STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165427	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWTON HEALTH CARE CENTER	200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and resident interview, the facility failed to provide sufficient staffing to ensure residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. (Residents #2, #3, #4, #5, #6) The facility reported census of 54 residents. Findings include: In an interview on 7/22/20 at 2:30 p.m. the Administrator stated their first case of COVID 19 was confirmed positive on 7/10/20 along with three others. The Administrator stated they enacted their COVID 19 Unit, which quickly expanded due to multiple residents becoming infected. According to a COVID 19 tracking document provided by the facility: 4 residents were confirmed positive on 7/10/20. 5 residents were confirmed positive on 7/11/20. 11 residents were confirmed positive on 7/14/20. 8 residents were confirmed positive on 7/15/20. 15 residents were confirmed positive on 7/19/20. 7 residents were confirmed positive on 7/25/20. 1 resident was confirmed positive on 7/16/20. Daily assignment sheets for the COVID 19 unit indicate: 7/14/20 census 20 with 1 nurse, 1 aide assigned all three shifts. 7/15/20 census 28 with 1 nurse, 1 aide assigned all three shifts. 7/16/20 census 27 with 1 nurse, 2 aides 6a-10p and 1 nurse 1 aide overnight shift. 7/17/20 census 26 with 1 nurse, 1 aide 6a-2p, 2 aides 2p-6p, 1 aide 6p-6a. 7/18/20 census 24 with 1 nurse, 1 aide 6a-10a, 2 aides 10a-2p, 1 aide 2p-6p, 2 aides 6p-10p, 1 aide 10p-6a. 7/19/20 census 38 with 1 nurse, 1 aide 6a-6p, 2 aides 6p-10p, 1 aide 6p-6a. 7/20/20 census 38 with 1 nurse, 3 aides 6a-2p, 4 aides 2p-6p, 3 aides 6p-10p, 1 aide 10p-6a. 7/21/20 census 38 with 2 nurses 6a-2p, 1 nurse 2p-6a, 2 aides 6a-10p, 1 aide 10p-6a. 7/22/20 census 38 with 1 nurse, 3 aides 6a-6p, 2 aides 6p-6a. 7/23/20 census 38 with 1 nurse, 3 aides 6a-10p, 1 aide 10p-6a. 1 shower aide. 7/24/20 census 38 with 2 nurses 6a-6p, 1 nurse 6p-6a, 3 aides 6a-4p, 2 aides 4p-6p, 3 aides 6p-6a. 7/25/20 census 46 with 2 nurses 6a-6p, 1 nurse 6p-6a,2 aides 6a-2p,3 aides 2p-6p,5 aides 6p-10p,3 aides 10p-6a. In an interview on 7/23/20 at 2:05 p.m. Staff B, Certified Nurse Aide (CNA), stated she is assigned to the COVID 19 Unit, since already being positive and recovered from COVID 19. Staff B seemed frustrated and stated there is not enough staff or supplies to adequately meet the resident's needs. These people are sick and in bed. Residents are getting sores from staying in bed all day. We run out of bed sheets and pads and have to call laundry for more. Staff B stated concerns have been reported to management. In an interview on 7/28/20 at 12:53 p.m. Staff K, Registered Nurse (RN), stated she was frustrated with not having enough help and not being able to properly care for the residents. Staff K indicated early on when the COVID 19 just started there was often only a nurse and aide to take care of 20 plus residents who were sick and needy. Staff K stated the day that Resident #1 was sent to the hospital the first time (7/15/20), it was just her and an aide and Staff D, MDS Coordinator was helping. Staff K stated she doesn't know what the census was that day (28). In an interview on 7/27/20 at 12:45 p.m. Staff L, CNA, stated she had previously had COVID 19 and volunteered to work the COVID unit. Staff L stated she was a shower aide and just started 7/24/20, but today was pulled to the floor to help and hasn't given any showers. Staff L stated they are short staffed and administrative people helping like today is unusual. Staff L stated it is difficult to provide quality care when there is not enough help According to Resident #2's Minimum Data Set (MDS) assessment with assessment reference date of 