STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165538	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE RIDGE CARE CENTER	1005 7TH STREET NE ORANGE CITY, IA 51041

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 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, interview, and record review, the facility failed to protect all residents in the facility by not following acceptable infection control practices for COVID-19. The facility failed to thoroughly screen and document staff results, from all facility departments, for COVID-19 prior to the staff working with and/or caring for residents in the facility. These facility staff cared for all residents of the facility and/or provided services to all residents of the facility. Furthermore, when facility staff reported having symptoms of possible COVID-19 infections, including cough and sore throat, there was no evidence of the facility following-up on the staff who reported these symptoms. In total, the facility failed to thoroughly screen staff and document the results of the screening in over 100 individual instances starting in March. A determination was made that the facility's noncompliance with one or more requirements of participation placed all residents in the facility in immediate jeopardy, beginning on [DATE]. On [DATE] at 2:30pm, the Administrator was notified of the immediate jeopardy at F880, Infection Prevention and Control. The immediate jeopardy was removed on [DATE] after the surveyor verified implementation of a removal plan. The scope and severity was lowered to an F (widespread potential for more than minimal harm). Findings include: - Review of CMS guidance, documented in QSO memo ,[DATE] NH, released [DATE], documented the following: How should facilities monitor or limit visitors? Facilities should screen visitors for the following: 1. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/[MEDICATION NAME]/index.html 2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat. 3. Has had contact with someone with or under investigation for COVID-19. The guidance also documented: How should facilities monitor or restrict health care facility staff? The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above). - Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work. - Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should: Immediately stop work, put on a facemask, and self-isolate at home; Inform the facility's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment). On [DATE] at 9:00am, Nurse Aide (NA1) indicated that staff must screen themselves before beginning their shift. Staff would enter through the back door of the facility, clock in, walk down the east or west maintenance hall, and then exit in front of the entrance to the two east or west units. Staff would then enter the unit and screen themselves in the family room. The family rooms were the very first rooms someone would walk by when they entered the unit. NA1 indicated that staff would take their temperatures and answer a series of questions. Staff would document the information on a screening form. NA1 indicated that three residents and one one staff person developed COVID-19. On [DATE] at 9:16am, Licensed Practical Nurse (LPN1) indicated that staff must be screened before each shift. Staff would enter in the back door, clock in, walk through the back halls to their assigned unit, and screen themselves in the family room. LPN1 indicated that the staff must take their temperatures and answer a series of questions before working, and that this information would be documented on the screening log. LPN1 indicated that the facility currently had a COVID-19 unit, which housed two residents. Review of the facility's Employee-Visitor Screening Log documented that staff must write down the date, their name, temperature, and answer three yes or no questions: if they had shortness of breath, new or changed cough, or other respiratory symptoms. The log failed to include all screening questions, including travel and contact with someone with or under investigation for COVID-19. Review of the facility's screening logs, dated [DATE] forward, revealed the following: In the month of March, 2020, the facility failed to ensure that one visitor answered the screening questions and failed to ensure that a second visitor documented their temperature. The facility also failed to ensure that one staff person answered the screening questions. The facility failed to ensure that two staff documented their temperatures. The facility failed to ensure that two staff documented their temperatures and answered the screening questions. Additionally, NA2, responsible for assisting with the care of residents, reported experiencing possible signs or symptoms of COVID-19 on the 21st and 22nd. NA2 worked their shift both days that the symptoms were reported. In the month of April, 2020, the facility failed to ensure that a visitor answered the screening questions and document their temperature, failed to ensure that four visitors documented their temperatures, and failed to ensure that five visitors answered the screening questions. The facility failed to ensure that three staff documented their temperatures and answered the screening questions, failed to ensure that four staff answered the screening questions, and failed to ensure that seven staff documented their