STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165550	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOLON NURSING CARE CENTER	**523 EAST FIFTH STREET SOLON, IA 52333**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family and staff interview, the facility failed to document complete assessments on four out of seven residents who had tested positive for the Coronavirus Disease (COVID-19) Residents #3, #4, #5, #7. The facility reported a census of 70 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) quarterly assessment completed 7/16/20 identified the resident as cognitively impaired with a BIMS (brief interview or mental status score) of 0 out of 15, required extensive staff assistance with most activities of daily living and one unhealed stage 2 pressure ulcer. A review of the care plan identified the resident with the problem of requiring assist with ADLs (activities of daily living) with the long term goal target date 7/17/20 Interventions included: My COVID test is positive. I am in droplet isolation until signs/symptoms resolve and I receive a negative COVID test. CDC guideline update published 7/20/20 - I need to be in droplet isolation for at least 10 days from the onset of my symptoms, and have 24 hours without a fever and without fever reducing medications, and my symptoms have improved. No repeat testing is needed. The care plan did not have documentation of the need to assess the resident's vital signs and for signs/symptoms of COVID-19. A review of the facility report of employees/residents tested for COVID-19 revealed the resident had positive test results on 7/14/20 A review of the vital signs section in the electronic medical record revealed no documentation of the following: a. temperature or O2 sat (oxygen level) on either first or second shift on July 18, 19, 24, 25, 26, 27 b. on day shift of temp or O2 sat on July 20, 22, 23 A review of forms titled: prevent COVID-19 and another with vital signs and untitled revealed no documentation on the second shift on July 19, 20, 21, 24, 25. A review of the nurse's progress notes revealed the following: 7/28/20 at 3:09 p.m. Doctor notified of the family requesting resident be sent to ER (emergency room). Received order to send to ER (emergency room). 7/28/20 at 3:40 p.m. Ambulance crew here and resident assisted to cot. All paperwork sent and family is aware of bed hold policy. Called report to the hospital. A review of the transfer form to the hospital dated 7/28/20 at 3:00 p.m. with primary [DIAGNOSES REDACTED]. However, no COVID transfer form found on the record. A review of the July and August 2020 medication administration records (MARs) and physician orders [REDACTED]. During an interview on 7/30/20 9:17 a.m., the director of nursing reported, the COVID communication form had been sent with the resident when she went to the hospital and the facility did not have a copy of it. 2. Resident #4's MDS annual assessment completed 6/26/20 identified the resident as cognitively Impaired with a BIMS score of 8 out of 15 and required extensive staff assistance with most activities of daily living. A review of the care plan identified the resident with the problem of: I have [MEDICAL CONDITION] and am unable to complete my cares, I need assist with my ADLS. (with the long term goal date of 10/7/20) and intervention listed on 7/20/20: My COVID test is positive. I am in droplet isolation until signs/symptoms resolve and I receive a negative COVID test. CDC guideline update published 7/20/20 - I need to be in droplet isolation for at least 10 days from onset of my symptoms and have 24 hours without a fever and without fever reducing medications and my symptoms have improved. No repeat testing is needed. The care plan did not have documentation of the need to assess the resident's vital signs and for signs/symptoms of COVID-19. A review of the facility report of residents and staff who tested for COVID-19 identified the resident as positive on 7/16/20. A review of the vital signs section and progress notes revealed no documentation of vital signs, assessment of resident for signs/symptoms of COVID-19 for July 18, 19, 24, 25, 26, 27, 28, 31, 11, 2, 3, 4 A review of an untitled form and prevent COVID-19 form revealed no documentation of temperatures or O2 sats on second shift on July 18, 19, 24, 25, 26, 30, and August 3. A review of the July and August 2020 MARs and physician orders [REDACTED]. 3. Resident #5's MDS quarterly assessment completed 5/15/20 had documentation of the following Diagnoses: [REDACTED]. It also identified the resident as cognitively impaired with a BIMS score of 10 out of 15 and totally dependent on staff for assistance with all activities of daily living. A review of the care plan identified the resident with the problem of being unable to complete cares and needed assist with ADLs and on 7/19/20 had the following intervention: My COVID test is positive. I am in drop isolation until signs/symptoms resolve and I receive a negative COVID test. CDC guideline update published 7/20/20 I need to be in droplet isolation for at least 1 0 days from onset of my symptoms and have 24 hours without a fever and without fever reducing medications and my symptoms have improved. No repeat testing is needed. The care plan did not have documentation of the need to assess the resident's vital signs and for signs/symptoms of COVID-19. A review of the facility report for residents/employees tested for COVID-19 identified the resident as testing positive on 7/18/20. A review of the progress notes revealed the following: 07/22/20 at 10:17 a.m. At 0900 this nurse observed resident sitting in wheelchair on 5 liters of oxygen per nasal cannula with an SPO2 (measurement of oxygen) of 86% (normal range should be above 90). The resident denied shortness of breath. After increasing oxygen to 6 liters per nasal cannula and rechecked SPO2 two minutes later SPO2 read 83%. At 10:00 dispatchers arrived. Resident assisted from wheelchair to gurney via hoyer lift. Notes did not have documentation of assessment or vital signs/O2 sat documented in nurse's notes from 7/18/20 through 7/21/20 A review of the July and August 2020 MARs and physician orders [REDACTED]. 