STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to implement appropriate infection control practices and procedures to prevent the spread of novel Coronavirus 2019 (COVID-19). Staff did not implement appropriate infections control practices and screening. Resident #1 was not isolated when exhibiting COVID symptoms. The facility reported seven residents and 14 staff members diagnosed with [REDACTED]. Findings include: 1. On 9/22/20 at 9:35 AM, the surveyor entered the facility and received a directive to screen herself. The kiosk asked surveyor to enter their phone number, then answer the following questions A. Are you experiencing any symptoms of COVID-19 (fever, cough, sore throat, body aches, runny nose, shortness of breath, nausea, weakness, vomiting, diarrhea, or loss of appetite)? B. Have you been exposed to anyone with COVID-19 in the past 14 days. C. Enter body temperature, who took the temperature. The staff then directed this surveyor to take their own temperature to enter into the kiosk questionnaire. On 9/22/20 at 9:38 AM, observed a resident answer the kiosk questions, pick up the thermometer, take their own temperature, and exit the facility. On 9/22/20 at 9:42 AM, observed two guests waiting to complete the kiosk questionnaire to exit. Each guest answered the questions and took their own temperatures. On 9/22/20 at 10:17 AM, the Administrator reported there had been positive cases the entire time, but the first resident case was on 9/9/20. The Administrator said all of the cases were from the memory care unit as it was hard to keep them socially distance and wearing masks. The weekend around 9/9/20 was the first time to have staff who worked and didn't know they were positive. If a staff member was positive for COVID-19, they were removed from work and follow all of the protocols. The Administrator stated they had staff positive for COVID-19 and visitors that were positive for COVID-19, so it was hard to know how the resident's gotten COVID-19. Before 9/9/20, all the residents have been COVID-19 free. The positive cases of COVID-19 go into the Bayberry Neighborhood while the unknown cases go in the Evergreen Neighborhood on the second half of the wing. On 9/22/20 at 12:22 PM, in the Bernstein Neighborhood observed three tables of residents that were less than six feet apart. One table had three residents sitting at a square table less than six feet apart. Two tables had two residents that sat across from each other. On 9/22/20 at 12:45 PM, when trying to complete the kiosk questionnaire, the internet lost connection. Three attempts were required to complete the questionnaire, after the second attempt, the greeter attempted to help. This surveyor was instructed to take their own temperature to put it into the kiosk questionnaire. On 9/22/20 at 1:49 PM, the surveyor returned to the facility and completed the kiosk questionnaire and temperature per self. On 9/23/20 at 7:45 AM, observed residents at mealtime in the Bernstein Neighborhood and witnessed two residents sharing a table sitting across from each other, less than six feet in distance. On 9/23/20 at 7:52 AM, watched Staff D, Licensed Practical Nurse (LPN), adjust their mask with their hand and no hand hygiene. On 9/23/20 at 8:02 AM, Staff G, Dietary Aide, and Staff E, Housekeeping, reported that if the kiosk did not work, then there was a paper for the staff to write down their symptoms. On 9/23/20 at 1:45 PM, the Director of Nursing (DON) reported one additional staff member tested positive with COVID-19 during the routine surveillance testing. On 9/24/20 at 10:08 AM, observation showed Staff I, Certified Nurses' Aide (CNA), giving two new staff a tour. Staff I wore a face shield appropriately with face mask exposing their nose. On 9/24/20 at 10:17 AM, observation showed Staff J. Dietary Aide, washing hands in the Bernstein Neighborhood kitchen area. Staff J wore the face shield appropriately with the face mask lowered, exposing their nose. On 9/24/20 at 10:18 AM, observation showed the dining room with four tables with residents. At one of the tables, two residents sat across from each other less than six feet apart. On 9/24/20 at 10:19 AM, observation showed Staff D offer a resident a drink while touching their face mask to adjust and then without hand hygiene, puts away dirty dishes. After putting away the dirty dishes, Staff D sanitized hands. The review of the paper and electronic staff screening records for the Sunlight Neighborhood lacked documentation of seven staff screenings at the start of their shifts. On 9/29/20 at 10:57 AM, Staff J walked into the Applewood Neighborhood wearing a face mask, exposing their nose wearing a face shield appropriately. On 9/29/20 at 11:21 AM, Staff J entered the Bernstein Neighborhood wearing a face mask, exposing their nose with a face shield appropriately. On 9/29/20 at 11:22 AM, Staff D took a toy from a resident at the table and placed it on the piano without cleaning the toy. Staff D then sanitized their hands and placed a clothing protector on the resident. On 9/29/20 at 11:35 AM, observation showed Staff L, CNA, wearing an N95 mask (a regulated respirator face masks designed to protect from airborne