beds on that wing and the fire doors will be shut with a separate entrance from the rest of the facility. Staff H stated we will have designated staff to work exclusively on that unit. Observation on 4/30/20 at 2:07 p.m., Staff H conducting a staffing education for the oncoming evening staff. Staff H said to the staff in the huddle, we brought this (COVID-19) to them (residents) by not wearing our Personal Protective Equipment (PPE). During an interview with Staff G, DON on 4/30/20 at 2:23 p.m., the DON stated at this time we have 20 COVID positive residents and reports they still have pending test results and indicated those residents do not have any COVID symptoms. During an interview on 5/5/20 at 2:50 p.m. with Staff E, LPN, indicated she worked the night of 4/29/20 into morning of 4/30/20. Shortly after midnight on 4/30/20 the COVID-19 test results started to come in via fax. Staff E stated she did not have access to isolation gowns but did eventually find a few packs, stating I did the best I could. Staff E stated she put a gown in each room of the residents who results indicated they were positive for COVID-19. If the person was a 1 assist she put in 1 gown if required 2 staff put in 2 gowns. She stated there were residents who cohabited in rooms with a roommate who was negative so she hung the gown closer to the positive residents. The staff had to wear their same mask and shield into each room, negative or positive. She placed as many red isolation signs as many she could find on the positive rooms and had to photo copy some for the doors as she ran out. She indicated she started the positive residents on droplet isolation precautions. Staff E worked on 5/4/20 and 5/5/20 on Station 2 and reported the staff wore the same hazmat suit all day, in and out of resident rooms. She indicated there were a few residents on Station 2 who were negative for COVID- 19 on these days. During an interview with Staff M, CNA on 5/5/20 at 6:00 p.m., Staff M stated she worked day shift on 4/30/20 on Station 2. The staff knew we had COVID-19 positive residents but didn't direct us to wear anything but our face shields and masks. During an interview with Staff L, CNA on 5/6/20 at 12:52 p.m., Staff L stated she worked on 5/2/20 on Station 2. Staff directed her to wear the same white hazmat suit, goggles and masks into every room on Station 2. She voiced a concern with this but was told all the residents on Station 2 are positive for COVID-19. During an interview with Staff A, LPN on 5/7/20 at 5:30 a.m., Staff A stated she worked the night shift on 5/6/20 into the morning of 5/7/20. Staff A stated they have been having her work on Station 2 but tonight they assigned me to Station 1 because Station 2 is such a hard unit to work on with all the COVID-19 residents. Staff A stated when she worked on Station 2 she would wear the same white hazmat suit, mask and face shield the entire shift. Staff A stated they do not change into a different suit or put on a gown, she stated everyone has been exposed already. Staff A stated they re-test more residents on Station 2 who first returned with negative results because they were showing COVID-19 symptoms. Review of a COVID-19 Resident Log dated 4/29/20 revealed the following: a. Station 2 had 2 residents testing positive b. Station 3 had 11 residents testing positive, 3 inconclusive and 6 residents testing negative. Review of a COVID-19 Resident Log dated 5/14/20 revealed the following: a. 61 residents testing positive b. 4 residents testing negative; 1 on Station 2 and 3 on Station 1 c. 2 inconclusive (both residents refused to be retested ). d. 9 deaths Review of the COVID- 19 Policy and Procedure dated 4/2/20 directs the staff to assess the residents every shift for abnormal vital signs and noted respiratory symptoms. Should residents exhibit any of the following symptoms the facility shall initiate droplet isolation precautions for symptomatic residents and roommates if applicable for symptoms which included: 1. Fever greater than 100.4. 2. Sore throat. 3. Cough. 4. Decreased oxygen saturation levels. 5. Difficulty breathing or painful respirations. 6. Fatigue, body aches, headache or any other flu-like symptoms. The Policy further directed: a. The facility shall notify primary medical provider or their designee of symptoms. b. Residents will be placed into droplet isolation along with their roommate. c. Follow up testing shall occur per the order of the Primary Care Physician. d. Residents and room mate will remain in droplet isolation precautions until tests are return with definitive diagnosis. e. Should the resident require transfer to a hospital and is hospitalized , the roommate will continue droplet isolation requisitions until tests are confirmed or 14 day isolation period has been completed with no noted symptoms of illness. On April 30, 2020, the facility abated the Immediate Jeopardy. The facility provided education to the Nursing Staff and provided proper Personal Protective Equipment (PPE) for all staff. The facility also created a dedicated Area/Unit for the COVID-10 positive residents be moved to with assigned dedicated staff to care for those residents. At the time of exit, the scope and severity was lowered to an E after verification of staff's implementation of their policies and Infection Control procedures. |