temperatures. In the month of May, 2020, the facility failed to ensure that three visitors documented their temperatures and answered the screening questions, failed to ensure that four visitors documented their temperatures, and failed to ensure that six visitors answered the screening questions. The facility failed to ensure that a staff person documented their temperature and answered the screening questions, failed to ensure that four staff answered the screening questions, and failed to ensure that ten staff documented their temperatures. NA2 worked their shift after reporting possible signs or symptoms of COVID-19. Additionally, an unknown person, who did not leave their name, reported possible signs or symptoms of COVID-19. In the month of June, 2020, the facility failed to ensure that five visitors documented their temperatures and failed to ensure that eight visitors answered the screening questions. The facility failed to ensure that two staff documented their temperatures and failed to ensure that two staff answered the screening questions. Additionally, NA3 worked their shift after reporting possible signs and symptoms of COVID-19 and two hostesses (H2 and H3) (staff that serve meals and assist with unit activities) worked their shifts after reporting possible signs and symptoms of COVID-19. H1 worked three shifts after reporting possible signs and symptoms of COVID-19 before each shift. In the month of July, 2020, the facility failed to ensure that two visitors answered the screening questions and failed to ensure that three visitors documented their temperatures. The facility failed to ensure that one staff documented their temperature and answered the screening questions, failed to ensure that one staff person documented their temperature, and failed to ensure that seven staff answered the screening questions. The facility failed to ensure that eight staff and one unknown person documented accurate temperatures, when they documented temperatures ranging from 69.9F to 90.6F. Additionally, NA6 worked one shift, and NA4 worked two shifts after reporting possible signs or symptoms of COVID-19. H1 and H2 worked their scheduled shifts after reporting possible signs or symptoms of COVID-19. NA5 worked their shift after reporting possible signs and symptoms of COVID-19, was tested the next day, and was found to have COVID-19 after working their scheduled shift providing care to the residents of the facility. In the month of August, 2020, as of [DATE], the facility failed to ensure that two staff answered the screening questions. NA4 and H1 each worked one shift after reporting possible signs and symptoms of COVID-19. On [DATE] at 9:30am, the Administrator indicated that H4 tested positive for COVID-19 following an exposure outside of work on [DATE]. H4 worked on ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. H4 was not aware they were exposed until [DATE], at which point they did not return to work and were tested for COVID-19. H4 tested positive on [DATE]. On [DATE], a resident experienced a change in condition which required hospitalization . The resident was found to have COVID-19 on [DATE]. On [DATE], NA5 reported experiencing respiratory

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) symptoms on the staff screening log, but worked their shift. On [DATE], NA5 reported congestion and loss of smell, and was sent home and tested for COVID-19. On [DATE], NA5's results were positive. On [DATE], the facility tested all residents on that end of the building with the rapid-result COVID-19 tests. The facility identified three positive cases, who were then tested again. One resident was negative, and two were positive. One of the two positive residents later expired, following a decline in condition. The facility isolated the residents in a negative air-pressure unit. On [DATE], the facility tested all staff who worked on that end of the facility. All tests came back negative. On [DATE], a staff person who tested negative on [DATE] required admission to a local hospital, and at that time tested positive for COVID-19. The Administrator indicated that the facility was unable to determine the cause of the positive cases, and indicated that they believed that it was caused by an asymptomatic staff person. On [DATE] at 1:11pm, the Director of Nursing (DON) indicated that staff must screen themselves prior to starting their shifts. The DON indicated that the staff were good about reporting what could be symptoms of COVID-19 to the charge nurses, and that the nurse managers for the units oversaw the screening process. The DON indicated that over the last three months, there were maybe two instances of staff reporting symptoms. The DON indicated that she was unaware of any issues with the staff screening process. On [DATE] at 2:00pm, the Administrator indicated that the DON was responsible for overseeing the staff screening process, and that she provided some assistance with the oversight. The Administrator indicated that she was unaware of any issues with the staff and visitor screening process. Review of the facility's policy, titled Infection Control Program, COVID-19, dated ,[DATE], documented: Monitoring employees for fever or respiratory symptoms, such as, cough or shortness of breath at the beginning of their shift. They will actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat.