STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165387	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL VALLEY REHABILITATION AND NURSING AT PRIMGHA	**735 NORTH RERICK PRIMGHAR, IA 51245**

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interview and facility policy and procedure review the facility failed to immediately report to the Department of inspections and Appeals an elopement at the facility for one resident (Resident #5). The facility census was 31 residents. Findings include: 1. An Annual Minimum Data Set (MDS) assessment dated [DATE], documented Resident #5 had [DIAGNOSES REDACTED]. The MDS further documented the resident as feeling down, depressed or hopeless, no wandering and resident independent with all aspects of activities of daily living. The Preadmission Screening and Resident Review (PASRR) dated 5/1/19, included [DIAGNOSES REDACTED]. The PASRR also documented the resident as having tearfulness, feelings of hopelessness, worthlessness, threats towards others, [MEDICAL CONDITION], mood swings, withdrawn behavior, distrust, paranoia, worry, and panic reactions and known history of substance abuse/dependency, and would benefit from supported public transportation to ensure safe community access, and prior to hospitalization , he lived in the community alone, however, barriers with this arrangement, including safety concerns. A Care Plan with a start date 5/14/20 had a problem for which indicated Resident #5 had behaviors related to major [MEDICAL CONDITION], refusing medications, refusing meals, refusing cares, resistant to assistance with cares, and makes threats. Approaches include: *Resident has a court order to reside at facility due to alcoholism. May go for a walk of facility property for relaxation and exercise if BIMS meets the criteria. *The facility will attempt to find public transportation for resident when needed. *Provide adequate supervision during activities *Allow me to go on facility outings as deemed appropriate with the required supervision. A Psych Note dated 12/13/19 documented resident is doing OK, but got in trouble for walking off to get a pack of smokes. That was the third time. Medications reviewed in Nursing Facility Chart. Mood is sad. Review of the Cerro Gordo-Clerk of District Court dated 5/14/19, documented that it is ordered the Respondent shall transfer to RCF care with placement at(NAME)Valley located at 735 North Rerick Ave, Primghar IA. It is further Ordered that the ongoing provider for the Respondent shall be Tapestry Psychiatry who will see the Respondent at(NAME)Valley. The Nurses Notes dated 5/7/20 at 8:00 p.m., documented Resident #5 walked out front door. Nurse followed and requested resident return to facility. Nurse continued saying he didn't have permission to leave and needed to return or the sheriff would be called. Resident stated, why the hell do I have to stay here, I am leaving. Nurse stated again he doesn't have permission to leave and needed to return. Resident shrugged his shoulders and walked on. Nurse returned to facility to call sheriff. Staff aide walked to the drive and didn't see anyone walking on either side of the street. She then walked to the other exit and looked there as well. No Luck. Called Sheriff back to let them know resident is court ordered. She asked for a description and would notify the deputy. Administrator notified. The Nurse Notes dated 5/7/20 at 10:30 p.m., documented resident returned to facility in private car. Staff went to look around town. Sheriff notified of his return. Resident found by the police station. Staff rolled her window down and said don't ya think its time to come back to the facility. Resident agreed and got in the car. Resident reentered the facility and was sent to room. A document titled Elopement Form, dated 5/7/20 at 10:52 p.m. documented Resident #5 eloped at 7:58 p.m. Staff were alerted to the exit by alarm at the front door. Resident stated he just needed to get away. The temperature outside was 46 degrees, and the resident was returned to the facility via staff car. The Administrator was notified at 8:00 p.m. and the Police were notified at 8:02 p.m. There were no interventions identified to prevent the elopement from happening again. The Physician Notification Fax Form dated 5/8/20, documented resident eloped last night. Gone from facility from 8:00 p.m. - 10:30 p.m. Resident attempted elopement twice this a.m. Resident said I don't care if I die. Administrator is currently trying to get ahold of resident mental health advocate. May we have order for psych evaluation/treatment? Please advise. During an interview on 8/25/20 at 11:45 a.m., the facility Director of Nursing confirmed and verified the expectation of the staff is to know where the resident is at all times especially since the resident is court committed to the facility. During an interview on 8/25/20 at 3:30 p.m., Staff H (Registered Nurse) stated Resident #5 does show signs of wanting to leave the facility, he will tell staff that it is time to go to the store or gas station to get some alcohol, there are times he goes out the front door and the alarm sounds, other times he will be out smoking and tell the aide that is supervising the residents that he is leaving and will just walk away from the facility. Staff H stated that when you have one aide inside the facility and one aide outside supervising the residents you have to make a decision on residents safety, and with this resident the sheriff is called to find him and bring him back to the facility. Staff H stated that when the resident left the faciity on [DATE], one of the staff from the facility went to search for him and found him in a corn field. During an interview on 8/17/20 at 3:20 p.m., the facility Medical Director confirmed and verified the facility is responsible for the resident at all times in