08/03/20 at 10:34 a.m. (entry by social services) The resident has been transported to the hospital for evaluation. Family aware of bed hold policy and will reserve her bed for when she returns to the facility. The notes had no documentation of an assessment of resident by nursing on 8/3/20 when transferred to the hospital and still no documentation as of 8/5/20. A review of the hospital admission physician history and physical report dated 7/22/20 had documentation of the following: Patient says she has been short of breath for years and does feel like it is worse lately. Had a cough that has been mostly nonproductive Has felt some tightness, felt hot and chilled, denies pain in her chest. Physical examination: respiratory rate 26 to 30, saturating 95% to 98% on 5 liters of oxygen nasal cannula. Assessment: acute COVID-19 infection that appears moderate to severe with [MEDICAL CONDITION]. She is at high risk for decompensation and death from COVID-19. Disposition: admitting as inpatient to the ICU (intensive care unit). A review of the vital signs section and progress notes section of electronic medical records revealed no documentation of temperatures or oxygen saturations from July 18 through July 22. A review of the untitled form and prevent COVID-19 form revealed no documentation of temperatures or O2 sats on second shift on July 18, 19, 20. In an interview on 8/4/20 at 10:00 a.m., the director of nursing (DON) reported when a resident is transferred to the hospital, his expectation would be for the nurse to document the resident's symptoms, family notification and would expect this to be completed the day the resident leaves for the hospital. Regarding Resident #5, he reported she was readmitted to the hospital due to chronic [MEDICAL CONDITION], obesity hyperventilatio[DIAGNOSES REDACTED]. 4. Resident #7's MDS quarterly assessment completed 5/15/20 had documentation of the following Diagnoses: [REDACTED]. It also identified the resident as cognitively impaired with a BIMS (brief interview for mental status) score of 0 out of 15, totally dependent on staff for most activities of daily living. A review of the care plan identified the resident with the problem of: I need assist with my ADLs due [MEDICAL CONDITION] left hemi and left neglect (with the long term goal date of 10/7/20) and intervention listed on 7/19/20: My COVID test is pending. I

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) am in droplet isolation until signs/symptoms resolve and I receive a negative COVID test. 7/22 my COVID test is positive. The care plan did not have documentation of the need to assess the resident's vital signs and for signs/symptoms of COVID-19. A review of the facility report for residents/employees tested for COVID-19 identified the resident as testing positive on 7/21/20 at 9:43 p.m. A review of the nurse's progress notes had documentation of the following: 7/22/20 at 9:49 a.m. Family requests resident be sent to hospital due to Covid result et possible UTI (urinary tract infection). 7/22/20 at 10:15 a.m. ambulance here, resident assisted to cot with assist of two. 7/29/20 12:25 p.m. resident readmitted from the hospital today, recovering from UTI in which she will continue to have oral antibiotics and require nursing care and therapies for skilled nursing level of care. No documentation at all from 7/12/20 through 7/20/20. A review of the vital signs section in the electronic medical record revealed an entry on 7/21/20 at 4:10 p.m. which showed a blood pressure highlighted in red ink of 84/52. A review of the July and August 2020 MARs and physician orders [REDACTED]. A review of the hospital admission physician history and physical dated 7/22/20 had documentation of the following: blood pressure was 100/50, did drop to 86/46. Impression: [MEDICAL CONDITION], suspect most [MEDICAL CONDITION] secondary to urinary tract infection. Admit to intensive care unit. Review of nurse's notes did not show documentation to address the above blood pressure and no vital signs documented at all for 7/29/20 as of 5:41 p.m. A review of the untitled sheets and sheets labeled prevent COVID-19 did not have documentation of No documentation of temperatures or 2 sats from July 12th through 18,19, 20, 21,22, 30, [DATE], 5, 6, 7, 8, 9. In an interview on 7/27/20 5:07 p.m., Staff B, RN, reported after residents have tested positive for COVID-19, vital signs and O2 sats (oxygen saturations which measures level of oxygen) at least twice a shift. If the temperature starts to rise, the nurse should notify the DON (director of nursing) and watch for respiratory symptoms. During an interview on 7/29/20 10:23 a.m., Staff H, RN, reported after residents have tested positive for COVID-19, the nurse is responsible for documenting a full set of vitals with O2 sats and lung sounds daily. If