particles) and a face shield. The mask slid down, exposing Staff L's nose while covering their mouth. On 9/29/20 at 11:36 AM, observation showed Staff L replace the N95 mask above their nose using gloved hands. Staff L continued to wear the same gloves without hand hygiene. On 9/29/20 at 11:41 AM, observation showed Staff L wearing the same gloves and retrieving residents' food from the dining room aide, and delivered it to the residents. On 9/29/20 at 11:43 AM, Staff L spoke with a resident with an N95 mask below their nose, wearing a face shield. Staff L replaced the N95 mask replaced the mask covering their nose with no hand hygiene. On 9/29/20 at 11:47 AM, Staff L lowered the N95 mask below their nose and mouth under the face shield while leaning over the dining room table to visit with a resident. On 9/29/20 at 11:48 AM, Staff L lowered the N95 mask below their nose, and mouth leaned down next to a resident's ear and told the resident their name. On 9/29/20 at 11:52 AM, Staff L delivered the residents' laundry with the same gloves in the Sunlight Neighborhood; the laundry cart had no covering over the clothes. As Staff L delivered the clean laundry to the room with the clothing touching the staff gown. Staff L continued to put the laundry away. On 9/29/20 at 2:41 PM, the Director of Nursing explained that staff was to be six feet away from the resident if the face mask was pulled down to speak to the resident. The mask was allowed to be removed if six feet away because the residents became upset and would pull off the staff's personal protective equipment. If a staff member pulled down their mask, they shouldn't get up close to the resident's ear to visit with the resident. The staff should wear a face mask at all times over their nose and their mouth. The staff was expected to wash or sanitize their hands after touching their masks. The staff were given sanitizer when they first start; then, they were to sign out sanitizer if they need more. In the dining rooms, there was only to be one resident per table. The facility attempted to have only one chair per table, but the residents would move the chairs to sit with their friends. The staff was to encourage the residents not to sit together or hold hands. The memory care units used to have bright colored Xs to mark the places for chairs, but one of the residents saw it and tried picking them up. The resident ended up falling as a result. After the fall, the Xs were changed to a darker color, and no falls happened after. Screening questionnaire reviews The electronic screening record asked the following questions 1. Are you experiencing any symptoms of COVID-19 (fever, cough, sore throat, body aches, runny nose, shortness of breath, nausea, weakness, vomiting, diarrhea, or loss of appetite). - Applicable to vendors, families, friends, volunteers, residents, and staff 2. Have you been exposed to anyone with COVID-19 in the past 14 days? - Applicable to vendors, families, friends, volunteers, and staff 3. Have you worked in another facility or business with recognized COVID-19 cases? - Applicable to vendors and volunteers 4. Have you worked in another facility or business where you had a COVID-19 exposure without using proper personal protective equipment in the last 14 days? - Applicable to staff A visitor will receive a warning message if they answer yes to any screening question or enter a body temperature greater than 100.0. The paper screening record indicated staff MUST sign-in and out at the beginning and end of shift. The paper

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

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) asked the following questions 1. Date 2. Time 3. Name 4. Temperature 5. Write signs or symptoms of illness you have - fever - sore throat - cough - runny nose The updated paper screening record dated 9/29/20 indicated staff MUST sign IN AND OUT (at beginning AND end of shift). The paper asked if you have signs or symptoms of illness: cough, fever, headache, shortness of breath, diarrhea, the new loss of taste and smell, body aches, chills, fatigue, sore throat, congestion or runny nose, nausea, or vomiting? The paper asked the staff to complete the following questions 1. Date 2. Name 3. In time 4. In temperature 5. Signs or symptoms of illness (yes/no) 6. Out time 7. Out temperature 8. Out signs or symptoms of illness (yes/no) Follow-up interview On 9/29/20 at 4:11 PM, the Administrator said they would need to hire four full-time employees to screen the four entrances, as they did not want staff working with the infected or exposed residents to expose the other staff or visitors. 