and out of the facility. During an interview on 8/26/20 at 9:10 a.m., the Chief Deputy explained that the facility is responsible for Resident #5 and since he is court committed it is up to the facility to make sure that he is supervised at all times, and that the facility and the sheriff department have no agreements or understanding that it is the responsibility of the sheriff department to find the resident when he exits the facility. The Deputy went on to explain that there are times when the facility will call and another call takes precedents over the resident being gone to long. Most of the time the sheriff department will find the resident at the gas station buying alcohol and then it will be confiscated and taken away, the resident is very good about getting into the police car and going back to the facility. During an interview on 8/26/20 at 10:10 a.m., Staff I (Maintenance Supervisor) explained that on 5/7/20 between 10:00 p.m. - 10:15 p.m., a telephone call was placed that Resident #5 was gone longer than normal and if they would mind going out to find him. Staff I stated they got into their car and started to head around town looking for Resident #5, while driving received a phone call that the resident was seen up town by the hardware store, so the staff headed up town and by the time got there the resident was across for the police station. Staff I explained to the resident that it was time for them to go back to the facility, the resident got into the staffs car and came straight to the facility, the resident got out and went in with no problems. The online abuse incident reporting list for the facility identified no self-reported incidents from 4/22/20-6/22/20. The Facility Resident Abuse Policy and Procedure dated as last reviewed on 3/24/20, directed the Administrator and Director of Nursing shall coordinate all investigations ensuring the safety and report findings to the regulatory agencies as required. All reportable incidents resulting in patient harm or potential for patient harm should be reported the Department of Inspections and Appeals (DIA) within 24 hours after discovery of the incident. In an interview on 9/2/20 at 11:20 a.m. the Administrator stated elopements are to be reported to DIA immediately. Reviewed the Elopement form dated 5/7/20 and stated not sure why Nurse H filled out the form as Resident #5 would not be considered an elopement risk due to BIMS of 13 and fall risk of 4.
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident, staff interview and facility policy and procedure the facility failed to ensure each resident received adequate supervision to prevent elopement for 2 residents, (Resident #5, Resident #16), who exited the facility unsupervised, which resulted in an immediate jeopardy to residents health and safety. The facility failed to follow the plan of care for a resident which sustained a fall with a fracture while in an EZ lift. (Resident #13). The facility census was 31 residents. Findings include: 1. An Annual Minimum Data Set (MDS) assessment dated [DATE], documented Resident #5 had [DIAGNOSES REDACTED]. The MDS documented resident as feeling down, depressed or hopeless, no wandering and resident independent with all aspects of activities of daily living. The Preadmission Screening and Resident Review (PASRR) dated 5/1/19, included [DIAGNOSES REDACTED]. The PASRR also documented the resident as having tearfulness, feelings of hopelessness, worthlessness, threats towards others, [MEDICAL CONDITION], mood swings, withdrawn behavior, distrust, paranoia, worry, and panic reactions and known history of substance abuse/dependency, and would benefit form supported public transportation to ensure safe community access, and prior to hospitalization , he lived in the community alone, however, barriers with this arrangement, including safety concerns. A Care Plan with a start date 5/14/20, had a problem for which indicated Resident #5 had behaviors related to major [MEDICAL CONDITION], refusing medications, refusing meals, refusing cares, resistant to assistance with cares, and makes threats. Approaches include: *Resident has a court order to reside at facility due to alcoholism. May go for a walk of facility property for relaxation and exercise if BIMS meets the criteria. *The facility will attempt to find public transportation for resident when needed. *Provide adequate supervision during activities *Allow me to go on facility outings as deemed appropriate with the required supervision. Review of the Cerro Gordo-Clerk of District Court dated 5/14/19, documented it is ordered that the Respondent shall transfer to RCF care with placement at Pearl Valley located at 735 North Rerick Ave, Primghar IA. It is further Ordered the ongoing provider for the Respondent shall be Tapestry Psychiatry who will see the Respondent at Pearl Valley. The Elopement Risk Tracking Log dated 5/28/20, documented resident as alert, ambulatory, history of previous elopements, left property, eloped in the evening, staff educated on wander list and care plan addresses wandering and risk for elopement. A Psych Note dated 12/13/19 documented resident is doing OK, but got in trouble for walking off to get a pack of smokes. That was the third time. Medications reviewed in Nursing Facility Chart. Mood is sad. The Nurses Notes dated 5/7/20 at 8:00 p.m., documented resident walked out front door. Nurse followed and requested resident return to facility. Nurse continued saying he didn't have permission to leave and needed to return or the sheriff would be called. Resident stated Why the hell do I have to stay here, I f***ing leaving. Nurse stated again he doesn't have permission to leave and needed to return. Resident shrugged his shoulders and walked on. Nurse returned to facility to call sheriff. Staff aide walked to the drive and didn't see anyone walking