resident has a fever and the nurse gave an antipyretic, would check again afterward and document. In an interview on 7/29/20 1:46 p.m., Staff I, OMT, reported after residents have tested positive for COVID-19,the aides will take all the residents' vitals and O2 stats on first and 2nd shift once a shift and write it on a sheet of paper. The nurses are responsible for documenting those on paper sheet in the narcotic book. During an interview on 7/29/20 2:20 p.m., Staff J, CNA, reported after residents have tested positive for COVID-19, the aides check temperature and O2 sat twice a day on every resident (more frequently if not doing well), document on paper and give it to the nurses and the nurses document that on the electronic record, not really sure. In an interview on 7/30/20 10:35 a.m., Staff K, CNA, reported after residents have tested positive for COVID-19, the nurses check the vital signs themselves. If they get busy, they will ask the aides to check the vital signs which should be done at least 4 or 5 times in a shift. In an interview on 8/3/20 9:28 a.m., the DON reported after residents have tested positive COVID-19, he would expect the staff to check vital signs a couple of times a shift. If they are relatively asymptomatic, he would expect the staff to check O2 sats and temps a couple of times a shift. During an interview on 8/4/20 at 12:12 p.m., the DON reported he had never written a policy for assessment and intervention. A review of an untitled policy dated 3/27/20 had the following documentation: all residents should be screened for COVID-19 by taking their temperature and oxygen saturation at least twice per day on first and second shifts and more often if necessary. If findings show an increase in temperature or decrease in oxygen saturations from their norm, then they should be placed in the palliative care unit for isolation.
F 0730 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on record review and staff interview, the facility failed to provide documentation to show annual evaluations had been completed on six out of six staff members who had a hire date more than 12 months ago. The facility reported a census of 70 residents. Findings include: A review of the Human Resources records for six staff members revealed the following did not have documentation of annual evaluations completed: a. Staff P, Licensed Practical Nurse (LPN) hired in 2018. b. Staff B, Registered Nurse (RN) hired in 2015. c. Staff C, RN hired in 2012. d. Staff G, Certified Nurse Aide (CNA) hired in April, 2019. e. Staff S, CNA hired in 2017. f. Staff T, Maintenance hired in 1995. During an interview on 8/5/20 at 1:08 p.m., the Administrator reported if there had been no evaluation forms in the Human Resources records, they had not been completed. Each Department Manager is responsible for completing those evaluations. In an interview on 8/10/20 at 6:33 a.m., the Administrator reported the Human Resources Manager and Administrator provide lists of employees and dates evaluations are due to be completed, which then the Department Heads should return the completed evaluations to human resources. She could not provide an explanation as to why the annual evaluations had not been completed.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, family and staff interviews, the facility failed to implement and monitor an effective screening process for staff to prevent a Coronavirus Disease (COVID-19) outbreak affecting 36 of 70 residents causing 5 residents to be hospitalized and failed to provide staff education. The facility reported a census of 70 residents. Findings include: 1. A review of the facility Screening Forms revealed no consistency with completion of the Screening Form; as evidenced by the following: a. The week of 7/21/20 through 7/28/20: 6 staff came in to work with symptoms and instructed to continue to work on positive COVID Unit with no testing completed to determine if they were COVID positive and not sent home. b. No official screener consistently in place to monitor those coming through the front entrance when employees enter. c. On 7/27/20, the Surveyor entered at 9:28 a.m. greeted by Administrator, Director of Nursing (DON), and Dietary Director. At 10:18 a.m., after prompting by the Surveyor, the DON then screened the surveyor d. On 7/28/20, the surveyor entered the facility and completed the screening form, took her own temperature, however, no verification received from any of the staff on the information provided. 2. Documentation lacked staff education on COVID-19 after April 2020. A review of nine human resources records revealed no documentation of education after April 2020. 3. The facility failed to restrict visitors from entering the facility per CMS guidance. a. One resident's spouse who lived in the independent living apartments was entering. The spouse entered the facility six or seven times in the span of a month. The facility instructed the spouse to call first prior to entering the facility and try to monitor at mealtimes which was usually when the spouse would come to visit b. The family of two other residents were allowed to visit the residents who had not been identified to be in the active phase of dying or receiving hospice services. During an observation on 8/5/20 1:08 p.m., the Administrator showed the signs posted on the entrance from the independent living apartments to the facility. The door had a push bar and required the person to push a button to deactivate the alarm. On the other side of the door were signs posted on red paper with bold font with instructions that no visitors allowed in the facility (no date posted on the sign). A button to push would deactivate the alarm in order to enter the facility. She also reported a visitor who lived at the independent living apartments knew how to deactivate the alarm and staff would not know he entered the facility until they actually saw him. During an observation on 8/6/20 at 5:27 a.m., the Surveyor entered through a door, which had signs posted employees only, push button to enter. The Surveyor entered the facility, silenced the alarm, since no staff near the entrance, took own temperature and answered screening questions on the Screening Tool which asked if symptoms of cough, sore throat or new shortness of breath. At 5:42 a.m., Staff U, Registered Nurse (RN), informed the surveyor of the need to have her temperature taken and answer screening questions. During an observation on 8/6/20 at 6:14 a.m., Staff V, agency Certified Nurse Aide (CNA) screened by Staff U, RN who asked if she had any symptoms. Staff V reported she had a cough that she has had for a couple days, not constant, but had allergies [REDACTED]. Staff U instructed her to wait while she talked to the DON. The DON asked Staff V if she had the cough constantly or any contact that was positive. Staff V reported she had been working the COVID unit and that she had a history of [REDACTED]. At 6:21 a.m., Staff U asked Staff V what the DON said. Staff V reported he never responded. Staff U then instructed Staff V that she would be alright to work. Staff V proceeded to don mask, face shield and isolation gown before going out to the hallway where resident rooms were located. During an observation on 8/6/20 at 12:15 p.m., Staff V, CNA wore a mask, face shield, isolation gown, stood outside a room in the 200 hallway (one of the units designated for residents who tested positive for COVID-19). She reported she had not had any problems with coughing since she punched in this morning. No coughing noted during this observation. During an observation on 8/6/20 from 1:50 p.m. through 2:19 p.m., Staff P, Licensed Practical Nurse (LPN) utilized the original screening form utilized when the survey began on 7/27/20 on 12 employees. The form did not address other symptoms such as diarrhea, headache, or if they had been exposed to anyone that tested positive for COVID-19. In an interview on 7/27/20 at 2:23 p.m., Staff A, CNA, reported the following: a. The screening process is not consistent, staff are expected to take their own temperature and answer the questions, however, there are people not doing this and nothing is done about it. Approximately 75% of the staff will forget to complete the screening process. b. There are several people that work here

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) that have tested positive and are allowed to work. There is one CNA tested positive, she had a fever, cough, and sore throat, and never been quarantined, and they told her she could work with the residents who have already tested positive. c. On Friday (7/24/20), Staff A had been vomiting, had a fever of 100.9 then they took it again 98.9 then 100.1. She also had a cough and sore throat, very dizzy and not sent home. The symptoms started when she first arrived to work, she worked the entire shift and was not tested until 7/27/20. She also reported all employees who have symptoms are supposed to get tested here. During an interview on 7/27/20 at 5:07 p.m., Staff B, RN, reported the following: a. Employees are expected to take their own temperature and answer the screening questions. Usually a nurse is supposed to be there. b. When asked if the screening completed consistently, she reported she is not always good about signing out and checking her temperature before she leaves for the day. In an interview on 7/28/20 at 7:38 a.m., Staff C, RN, reported the following: a. Employees are supposed to check their own temperature and answer the questionnaire when they enter and when they leave for the day. b. The facility protocol is that if an employee has tested positive for COVID and asymptomatic, they can continue to work on the 2 COVID units. She also reported if an employee had any symptoms, they would need to stay home for 14 days. During an interview on 7/28/20 at 7:54 a.m., Staff D, CNA, reported when employees start their shift, they are to take their own temperature and answer four questions. If anyone answers yes to any of the questions, they will be asked to go home but before going home, the DON would need to do the COVID-19 test out in the parking lot. No one sits at the table (where the screening is completed by employees), but at shift change there is always a nurse around. In an interview on 7/28/20 at 11:30 a.m., Staff E, Dietary Aide, reported on 7/21/20 and 7/22/20 she had marked the screening tool as yes for cough and sore throat, and not sent home, she worked for the next few days afterward. She had never had been told to stay home and did not know what symptoms she should have to stay home. During an interview on 7/28/20 3:41 p.m., Staff G, CNA, reported the following: a. Employees are to check their own temperature and answer questions upon arriving and before leaving. If anyone answers yes to any of the questions they can still work unless they had a temperature above 100.4. b. The screening is not completed consistently and she admitted she is one that forgets to, as there is no one to enforce the staff to complete it. c. On 7/24/20 she answered yes on the screen for cough and not instructed to go home. d. There are two residents in the 200 hall (one of the units designated for COVID positive residents) that are still negative for COVID, not sure why they are not in the other hallway where the other negative residents are. During an interview on 7/29/20 10:23 a.m., Staff H, RN, reported the following: a. Employees are to take their own temperature before their shift and before leaving. There is no staff sitting at the entrance by the dining room. There is usually a nurse by the employee entrance. b. If anyone answers yes to any questions should call the DON and if anyone had a temperature above 100, should go home. During an interview on 7/29/20 at 2:52 p.m., the Director of Nursing (DON) reported he did not have a written policy on when to contact the public/state health departments of outbreaks and did not have any surveillance on the residents who tested positive for COVID-19. In an interview on 8/3/20 9:28 a.m., the DON reported the following: a. If a staff member marks any of the screening questions with a yes, they are to report it to him and he would check them. b. He would send staff home if they had a temperature above 100.4, he would recheck in an hour and if still above 100.4, he would test them and send them home until he got the test results. If they have a negative test, then they can work. c. There are three residents residing in the 200 hall (designated for COVID positive residents) that have been negative for COVID. There have been no other rooms for them to move to. A review of the list of residents revealed 8 empty beds in the 100 hallway and 4 empty beds in the 300 hallway. During an interview on 8/4/20 at 10:00 a.m., when asked what he felt caused the outbreak to occur, the DON reported the following: a. The facility had a visitor come through a hallway connecting the independent living apartments (where he resided) to the facility through a door which can not be locked. He would just walk through the door as he knew how to silence the alarm to the door b. The visitor probably entered the facility 6 or 7 times over the course of a month, during that time he had not tested positive for COVID-19 c. On 7/10/20 the visitor's daughter reported he had tested positive for COVID-19 d. When the DON became aware of the visitor coming to the facility, he asked him to call the facility first so they could meet him at the door. The DON reported there had not been much he could do except monitor meal times, which is usually when he would visit. In an interview on 8/6/20 at 1:02 p.m., Staff V, CNA reported when she came to work this morning, the DON never returned to tell her if she should go home and had not tested her for COVID-19. She also reported her first day to work was 7/31/20 and no one took her temperature or screened her. She followed the other employees, took her own temperature, and answered the questions on the screen. During an interview on 8/10/20 at 7:56 a.m., the DON reported beginning 8/10/20; he will start a line list of monitoring residents and staff that tested positive for COVID-19. When asked for a copy of the facility policy on COVID-19 outbreaks, the DON provided the following: a. A checklist provided by the Iowa Department of Public Health dated 3/27/29 titled: Checklist for Long-Term Care Facilities experiencing COVID-19 outbreaks had documentation of the following: a. Screen all employees for fever and cough/breathing problems at the start and end of each shift. Ill staff should be sent home immediately b. No visitors should be allowed in the facility (unless end of life situation per CMS guidance). b. An untitled form dated 3/27/20 with documentation of the following: all residents should be screened for COVID-19 by taking their temperature and oxygen saturation at least twice per day on first and second shifts, and more often if necessary. If findings show an increase in temp or decrease in oxygen saturations from their norms, then they should be placed in palliative care unit for isolation. c. A form titled: COVID-19 Isolation Plan dated 4/6/20 with documentation of the following: If a resident were to test positive for COVID-19 or be presumed positive based on symptomology, that resident would be placed in the palliative care unit for isolation. Selective staff would be designated to work on the unit and not other units while a resident is isolated. In the event that more than four beds are needed to isolate, then the residents in the skilled unit would be incorporated into the nursing home, and the unit would be set up for isolation. In the event that they would need to use more than those 13 beds, then the east hall would be set up for isolation. A review of the facility policy tiled: Infection Control Program dated 2009 had documentation of the following: The facility will perform surveillance and investigation of infections, prevent, and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions. The infection control nurse/designee in case of an outbreak of a communicable disease will: monitor and document infections, including tracking and analyzing outbreaks of infections as well as implementing and documenting actions to resolve related problems. A review of the facility policy titled: Checklist for Long Term Care Facilities experiencing COVID-19 outbreaks (Iowa Department of Public Health stamped) dated 3/27/20 had documentation of the following: screen all employees for fever and cough/breathing problems at start and end of each shift. Ill staff should be sent home immediately. A review of the COVID-19 Isolation Plan dated 4/6/20 had the following documentation: a. If a resident were to test positive for COVID-19 or be presumed positive based on symptomology, that resident would be placed in the palliative care unit for isolation. Selective staff would be designated to work on the unit, and not other units while a resident is isolated. b. In the event that more than 4 beds are needed to isolate, then the residents in the skilled unit would be incorporated into the nursing home and the unit would be set up for isolation. In the event that we would need to use more than those 13 beds then east hall would be set up for isolation. A review of the facility policy titled: Long Term Care Respiratory surveillance line list had documentation of the following: The respiratory surveillance line list provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home. The information in the columns of the worksheet capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes. The incident detailed above resulted in determination of Immediate Jeopardy for the facility and notified of such on 8/4/20 at 4:15 p.m. The Facility staff abated the Immediate Jeopardy situation on 8/7/20 through the following actions: a. Changed the screening area for staff to the employee entrance on the north side of the building. b. Assigning a designated employee (the Nurse coming off shift) to be available to complete all screenings to include temperature and screening questions and anyone presenting with either a temperature or failing the screening questions will be sent home. c. All staff reeducated to not report to work if displaying any symptoms of COVID-19, and reeducated that visitors are not allowed in the building unless prior approval by the Administrator and/or DON. d. The residents in the independent living area connected to the facility contacted and additional signage posted at entrance doors to notify of visiting restrictions imposed in the Nursing Home. e. The questions on the Screening Tool were changed to be more inclusive of COVID-19 signs and symptoms. Based on the results of the corrective measures taken by the facility lowered the scope and severity of the deficiency from an L level to an F level.
F 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	Based on record review and interview, the facility failed to notify residents and their representatives/families by 5 p.m. the next calendar day following the occurrence of confirmed infections of COVID-19. The facility reported a census of 57

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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 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	(continued... from page 3) residents. Findings: 1. Review of a laboratory report revealed Resident #8 tested positive for the 2019 Novel Coronavirus on 8/25/20. The facility lacked documentation of notification to all facility residents and their representatives of the positive test. 2. Review of a laboratory report revealed Resident #9 tested positive for the 2019 Novel Coronavirus on 8/27/20. The facility lacked documentation of notification to all facility residents and their representatives of the positive test. 3. The Minimum Data Set (MDS) Assessment Tool, dated 8/20/20, listed Resident #10's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. During an interview on 9/3/20 at 9:15 a.m., Resident #10 stated the facility did not give him any recent updates about any positive COVID-19 cases in the facility. 4. During an interview on 9/2/20, Resident #5's resident representative stated the facility did not inform him of any positive COVID cases since at lease a month prior. A 5/13/20 Iowa Health Care Association document, utilized as a policy by the facility, directed facilities to notify residents and resident families by 5 p.m. the day after positive test results of COVID-19 were confirmed. During an interview on 9/2/20 at 1:38 p.m., the Social Services Designee stated she did not notify any residents or resident family members after Resident #8 tested positive as she was not working in the days following the test. She stated after Resident #9 tested positive, she notified all of the residents that same day but did not document it. She stated she did not notify any family members of the positive test though. During an interview on 9/2/20 at 1:55 p.m., the DON(Director of Nursing) stated the facility did not notify residents and resident representatives of every positive COVID-19 case. He stated it was his understanding he did not have to do this since they had an initial outbreak.
F 0947 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on record review and staff interview, the facility failed to provide documentation to show the required 12 hours per year of inservice trainings were completed by two of three Certified Nurse Aides (CNA). The facility reported a census of 70 residents. Findings include: 1. A review of the Human Resource files of two certified nurse aides (CNAs) revealed the following: a. Staff G, CNA with a hire date of April 2019, did not have any documentation to show inservices had been completed at all for the year 2020 b. Staff S, CNA with a hire date of March 2017 did not have any documentation to show inservices had been completed at all for the year 2020 During an interview on 8/10/20 at 9:15 a.m., the Administrator reported the facility had suspended all staff inservices/education in April 2020.