7/15/20, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 indicating an intact cognitive status. Resident #2 required supervision to limited assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs. Bathing was coded as not observed during the assessment period. Resident #2's [DIAGNOSES REDACTED]. Resident #2 was moved to the COVID 19 unit when confirmed positive on 7/11/20. According to bathing records obtained 7/29/20, Resident #2 is to receive baths/showers every Monday and Thursday. The last recorded bath or shower was on Friday 7/10/20. Resident #2 has not had a shower or bath while on the COVID unit through 7/29/20. In an interview on 7/27/20 at 1:08 p.m., Resident #2 stated she has only had one shower since being on the COVID unit. (16 days). According to Resident #3's MDS assessment with assessment reference date of 6/10/20, Resident #3 had a BIMS score of 15 indicating an intact cognitive status. Resident #3 required supervision to limited assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs and physical assistance with bathing. Resident #3's [DIAGNOSES REDACTED]. Resident #3 was moved to the COVID 19 unit when confirmed positive on 7/11/20. According to bathing records obtained 7/29/20, Resident #3 is to receive baths/showers every Monday and Thursday. The last recorded bath or shower was on Sunday 7/12/20. Resident #3 has not had a shower or bath recorded since that time while on the COVID unit through 7/29/20 (17 days). According to Resident #4's MDS assessment with assessment reference date of 7/18/20, Resident #4 had a BIMS score of 15 indicating an intact cognitive status. Resident #4 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs. Bathing was coded as not observed during the assessment period. Resident #4's [DIAGNOSES REDACTED]. Resident #4 was moved to the COVID 19 unit when confirmed positive on 7/11/20. According to bathing records obtained 7/29/20, Resident #4 is to receive baths/showers every Monday and Thursday. The last recorded bath or shower was on Saturday 7/18/20. Resident #4 has not had a shower or bath recorded since that time while on the COVID unit through 7/29/20 (11 days). In an interview on 7/27/20 at 12:15 p.m., Resident #4 stated she has only had one shower since being on the COVID unit (16 days). According to Resident #5's MDS assessment with assessment reference date of 7/4/20, Resident #5 had a BIMS score of 15 indicating an intact cognitive status. Resident #5 required extensive assistance with bed mobility and transfers and limited assistance with dressing, toilet use and personal hygiene needs and physical assistance with bathing. Resident #5's [DIAGNOSES REDACTED]. Resident #5 was moved to the COVID 19 unit when confirmed positive on 7/25/20. According to bathing records obtained 7/29/20, Resident #5 is to receive baths/showers every Monday and Thursday. The last recorded bath or shower was on Saturday 7/18/20. Resident #5 has not had a shower or bath recorded since that time (11 days). According to Resident #6's MDS assessment with assessment reference date of 4/22/20, Resident #6 had a BIMS score of 7 indicating a severely impaired cognitive status. Resident #6 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs and physical assistance with bathing. Resident #6's [DIAGNOSES REDACTED]. Resident #6 was moved to the COVID 19 unit when confirmed positive on 7/19/20. According to bathing records obtained 7/29/20, Resident #6 is to receive baths/showers every Monday and Thursday. The last recorded bath or shower was on Saturday 7/18/20. Resident #6 has not had a shower or bath recorded since that time while on the COVID unit through 7/29/20 (10 days). In an interview on 7/27/20 at 12:15 p.m. Resident #6 stated she thought she has had a shower since being on the COVID unit, but couldn't remember when. .
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 and staff interviews, the facility failed to implement and monitor a complete and consistent screening process for staff and visitors to prevent a COVID 19 outbreak for 52 of 56 residents. The facility reported census was 54. Findings include: According to the facilities COVID 19 Pandemic Guidelines: *All employees, contractors, consultants and all other type of person entering the building will be subject to the screening process. Each

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) employee will be screened prior to starting their shift each day they work. *The screening process will be in accordance with CDC guidelines with the following questions: 1. Do you currently have any respiratory symptoms such as fever, cough, sore throat, shortness of breath, or any other type of upper respiratory symptoms? 2. Have you traveled outside the country in the last 14 days to restricted areas? 3. Have you been in contact with any person or entity who has been exposed, being investigated, or diagnosed with [REDACTED].*Any person answering YES to above questions will be restricted from entering. *The facility will also screen related to temperature readings. Those individuals with a temperature reading above 99.1 orally will be restricted from entry. *For employees, contractors, and consultants who have no negative responses to the screening process, they will be required to wash their hands and proceed to their designated work area. According to the Employee/Contractor Screening form used by the facility, staff are to print their name and title and answer; 1. Do you have any respiratory symptoms such as fever, chills, cough, sore throat, congestion, runny nose, shortness of breath or any other type of respiratory symptoms or any nausea, vomiting, diarrhea, headache, fatigue, muscle body aches, loss of taste or smell? 2. Have you had any contact with any person or entity who is being investigated (test pending), or diagnosed with [REDACTED].? 3. Have you traveled internationally in the past 14 days to restricted international countries? 4. Have a nurse check their temperature and route and record it. (must be less than 99.1 orally) 5. Hands and shoes sanitized and mask and face protection provided. 6. Employee signature. 7. Screener signature. In an interview on 7/28/20 at 8:09 p.m. the Director of Nursing (DON 1) stated she first developed symptoms of a runny nose and cough on or around 7/1/20 which she thought was just allergies. The DON 1 stated she was afebrile. The DON 1 remained at work and worked the next day (7/2/20) before taking off for the Fourth of July holiday. On Friday, 7/3/20 a family member developed a temperature and diarrhea and by Monday, 7/6/20, they were both tested for COVID 19. The DON 1 was confirmed positive with COVID 19 on 7/11/20. The DON 1 stated her symptoms worsened with a cough and shortness of breath and she went to the hospital emergency roiagnom on [DATE] or 7/12/20. The DON 1 stated she returned to work on 7/19/20. The DON 1 stated the screening process requires staff to answer questions and check their temperature. A nurse is supposed to verify the answers and temperature, then sign the screening tool. Staff are to be sent home if they have any symptoms noted on the screening tool. Review of the facilities Employee/Contractor Screening tool from 7/1/20 through 7/7/20 noted 243 entries in which 164 entries or 67.5% did not have a nurse signature verifying the answers and temperatures of the employees entering the building. According to the Employee/Contractor Screening tool, Staff A, Registered Nurse (RN), failed to fill out the screening form on 7/1/20 and on 7/2/20, 7/4/20, 7/5/20, 7/8/20, indicated affirmative for having symptoms related to COVID 19. In an interview on 7/23/20 at 5:15 p.m., Staff A, RN, stated sometime in mid-June her friend became positive for COVID 19 and at that time, she was quarantined and did not work for a couple weeks. On 6/24/20, the facility tested all of their staff and she was negative, but noted at around that time she had lost her sense of taste. Once she returned to work her loss of taste persisted and when she told her supervisors, they stated it was probably just her allergies and allowed her to continue to work. In early July her symptoms included headache and nausea. Staff A stated she continued to work despite indicating her symptoms on the screening tool. On 7/16/20, after an outbreak of COVID 19 in the facility, the facility tested all of their staff again and this time she was positive for COVID 19. According to the Employee/Contractor Screening tool on 7/3/20 and 7/4/20, Staff B, Certified Medication Aide (CMA) indicated affirmative for having symptoms related to COVID 19. In an interview on 7/23/20 at 2:05 p.m., Staff B, CMA, stated