on either side of the street. She then walked to the other exit and looked their as well. No Luck. Called Sheriff back to let them know resident is court ordered. She asked for a description and would notify the deputy. Administrator notified. The Nurse Notes dated 5/7/20 at 10:30 p.m., documented resident returned to facility in private car. Staff went to look around town. Sheriff notified of his return. Resident found by the police station. Staff rolled her window down and said don't ya think its time to come back to the facility. Resident agreed and got in the car. Resident reentered the facility and was sent to room. The Physician Notification Fax Form dated 5/8/20, documented resident eloped last night. Gone from facility from 8:00 p.m. - 10:30 p.m. Resident attempted elopement twice this a.m. Resident said I don't care if I die. Administrator is currently trying to get ahold of resident mental health advocate. May we have order for psych evaluation/treatment? Please advise. The Nurse Notes dated 6/30/20 at 7:10 p.m., documented resident was out for smoke break and told aide he was going to the gas station and walked off. Aide attempted redirection, failed. Nurse notified, Director of Nursing, Administrator and Sheriff called. Resident was seen about 10 minutes later walking past the facility on the other side of the street. Nurse went to end of sidewalk, called residents name. Resident returned with a bottle in his hand covered by a paper bag. Nurse asked the contents, resident stated a bottle. Nurse confiscated a bottle of rum that was 1/3 consumed. Resident back in the facility, send to room. Director of Nursing and Administrator and Sheriff notified. Aides came from residents room stating he was talking about smoking in the room and using the lighter bought to burn this place down. Nurse attempted to take what ever resident had, unsuccessful. Sheriff notified again, said its not a police matter. Residents room searched, needle and thread found. No cigarettes, matches or lighter found. No evening smoke break for resident. Doctor notified by facsimile. The Psych Note dated 7/1/20, documented follow up to see patient depression and anxiety. Resident #5 left the facility last night. He went to buy some alcohol. When he entered again, staff asked him what he has with him, he opened the bottle and took a gulp. Today he said he was out of cigarettes and needed to go and buy some. Said he can wait till next day when orders going to store. Said OK. Talking about incident previous night and looked remorseful. The Social Service Progress Notes dated 7/1/20, documented resident left building last night, came back with a bottle of alcohol. Drank part of it, staff found it. Will have him see psychologist today. The Nurses Notes dated 7/14/20 at 2:00 p.m.-10:00 p.m., documented resident escaped or eloped from the facility at 9:15 p.m., and went to the gas station. Resident bought a bottle of vodka and a pack of cigarettes per the report form the gas station. Residents vodka was destroyed by the city sheriff and was left with the pack of cigarette. Cigarette was kept at the residents cigarette box. Police escorted residents back to the facility at 9:40 p.m. Review of Pearl Valley Concern Form: dated 7/14/20, documented staff concerned Resident had an elopement since he is court ordered to Pearl Valley. Resident left to go to the gas station to purchase alcohol-Sheriff was called due to his history of alcoholism and has no order for drinking. The O'Brien County Sheriff inventory of seized property dated 7/14/20 at 9:30 a.m., documented property seized a bottle of black velvet. Review of the Call for Service Record dated 7/14/20 at 9:16 p.m., documented Resident #5 walked out, he is court ordered to be there. No idea where he went, but possibly the gas station or the bar. Taller, curly gray hair-probably wearing jeans and tennis shoes. Left around 9:15 p.m., at 9:27 p.m., located subject-wearing shorts/black shirt. Will be giving him a ride back to Pearl Valley, at 9:32 p.m.,seized a bottle of back velvet that was still in the paper bag, at 9:41 p.m., subject also had matches and cigarettes that he turned over to staff. Will be an internal disciplinary matter. at 9:45 p.m., Resident turned over a book of matches and a pack of cigarettes to staff, Resident was upset about being court ordered to the facility and being there for over a year. The Social Service Progress Notes dated 7/15/20, documented resident left the building last night. He went to the store and bought alcohol and drank it. He is court ordered. Police picked him up and brought him back. Will have him see the psychologist today. The Psych Note dated 7/15/20, documented follow up to see patient for depression and anxiety. Resident took off again last night, bought some alcohol, made a picture of a woman on hangman of the wall. He is also refusing to eat again. The police brought him back. When resident entered he admitted what he has done. Said he was bored. He was asking the police to put him in jail for a night just to be away for awhile. Resident said he had to check in his alcohol and cigarettes and will not see that again. During an interview on 8/25/20 at 11:45 a.m., the facility Director of Nursing confirmed and verified the expectation of the staff is to know where the resident is at all times especially since the resident is court committed to the facility. During an interview on 8/25/20 at 3:30 p.m., Staff H (Registered Nurse) stated Resident #5 does show signs of wanting to leave the facility, he will tell staff that it is time to go to the store or gas station to get some alcohol, there are times he goes out the front door and the alarm sounds, other times he will be out smoking and tell the aide that is supervising the residents that he is leaving and will just walk away from the facility. Staff H