2. The Minimum Data Set (MDS) completed for Resident #1 with an Assessment Reference Date (ARD) showed a Brief Interview for Mental Status not completed. The MDS identified the resident with short and long-term memory loss with severe cognitive impairment. The resident had [DIAGNOSES REDACTED]. Record review The Medication Administration Record [REDACTED]. Notify the primary care provider and supervisor if any symptoms were noted: Fever of 100.4 or higher. Assess the resident's lung sounds. Report any signs or symptoms of respiratory infection, loss of appetite, weakness, nausea, diarrhea, cough, sore throat, loss or change of smell then initiate contact/droplet precautions. The resident was charted to have abnormal lung sounds from 9/6/20 through 9/11/20 every day except 9/8/20. The progress note completed on 9/5/20 at 10:54 PM showed the infrared thermometer read 100.3. The temperature was rechecked by axillary (armpit). The vital signs showed a temperature of 98.6, a pulse of 100, respirations of 20, blood pressure of 124/52, and a pulse oximeter of 93 percent (%) on 2 liters (L). The resident's lungs were clear in all lobes. The heavy blankets were removed from the resident, and scheduled Tylenol (for fever) was given. The progress note completed on 9/6/20 at 2:18 PM indicated the resident present in the dining room for breakfast. The resident was observed sleeping at the dining room table, so staff transferred the resident back into bed. The resident refused to get up for lunch, so the staff saved the resident's food in the fridge. The progress noted completed on 9/6/20 at 9:22 PM, documented the resident started an antibiotic (ABT) this shift for an upper respiratory infection (URI), no adverse reactions noted. The resident's vital signs were within normal limits (WNL) except running a low-grade temperature of 99.4 degrees Fahrenheit (F) then 98.3 F. The resident had expiratory wheezing and a productive cough, as needed (PRN), tesslon pearls (for cough) given with relief. The progress note completed on 9/6/20 at 9:30 PM showed the nurse to nurse report passed on that the resident had been having increased coughing. The resident was brought to the dining room at about 5:15 PM and began to dry heave. The resident was taken out of the dining room and had small emesis clear to a yellow color. The resident had a non-productive moist cough throughout the shift, and a slight fever of 99.8 F. Hospice notified and came to assess the resident. The resident started on [MEDICATION NAME] (Z-pak) this shift and [MEDICATION NAME] pearls PRN three times a day. The resident started the antibiotic (ABT) this shift with no adverse reactions noted. The telephone order dated 9/6/20 showed an order for [REDACTED]. The Plan of Care was discussed with the staff due to the resident's recent health issues. The resident sat in a wheelchair with nothing to say when asked. A review of the resident's chart showed the resident with an intermittent low-grade temperature over the last few days. Staff placed a call to the Nurse Practitioner that ordered Z-Pak and [MEDICATION NAME] Pearls PRN (as needed). The progress note completed on 9/7/20 at 9:52 AM indicated staff completed the head to toe skin assessment after the resident's scheduled shower that shift, with no new skin issues noted. The resident's vital signs were: temperature 97.7, pulse 79, respirations 20, blood pressure of 123/64, and oxygen saturation of 83% on room air (RA). The lung sounds assessed as wheezy in all lobes. The resident received an ABT for possible [MEDICAL CONDITION] with no coughing noted at the time. Oxygen was applied, and oxygen saturation rose to 95% on 2 Liters (L) ; the nurse attempted to administer an [MEDICATION NAME] inhaler for congestion. The resident was unable to take due to a cognitive deficit. This nurse called hospice, who called the on-call doctor. The progress noted completed on 9/7/20 at 1:10 PM; the resident continued on an ABT for possible [MEDICAL CONDITION]. An occasional moist cough was noted. Vital signs WNL, bilateral Rhonchi noted to the lung and did not clear with coughing. The progress note completed on 9/7/20 at 2:02 PM showed hospice returned the call with an okay (ok) to discontinue the [MEDICATION NAME] Inhaler and start [MEDICATION NAME] 0.5 milligrams (mg) / [MEDICATION NAME] 3 mg / 3 milliliters (mL) vial (for lung congestion) every six hours PRN. The progress note completed on 9/7/20 at 9:51 PM revealed the resident received an ABT for possible [MEDICAL CONDITION]. Staff administered PRN [MEDICATION NAME] pearls at 7:36 PM. The resident's lung sounds were wheezy upon auscultation. The resident had a moist productive cough during the shift. The sputum was a small amount of a yellowish color. The nebulizer solution was not delivered from pharmacy yet. The RN (registered nurse) Comprehensive assessment dated [DATE] at 1:35 AM, showed the resident at the table during the assessment. The facility nurse reported the resident appeared more alert and could walk with assistance with a walker to the restroom in their room using a wheelchair for distance out of the patient room. The progress note completed on 9/8/20 at 4:23 AM indicated the resident continued on an ABT for possible [MEDICAL CONDITION]. The resident lungs sound assessment showed slightly congested lungs. No adverse reactions were noted with no signs or symptoms of pain noted. The vital signs were: temperature of 98.3 F, pulse of 72, respirations 20, blood pressure 148/82, and oxygen saturation 94% 2 L. The progress note completed on 9/8/20 at 12:29 PM showed the facility received a telephone order from the hospice nurse for the ok for two staff to assist the resident with transfers, wheelchair, and mechanical lift PRN when