on 7/3/20 she arrived to work with a headache, low-grade temperature and sore throat. Staff B stated she indicated this on the screening form and informed the Assistant Director of Nursing (ADON) she was not feeling well. The ADON asked Staff B if she felt ok to stay and work and she responded I guess so and remained at work. On Saturday, 7/4/20, Staff B returned to work, still not feeling well and stayed until about noon before leaving. Staff B stated her symptoms had gotten worse and on 7/6/20, the ADON stated she needed to get tested . Staff B stated she got tested that day and on 7/10/20, got results indicating she was positive for COVID 19. Staff B stated she remained off work until returning on 7/20/20. In an interview on 7/30/20 at 1:30 p.m., the Assistant Director of Nursing (ADON) stated on 7/3/20, Staff B had reported not feeling well, but had no cough or temperature and was allowed to work. The ADON stated she had later heard Staff A, RN, sent Staff B home early on 7/4/20. According to the Employee/Contractor Screening tool, Staff C, Certified Nurse Aide (CNA) on 7/5/20 and 7/6/20 indicated affirmative for having symptoms related to COVID 19. In an interview on 7/23/20 at 2:30 p.m. Staff C, CNA, stated on 7/4/20 and 7/5/20 she was having migraine headaches and a stomach ache, but continued to work her shifts. The next day on Monday, 7/6/20, she was achy and had a bad cough. She was telling everyone at work she was not feeling well, including Staff D, MDS Coordinator, Staff E and the ADON. Staff C stated she was asked if she wanted, tested and if so she would have to be sent home. Staff C stated she insisted on being tested and the ADON gave her the test. Staff C stated she was sent home and for the next five days had a very elevated temperature. Staff C stated that on 7/11/20 she got results indicating she was positive for COVID 19. Staff C stated she was not scheduled to return to work until 7/27/20. According to the Employee/Contractor Screening tool, Staff G, Licensed practical Nurse (LPN) on 7/4/20, 7/5/20, 7/6/20 and 7/9/20 indicated affirmative for having symptoms related to COVID 19. In an interview on 7/30/20 at 11:24 a.m., Staff G, LPN, stated on 7/4/20, 7/5/20, 7/6/20 and 7/9/20 she had been responding yes on the facilities screening tool related to nausea, vomiting and diarrhea. Staff G stated she thought the symptoms were related to her medication. Staff G stated the Director of Nursing allowed her to continue to work. Staff G stated she has been tested for COVID 19 three times (6/24, 7/16, 7/30) by the facility and once at her doctors and all were negative. Staff G questioned about an entry on the screening tool on 7/15/20 in which she answered affirmative to exposure to someone with COVID 19 and recorded a temperature of 99.3. Staff G stated the Administrator was notified and she was sent home. Staff G stated the next day she was scheduled on the COVID 19 positive halls and has been assigned there since. In an interview on 7/30/20 at 2:25 p.m., the Director of Nursing (DON 1) stated she does not recall having any conversations with Staff G about her symptoms and working status in early July. In an interview on 7/23/20 at 1:05 p.m., Staff D, MDS Coordinator, stated on 7/1/20 she had an increase in allergy symptoms, runny nose, nasal stuffiness, but no cough, shortness of breath, headache or temperature. Staff D stated she worked 7/1/20, 7/2/20 and until noon on Monday, 7/6/20. Her stuffiness continued and she was swabbed for COVID 19 and sent home. On 7/7/20 Staff D stated she visited her physician who thought it was sinusitis. Staff D stated that on 7/10/20 she received her results, which were positive for COVID 19. During an observation on 7/22/20 at 2:48 p.m. Staff F, CNA, observed entering the room of Resident #5, who was on isolation precautions related to developing symptoms of COVID 19, but remained on the non-COVID hall. Staff F removed his gown, mask, exchanged them for a disposable gown, mask, and then donned gloves prior to entering the resident's room. Staff F did not sanitize his hands prior to donning gloves. When finished attending to Resident #5's needs which included some physical contact, Staff F doffed his gown, gloves and mask and disposed them in a box without a hazard bag lining it. Staff F then re-donned his original gown and N95 mask and again failed to complete hand hygiene. At 3:05 p.m. Staff F returned to Resident #5's room, again removing his cloth gown and N95 mask, then donning a disposable gown, disposable mask and gloves all without completing hand hygiene. Staff F physically assisted Resident #5, then doffed his gown, gloves and mask, exited the room and re-donned his cloth gown and N95 mask again without washing or sanitizing his hands. Observations found no sanitizer available within the proximity of the