stated that when you have one aide inside the facility and one aide outside supervising the residents you have to make a decision on residents safety, and with this resident the sheriff is called to find him and bring him back to the facility. Staff H stated when the resident left the faciity on [DATE], one of the staff from the facility went to search for him and found him in a corn field. During an interview on 8/17/20 at 3:20 p.m., the facility Medical Director confirmed and verified the facility is responsible for the resident at all times in and out of the facility. During an interview on 8/26/20 at 9:10 a.m., the Chief Deputy explained the facility is responsible for Resident #5 and since he is court committed it is up to the facility to make sure that he is supervised at all times, and that the facility and the sheriff department have no agreements or understanding that it is the responsibility of the sheriff department to find the resident when he exits the facility. The Deputy went on to explain there are times when the facility will call and another call takes precedents over the resident being gone to long. Most of the time the sheriff department will find the resident at the gas station buying alcohol and then it will be confiscated and taken away, the resident is very good about getting into the police car and going back to the facility. During an interview on 8/26/20 at 10:10 a.m., Staff I (Maintenance Supervisor) explained that on 5/7/20 between 10:00 p.m. - 10:15 p.m., a telephone call was place that Resident #5 was gone longer than normal and asked if they would mind going out to find him. Staff I stated that they got into their car and started to head around town looking for

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Resident #5, while driving received a phone call the resident was seen up town by the hardware store, so the staff headed up town and by the time got there the resident was across from the police station. Staff I explained to the resident that it was time for them to go back to the facility, the resident got into the staffs car and came straight to the facility, the resident got out and went in with no problems. 2. A Quarterly MDS with an assessment reference date of 5/29/20, documented Resident #16 with [DIAGNOSES REDACTED]. The MDS documented the resident BIMS score of 13, does have delusions, physical behaviors, verbal behaviors and other behaviors (physical symptoms such as hitting, or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). The MDS also documented the resident is independent in all aspects of activities of daily living and exhibits shortness of breath or trouble breathing with exertion (walking, bathing, transferring). Review of the Clerk of District Court dated 5/30/19, documented Resident #16 alleged to be seriously mentally impaired. Believe Respondent is seriously mentally impaired and is likely to injure himself or herself or others if allowed. Review of an affidavit on 5/30/19, documented in support of application alleging serious mental impairment documented that the resident can not take care of himself. He threatens to hurt himself and others. He can be verbally and physically aggressive. He is non-compliant with taking his medications and his daily cares such as bathing, changing clothes and follow simple directions. He has threatened staff and residents on several occasions and does not understand his behaviors is wrong. It would not be appropriate or safe for resident to be out of a facility, he is able to receive 24 hour care at a facility level where he can be monitored and cared for in his best interest. Review of an affidavit on 5/30/19, documented the resident has alcoholic dementia, he tries to drink himself to death. He becomes violent and threatens to kill family members. The PASRR dated 4/3/19, documented Resident #16 had [DIAGNOSES REDACTED]. The resident would benefit from having no access to alcohol appears to be helpful. He appears in need of an environment in which he is not able to leave. It is felt that an evaluation for neurocognitive disorder may be helpful in understanding some of his behaviors and in developing a treatment plan. The resident has difficulty with decision making and judgement, mobility and ambulation, and memory problems. The Care Plan with a problem start date 4/16/19, identified a problem with Resident #16 had behaviors related to [MEDICAL CONDITION], false accusations, yelling, cursing, delusions, and make threats. Approaches include: *I will have a separate smoke break from another resident. *I will let staff open and close the door during smoke breaks, staff will give me reminders to stay away for the door during smoke breaks. *Approach from front due to possible impaired peripheral vision. Review of the facility, Resident sign-out/sign-in log documented the resident signed himself out at these dates and times: 4/19/20 at 7:45 a.m. signed self out and sign in at 8:30 a.m. 5/1/20 at 10:15 a.m., and no time of returning to the facility. The Elopement Risk assessment dated [DATE], documented the resident is considered to be at risk for elopement, proceed with care plan. Observation on 8/18/20 at 8:25 a.m., surveyor was heading north on Highway 59 through Primghar Iowa when noticed a male that was walking on the east side of the highway heading south wearing shorts, t-shirt and tennis shoes. The resident was between 5th Street Northeast and 6th Street Northeast. Observation on 8/25/20 at 8:10 a.m., Resident #16 sitting in an armed chair in front of the facility smoking a cigarette. During and interview on 8/25/20 at 8:10 a.m., the resident stated that he can leave the facility anytime that he wants, he sometimes will sign himself out and sometimes don't. He continued to say that he can be gone for as long as he wants and can go where ever he wants, I am not court committed here and I can come and go when ever. Resident stated sometimes he walks around town, depends on the day, and no staff assist him and no staff to supervise him. He has no way of calling the facility if he gets lost or falls. During an interview on 8/18/20 at 8:30 a.m., questioned the facility Social Worker in regards to the male that was ambulating on the side walk across the street. The Social Worker confirmed and verified by looking out the window that it was Resident #16, and continued to state the resident will leave the facility whenever he wants, he is not court committed to the facility and has a right to leave when he wants. During an interview on 8/25/20 at 12:00 p.m., the facility Director of Nursing confirmed and verified the expectation of the staff is to make sure the resident is safe and that the resident needs supervision when leaving the facility premises. Resident Leave Policy dated 5/1/19, stated the purpose of this policy is to define resident rights to leave facility premises for therapeutic, medical and leisure activities after assessment of their cognitive capabilities and safety awareness. *Resident will all be assessed per the facility BIMSs assessment upon admission, quarterly and as indicated for significant or acute changes to cognition and decision making capabilities. Residents with a BIMS level of 12 or higher who are capable of making said decisions. The resident will follow the facility protocols and or be encouraged to sign themselves out of the facility and back into the facility upon returning to the premises. Non compliant residents or residents who are not willing to sign the signature sheet shall be educated and care planned accordingly. 3. A Significant Change Minimum Data Set (MDS) assessment tool, dated 5/15/20, documented Resident #13 with a Brief Interview for Mental Status (BIMS) score of 15, for which indicates no impaired decision making abilities and no long or short term memory problems, and required extensive assistance with bed mobility, dressing, toilet use and personal hygiene and activity did not occur for transfers, and locomotion on and off the unit, and impairment of upper extremity for functional limitation in range of motion. The MDS documented the resident with [DIAGNOSES REDACTED]. The residents plan of care with a problem start dated 9/19/19 and a edited date 7/24/20, had a problem area that Resident #13 is limited in ability to transfer related to non weight bearing status. Approaches include: *I use the EZ stand during day shift for functional transfers with an Assist of 2. *Make sure my left hand is gripping the handle. *Use strap for my legs. *Use strap around my waist. *Ensure assistive devices available and in good condition. *Resident is assisted by nursing. Dependent on the staff for all activities of daily living at the time. An Incident/Accident Report dated 5/5/20 at 1:30 p.m., documented equipment involved: mechanical stand assist lift. Resident was being assisted to bathroom and was reported the resident had slipped out of EZ stand and was lowered to the floor. No immediate injuries noted. Resident denies pain at this time. A Root Cause Analysis Investigative tool dated 5/5/20 documented: *Description of incident: Resident was being transferred in the EZ stand lift. Resident knee slid out of place and resident released her/his hands, resulting in lowering to ground. Certified Nursing Assistant held resident and helped lower to floor. Preventing any injuries. Resident was assessed. No injuries noted. Resident did not hit head. Resident complained of right shoulder pain at 7/10. As needed pain medication given. No bruising noted. 1. When did the Incident Occur? (time of day/shift): 1:30 p.m., on 5/5/20 on the 6:00 a.m. - 2:00 p.m. shift. 2. Where did the Incident Occur? (location/outside/resident room/outdoors/indoors) Resident room [ROOM NUMBER]. 3. When was the resident last visualized? at time of 4. What was the resident doing when last visualized? Being transferred to toilet. 5. Who last visualized the resident? CNA 6. What was the resident attempting to do when the Incident happened?. toileting 7. When was the resident last toileted? one hour before. 8. Was the resident continent or incontinent at the time of the incident? continent 9. When was pain last assessed and managed? during scheduled medication pass. 10. When was the resident last assisted with position changes? at time of 11. Vitals at time of incident? temp. 98.7, pulse=80, blood pressure 100/78 and O2 SATs at 94%. 12. Hydration status? Was the resident adequately hydrated? Adequate hydration. No antibiotics. Skin turgor good, color, with in normal limits, moist. 13. What did the resident say they were doing at the time of the incident? being helped to the toilet. Employee/Witness Statement dated 5/5/20: Please include the following information in your report: 1. date/time when incident occurred: 5/5/20 at 1:40 p.m. 2. Location where incident occurred: in resident room. 3. Who was involved: CNA/Resident 4. What you were doing immediately before the incident: getting stand to lift the resident. 