tired or weak. The progress note completed 9/8/20 at 1:10 PM, indicated the Chief Executive Officer (CEO) notified the resident's representative that the medical director gave orders to test all the neighborhood residents due to a secondary to the potential exposure of COVID-19. The progress note completed on 9/08/20 at 4:43 PM revealed the nurse obtained a nasopharyngeal swab for COVID-19 per the medical director's order and labeled the specimen per guidelines from the State Hygienic Laboratory (Lab) and placed in the fridge for pick up by the state hygienic lab. The progress note completed on 9/8/20 at 8:37 PM showed the resident continued on an ABT for [MEDICAL CONDITION]. The resident's vital signs assessed with [REDACTED]. The resident needed the assistance of two staff to get into the wheelchair from the bed. The telephone order dated 9/8/20 showed a clarification to start [MEDICATION NAME] 500 milligrams (mg.) for one day per dose, then 250 mg tablet one tablet for four days, [MEDICATION NAME] one vial every six hours PRN dyspnea, and transfers of one to two staff assistance and wheelchair, then use mechanical lift PRN due to tired or weak. The progress note completed on 9/9/20 at 2:02 AM documented the resident remained on an ABT for possible [MEDICAL CONDITION] with no adverse reactions. The resident's vital signs were: temperature of 97.6, pulse of 76, respirations of 20, blood pressure of 140/65. The resident's lung sounds assessed as congested. PRN [MEDICATION NAME] pearls administered at 10:54 PM for congestion. The progress note completed on 9/9/20 at 7:08 AM identified at approximately 5:30 AM, the resident with loose stools and a productive cough with emesis of phlegm. The hospice nurse called to update on the resident's status. The progress note completed on 9/9/20 at 2:22 PM indicated the resident remained on an ABT due to [MEDICAL CONDITION], with no adverse reactions noted. The resident had no emesis. Vital signs were: temperature of 97.5 F, pulse of 68, respirations of 20, blood pressure of 100/60, and oxygen saturation of 95% RA (room air). The resident had no signs or symptoms of pain. The resident had an occasional congested cough with clear lung sounds. The resident does nap often but was aroused easily. The progress note completed on 9/11/20 at 9:13 AM showed the resident with emesis and loose stools upon waking in the morning. The resident exhibited pronounced productive coughing and wheezing. After staff cleaned and made the resident comfortable, their condition improved. Staff left a message with the hospice nurse to contact the facility nurse due to the last dose of antibiotics given, and the condition did not improve. Progress note completed on 9/11/20 at 8:44 PM revealed the resident remained on an ABT for possible [MEDICAL CONDITION] with no adverse reactions noted and vital signs within normal limits. The resident continued with a moist and sometimes a productive cough. The resident's lung sounds assessed wheezy upon expiration. A PRN breathing treatment administered at 3:54 PM, only slightly effective. A new order received from the hospice for [MEDICATION NAME] (lung congestion) every six hours for seven days and kept the PRN dose the same. The telephone order dated 9/11/20 showed an order for [REDACTED]. The progress note completed on 9/12/20 at 5:49 PM indicated the resident had an oxygen saturation of 89% at 4:00 PM. The oxygen was increased to 3 L. The resident's oxygen was 93% at that time and nurse notified. The Social Service Progress Note completed on 9/18/20 at 2:16 PM revealed on 9/12/20, the resident moved to an isolation neighborhood due to COVID-19. The resident showed no adverse effects with the change in the environment. The progress note completed on 9/22/20 at 4:54 AM showed the resident very lethargic during care. The resident sucked lightly on the sponge when provided with oral care but the resident did not drink. The resident's [MEDICATION NAME] ([MEDICAL CONDITION]) was crushed and given by a syringe as the resident clamped their mouth closed. The progress note completed on 9/22/20 at 8:40 AM indicated they contacted the resident's family the resident's condition and was asked if they wished to visit due to the resident's decline. The family stated they would come that day. The family was advised to check-in at the front office and come indoor to apply personal protective equipment. Care plan review The care plan problem

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) dated 3/15/20 showed social isolation due to the resident's current focus of activity program was restricted temporarily due to the COVID-19 pandemic and group activity restrictions. The intervention dated 5/30/20 showed COVID-19: Staff should encourage activities, therapy, and other activities of daily living in the resident's room as able. The staff was encouraged to take the resident out of their room only if necessary and limit the number of people in the hallways during that time. The staff was to encourage quarantine recommendations as much as possible, with respect to the resident's rights and quality of life, ensuring all the residents' safety. Due to the resident's cognitive and hearing impairment, and decreased agitation/confusion, staff would pull down their mask to communicate with them. The resident also refused to wear a mask, which caused the resident confusion and more stress. The resident wanders the neighborhood; the staff was to encourage the resident to return to their room. The resident may become agitated and may cause more agitation. At times the resident did not like to be alone in their room. The resident often refused social guidelines. The resident declined to eat in their room and preferred to sit with other individuals while dining and, at times, was required to eat in the dining area due to their dining needs. The care plan problem dated 12/14/16 said the resident was admitted to the Sunlight Neighborhood. The resident lived at home with their family before going to the hospital for increased confusion and getting lost while driving. Per the family, the resident was very independent and needed twenty-four supervision that they couldn't provide. On 6/11/20, the resident started on hospice due to a condition decline related to [MEDICAL CONDITION] progression and anticipate further decline as the disease progresses. The intervention dated 9/11/20 stated the resident tested positive for COVID-19 on 9/8/20, the results were received on 9/11/20. The resident was moved to the designated quarantine neighborhood in the Bayberry Assisted Living. The resident was to remain in their room at all times, staff to wear conventional personal protective equipment when in contact with the resident when providing care. The staff was to encourage fluids or supplements frequently throughout the day to prevent dehydration. The staff was to reposition the resident every two to three hours and PRN per policy to prevent skin issues. A low air-loss mattress was provided while in isolation. The resident would continue to be assessed every shift for signs or symptoms due to COVID-19, and staff will notify the primary care physician PRN. The resident would return to the original room after the isolation period was met on 9/20/20. Interviews On 9/22/20 at 3:27 PM, Staff B, LPN, said that the resident returned to the floor and continued to have a bad cough. The resident was quarantined in the Bayberry for ten to fourteen days and recently moved back to the Sunlight Neighborhood. The resident was on hospice, and they had a lot of respiratory issues. On 9/23/20 at 10:22 AM, the Administrator and the DON reported the resident moved to the Bayberry Neighborhood on 9/11/20 after the resident's results came back positive. They went off the date the test was taken. The resident was moved back to the Sunlight Neighborhood the Sunday 9/20/20 after a call from the Medical Director based on the date the COVID-19 lab test was completed On 9/23/20 at 1:23 PM, Staff F, Certified Nurses' Aide (CNA), said they worked with the resident before they got sick. Staff F said the nurse called hospice when the resident started to have increased coughing. Staff F said they didn't wear gowns until the resident tested positive. Staff F said the resident was allowed out of their room after the resident started to cough, as they thought it was [MEDICAL CONDITION]. On 9/24/20 at 1:45 PM, Staff K, Unit Manager, said the resident was first tested on [DATE] as the facility learned there was a positive staff member that worked on 9/6/20 and 9/7/20. After this, all the Sunlight Neighborhood residents were tested on [DATE] with the state hygienic lab and was sent out the next day. On 9/11/20, a rapid test was completed on the resident, and that came back negative. Later in the evening on 9/11/20, the state hygienic lab results returned from the test on 9/8/20, indicating a positive COVID-19 result. Policy review The undated Interim Policy for Suspected or Confirmed Coronavirus (COVID-19) documented that the procedure was that people with the following symptoms or combinations of symptoms might have COVID-19. Cough Shortness of breath or difficulty breathing Or at least two of these symptoms Fever Chills Repeated shaking and chills muscle pain headache sore throat new loss of taste or smell. The section labeled Resident Care indicated that it might not be possible to distinguish patients that have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will likely be housed in the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. The section labeled Screening indicated staff was to actively screen all residents daily for fever and symptoms of COVID-19; if symptomatic, immediately isolate and implement appropriate transmission-based precautions. Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. The section labeled Employees had subsection labeled screening employees that stated the facility would actively verify the absence of fever and respiratory symptoms when employees report to work at the beginning of their shift. Document temperature, absence of shortness of breath, new or change in cough and sore throat, and other criteria as identified by state guidance. The facility would re-educate employees and reinforce strong hand-hygiene practices, appropriate utilization of personal protective equipment as indicated, cleaning, and disinfection.