room. On 7/23/20, Resident #5 tested for COVID 19 and discovered positive just days later. On 7/30/20 at 3:10 p.m., the facility was informed of an Immediate Jeopardy situation related to their screening process. The plan of correction included assigning a trained screener at the employee entrances to screen and monitor sanitation practices. A screening assignment sheet was used to identify who would be responsible for screening employees at designated times. The designated times were 5:00 a.m. to 6:00 a.m., 6:00 a.m. to 10:00 a.m., 1:30 p.m. to 2:30 p.m. and 5:30 p.m. to 6:30 p.m. During an observation on 8/3/20 at 2:00 p.m. Staff F, CNA entered through the employee entrance for the negative COVID halls. There was no screener present and Staff F filled out the screening questions and took his own temperature. Staff F then proceeded to the Nurse's Station, where he was then escorted back into the entry hallway by the assigned screener, DON 2. Staff F then re-entered the negative COVID halls and began working while the assigned screener, DON 2, remained at the screening table. According to the Screening Assignment sheet for 8/3/20, the Director of Nursing (DON 2) was assigned from 1:30 p.m. to 2:30 p.m. In an interview on 8/3/20 at 2:05 p.m., the interim Director of Nursing (DON 2) stated she was the scheduled screener from 1:30 p.m. to 2:30 p.m. The DON 2 stated she was on a phone call and did not get to the screening table until 1:45 p.m. Observations noted DON 2 escorting Staff F from the nurse's station, back into the entry hallway at around 2:02 p.m. In an interview on 8/3/20 at 2:08 p.m., Staff F, CNA, stated he entered the facility and answered the screening questions, took his temperature, sanitized his hands and disinfected his feet without a witness. Staff F stated he is the only one who comes in at 2:00 p.m. for the negative COVID side and checked in at the Nurse's Station before proceeding to work. Staff F stated he was requested by the DON 2 to return to the entry hallway. Staff F stated he was not informed by anyone of the new screening process. In an interview on

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) 8/3/20 at 3:06 p.m. Staff H, Maintenance Staff, stated he arrived at work around 9:30 a.m. that morning and filled out the screening questions, sanitized his hands, disinfected his feet and proceeded to the Nurse's Station to have the ADON check his temperature. Staff H stated there was no one sitting at the screening table when he arrived. According to the Screening Assignment sheet for 8/3/20, Staff I, CNA was assigned from 5:00 a.m. to 10:00 a.m. that morning. In an interview on 8/4/20 at 9:40 a.m. Staff J, CNA, assigned as the screener from 6:00 a.m. to 10:00 a.m. stated when they first started screening employees back in March, they had a designated screener at the entrance, but at some point they just stopped doing it. The Facility abated the Immediate Jeopardy situation by educating all staff by 8/4/20 regarding the screening process and not allowing a staff person to work if showing signs and symptoms of COVID. The screening process education included: -Staff instructed to enter by the front door. -The front doors will remain locked and anyone who enters must ring the doorbell to enter the facility. -The Screener will be positioned at the locked front door during specified hours. -If staff arrive outside the specified hours and the screener is not present, the employee will have to ring the doorbell for entrance, and whoever answers the doorbell will get the assigned screener. During observations on 8/4/20 from 5:57 a.m. to 7:10 a.m., the facility had a screener positioned at the front entry as staff arrived. The assigned screener appropriately screened employees as they entered the facility and checked temperatures as staff left. There were no concerns with the facilities current screening process. Based on the results of the corrective measures taken by the facility lowered the scope and severity of the deficiency from a L level to a F level.
F 0947 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**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 staff interview and record review, the facility failed to provide sufficient in-service training to ensure the competency of their Nurse Aides for 3 out of 10 Certified Nurse Aides (CNA) reviewed. The facility reported census was 54. Findings include: In an interview on 8/4/20 at 11:15 a.m. the Director of Nursing (DON2) stated the facility provides monthly inservices which staff are expected to attend. The DON2 provided the inservice documentation and sign in sheets, but no other training inservices. Review of 10 Nurse Aide Training Records, noted 3 CNA's, with over a year of service, did not receive the minimum (12 hours) in-service training required per year. (Staff M, N, O)