5. A brief description of what occurred (what you personally saw or heard): got resident all squared away, resident knee came out and resident let go of her hand and fell out. Called for help, and then helped her to ground. got help with resident. The Nurses Notes dated 5/5/20 at 1:30 p.m., documented resident was being transferred to toilet, resident knee slipped and CNA helped lower resident to floor. This nurse assessed resident, no injuries noted. No signs of internal injury. Resident voices no complaints. Resident is helped up and safely put into bed. This nurse asked resident if anything hurts. Resident replies no While assessing arms and shoulders resident complained of pain when palpating right shoulder. No signs of major injury noted. Resident was given as needed [MEDICATION NAME] per provider orders. Incident report filled out and sent to provider, awaiting reply. A facsimile dated 5/5/20, documented: resident was lowered to floor, doctor signed and dated 5/5/20 with acknowledged. monitor for injuries and low blood pressure. The Nurses Notes dated 5/8/20 with no time documented, facsimile sent to provider regarding concern about increasing pain. A facsimile dated 5/8/20 documented: resident has begun having increased pain in right arm/shoulder since incident on 5/5/20 (lowered to floor from lift) there is noted bruising now as well, under right arm. PLEASE ADVISE! Dr. acknowledged and recommend right arm x-ray (hummerus). sent to hospital on [DATE] at 3:00 p.m. The Nurses Notes dated 5/10/20 at 9:30 a.m., documented resident continues to have pain to right upper arm. Area is bruised, deep purple and swollen. Cold packs applied to promote comfort. The Nurses Notes dated 5/11/20 with no time documented, no reply received from provider related to incident. Director of Nursing notified and aware. The Nurses Notes dated 5/11/20 at 3:00 p.m.,

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) documented received order to transport resident to hospital for right arm X-ray. Resident was lowered to floor on 5/5/20 due to fail in EZ stand. Resident has been complaining of pain. 3:52 p.m., X-ray report shows mildly displaced [MEDICATION NAME] fracture at right humeral neck. Residents brother notified of fall and X-ray result. Please notify brother of ortho appointment on 5/12/20. A Physicians Notes Final Report dated 5/11/20 at 4:00 p.m., documented patient arrived at the emergency room by the ambulance for possible right arm fracture. History of Present Illness: The patient presents with right arm pain, arm swelling. The onset was 6 days ago and on 5/5/20. The course/duration of symptoms is worsening. Type of injury- Patient was being lifted by EZ stand on 5/5/20 and her left leg was not in correct position and the staff tried to catch her and lowered her to the ground. The characters of symptoms is pain, swelling and ecchymosis to right upper shoulder, tingling and numbness. Report: Right hummerus injury, right upper extremity bruising. Findings: A mildly displaced [MEDICATION NAME] fracture is present at the humeral neck. The frontal view suggests inferior displacement of the humeral head relative to the glenoid which may be related to a subluxation or dislocation. Pseudodislocation associated with a joint effusion can also have this appearance. Resident discharged back to the nursing home on 5/11/20 at 4:45 p.m. A Major Injury Determination Form dated 5/11/20 at 4:45 p.m. signed by the physician, documented residents right upper arm bruised and swollen, unable to move arm. Resident was lowered to the floor from the lift on 5/5/20, extensive assist with all activities of daily living. After reviewing the circumstances injury and prognosis of the patient, I believe the injury sustained is a major injury-needs referral to orthopedic care for further evaluation. A PRN (as needed) Medication Notes with these dates and times documented: 5/5/20 at 1:45 p.m., resident rates pain a 7/10 on a pain scale with 10 being the worst pain. Pain in the right shoulder. 5/8/20 at 11:00 a.m., resident rates pain at a 8/10 on the pain scale with general pain. 5/10/20 at 8:40 p.m., resident rates pain at a 10/10 on the pain scale with pain in the right shoulder. A Pain Evaluation dated 5/13/20, with no time documented resident has pain due to a mild fracture of right humeral neck and is aching and throbbing during movement with a total score of 3, and pain is relieved by medication and pain medication is effective on 5/5/20. A Fall Risk Evaluation dated 4/6/20, documented resident with no falls in the last 3 months and total score of 9. A Fall Risk Evaluation dated 5/13/20, documented resident at high risk for falls with a score of 11, for total score of 10 or above represents HIGH RISK. Review of the Resident Transfer Policy dated 1/19/20, stated it is the policy to transfer all residents in the safest manner possible to assure their safety. All residents who require a transfer with staff assist will be assisted with a gait belt for the transfer as the resident will allow. Residents who are transferred per Mechanical lift will be transferred via the recommended sling and or approved universal sling according to the manufacturers instructions and after staff have had lift training per the designated facility staff upon hire and annually thereafter. Review of the Arjo Sara 3000 lift instructions for use instructed: *Lower leg straps- accessory used to ensure that the lower parts of the patients legs stay close to the knee support. It passes around these, then around the patients lower calves. To fasten, click the strap into its socket as with a seatbelt. Ensure that the straps are firm but comfortable for the resident. *An assessment would have to be made whether the patient requires the lower leg straps. *The patients feet should always remain in full contact with the foot support. When lifting, check to ensure that the patients feet do not lift from the support or floor. If this should happen inadvertently lower the patient immediately until full foot contact with the support or floor is achieved. *Patients who can only hold on with one hand (those who have suffered a stroke may still be lifted with the Sara 3000, but their disable arm should be held down it in front of the body during the lift by the attendant (or a second attendant), while their functioning hand holds the patient support arm in the normal way. Only use this or other methods after a satisfactory professional assessment has been carried out on the individual patient. Care and Preventive Maintenance: The Sara 3000 is subject to wear and tear, and the following actions must be performed when specified to ensure that the product remains within its original manufacturing specifications. *Examine the sling, straps and clips for damage or fraying as required. Refer to sling documentation. To be done before each use and every 12 months by a qualified personnel, using the correct tolls and knowledge of procedures. Review of the facilities Inspection and Operation 2020/lift, Model #Sara 3000, documented no checks completed for the month of August, for wires, battery, hooks, bolts, wheels, frame and sling. The last inspection was completed on 7/9/20 with lift equipment/scales and oxygen concentrators. Review of a text message on 4/24/20 at 1:14 p.m., documented Its a SARA 3000. Part #HMXS22. During an interview on 8/19/20 at 1:45 p.m., Resident #13 stated Staff A and another staff member, but didn't remember who, came in to take the resident to the toilet. Staff A and the other staff, assisted the resident to sit on the edge of the bed and proceeded to apply the EZ stand sling around the residents back and positioned the resident feet on the foot plate on the EZ stand. Resident stated to Staff A that the strap that goes around the back of the calves was not applied and that the resident didn't feel safe without the strap. Staff A stated the strap was broke and that since the resident was only going a short distance to the toilet it will be ok. Resident #13 stated that their feet started to slip off the back of the foot plate and then their hand lost grip on the handle bars and the next thing she was on the floor. Resident #13 stated there were at least 3 other staff members that came in to assist her off the floor. Resident #13 stated her shoulder hurt right away and she told the nurse on that shift and that the doctor would be notified. During an interview on 8/20/20 at 12:00 p.m., Staff A, (Certified Nursing Assistant) stated on 5/5/20 a transfer was being done with Resident #13 with the EZ stand lift. Staff A stated the resident needed to use the bathroom so Staff A proceeded to place a sling behind the resident back and place the residents feet on the foot plate of the stand. Staff A stated she was informed that only one aide needed to use the EZ stand with Resident #13 and that it was a short distance from the bed to the bathroom and it would be ok to do the transfer alone. Staff A stated the resident commented the strap behind the residents calves was not secured tightly and the resident felt unsafe with the strap not secured. Staff A replied the strap was broken and that it would be safe to transfer without the strap. Staff A stated the EZ stand was being moved and the residents feet started to slip off the back of the foot plate and then the residents hand let go of the handle bar and down the resident went. Staff A stated went and got another staff member to assist the resident up off the floor using the hoyer lift. During an interview on 8/20/20 at 9:20 a.m., Staff B (CNA), stated that on 5/5/20 before 2:00 p.m., Staff B assisted Staff A with Resident #13 who had fallen out of the EZ stand. Staff B stated the EZ stand was towards the door of the resident room and the sling was still attached to the arms on the stand and Staff A was on the floor with the resident. Staff B stated the strap on the back of the EZ stand has been broke since April 14,2020. Staff B stated the maintenance man knew about the strap being broke and that it was not until after the resident fell did the strap get adapted. During an interview on 8/18/20 at 10:50 a.m., Staff G (housekeeper) stated the maintenance man knew about the strap on the EZ stand being broke but was not aware of when or if the facility keeps an audit on the equipment. During an interview on 8/20/20 at 2:30 p.m., the Maintenance Supervisor confirmed and verified the strap had been broken since April 2020 and that not until the resident fell out of the EZ stand lift did the strap get adapted to fit the lift. The Maintenance Supervisor stated that to their knowledge the lift is on a monthly inspection per the manufactures guidelines but is unsure when the inspections were checked last and if the straps are included in the inspection. During an interview on 8/24/20 at 11:30 a.m., Staff G, stated the straps that go around the resident calves when in the EZ stand need to be checked every time the lift is used and is unsure if this is being completed. The records that were provided to this surveyor indicated the equipment is inspected on a monthly basis, straps not included in the inspection. The facility abated the immediate jeopardy on August 27, 2020 by providing education to facility staff on the protocol of residents leaving facility property for approved leave of absence. Staff will be with residents who are leaving the facility property for leisure activity and appointments unless resident is deemed safe to leave without staff supervision per facility assessment findings, physician notification and agreement of them leaving. All residents must sign in and
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 clinical record review, staff and resident interviews and observations the facility failed to implement effective infection control measures in attempts to mitigate the transmission of the Covid 19 virus amongst their residents and failed to follow physician's orders [REDACTED].#3). and failed to follow policy and procedures for screening of employees prior to their shift and at the end of their shift. The facility reported a census of 31 residents. Findings include: 1. The Quarterly Minimum Data ((MDS) dated [DATE], documented Resident #3 with [DIAGNOSES REDACTED]. The resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated intact cognitive ability. Review of Resident #3's Care Plan dated 3/31/20 revealed the resident had increased risk of respiratory infection related to Covid-19 pandemic and directed staff to avoid unnecessary appointments and treatments outside of the facility setting during active covid period, facility will limit group activites and meals throughout the covid-19 activity period, encourage social distancing for activites while under precaustions, facility will monitor for change in condition or sign potential and isolate resident

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	165387	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL VALLEY REHABILITATION AND NURSING AT PRIMGHA	**735 NORTH RERICK PRIMGHAR, IA 51245**

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	(continued... from page 4) per facility protocol for covid-19 infection, staff to follow principles of infection control and universal precautions or droplet precautions when exhibiting sympotms of cold or respiratory infection. The Nurse Notes dated 8/6/20 at 7:30 p.m., documented Resident #3 taken outside for a lab draw by lab personnel. Lab results received at 4:45 p.m., results faxed and call placed to Nurse Practioner about results, order to transfer to emergency room via ambulance for stabilization and then transferred to another hospital, [DIAGNOSES REDACTED]. Resident assisted from bed to cart by 2 CNA and nurse and 2 ambulance personnel. Resident left facility at 5:15 p.m. Update from Emergency Medical Technician that resident was on her way to another hospital. Call not placed to resident representative since only number is work and closed for the day. The Nurse Notes dated 8/7/20 at 8:00 a.m., documented Covid-19 test results come back positive. Covid-19 detected. Director of Nursing, Administrator, Quality Assurance Nurse aware, Iowa Department Public Health aware, call made to provider to inform of positive results. Provider sends orders, resident is not in the facility at this time, resident is in hospital, awaiting provider orders. The Nurse Notes dated 8/7/20 at 9:45 a.m., orders received to perform Covid-19 testing on all residents and staff. Director of Nursing (DON), Administrator notified. DON reports to wait for futher instructions from Administrator. Administrator reports that corporate will not want us to test every resident, instead we will do vital signs/covid-19 assessment every 4 hours on every resident. Vital signs/covid assessments started. The Nurse Notes dated 8/7/20 at 2:00 p.m., documented nurse notified provider of supervisors refusal to follow the physicians orders. A Tapestry Health Fascimile dated 8/7/20, instructed to swab all staff and patient for COVID-19, DON or ID to contract tracing-anyone that was within 6 feet or Resdient #3 for more than 10 minutes needs to be isolated. dated and signed by the ARNP on 8/7/20. A Tapestry Health Fascimile dated 8/10/20 at 5:08 p.m., documented, Good Afternoon Dr. Do you happen to recall if you gave orders for all of our residents and staff to be covid tested in our Primghar location last week? We are following up resident conditions at the facility. A fascimile dated 8/10/20 at 4:41 p.m., documented, I did not give that order. The decision to do the testing lies with the DON, following the guidance of State Department of Health. I make recommendations, and sign the order. My recommendation was that you isolate the index case and his roommate, and the contact trace within the building. Anyone with contact closer than 6 feet for more than ten mintes, or directly touched or coughed upon is a contact. Based on those findings, you decide whether to treat this as a situation where you isolate a small number of patients to their rooms, and test them, or whether you need to do a large scale isolation with a quarantine ward. Testing everyone in the building will not be useful since it will also capture people who may already be carriers unrelated to this specific contact. In the meantime, everyone should be wearing PPE and should be assumed to be a carrier until proven otherwise. When you have made a decision about testing, I will be happy to discuss it with you and sign orders. Signed and dated by the Doctor on 8/10/20. During an interview on 8/13/20 at 11:10 a.m., Staff C (Certified Nursing Assistant) stated Resident #3 came back from the hospital on [DATE] and no isolation precautions were put in place, and no special precautions were given to the staff to keep the resident in their room since returning from the hospital. During an interview on 8/13/20 at 1:10 p.m., Staff D (Certified Nursing Assistant) stated Resident #3 came back from the hospital on [DATE] and no special isolation precautions were put into place when returned. During an interview on 8/13/20 at 2:10 p.m., Staff B (CNA), stated when Resident #3 came back from the hospital on [DATE], no isolation precautions were done since the resident was in the hospital for a few days. During an inteview on 8/17/20 at 1:15 p.m., the Dieatry Supervisor confirmed and verified Resident #3 did come out of her room when returned from the hosptial on 7/31/20, and ate lunch in the dining room. The Dietary Supervisor confirmed and verified the resident was not on isolation precautions when came back from the hospital. During an interview on 8/18/20 at 12:30 p.m., the Dietary Supervisor stated Resident #3 would come out for meals and would sit at the table with no mask on and to their knowledge Resident #3 was not on any isolation precautions since coming back to the facility. During a further interview on 8/18/20 at 5:10 p.m., Staff D (CNA) confirmed and verified Resident #3 came back from the hospital and was not placed in any isolation precautions and the resident needed extensive assistance for all activities of daily living. Staff D stated Resident #3 would of stayed in their room if explained that due to being out of the facility it is the facility policy to have the resident stay in their room for 14 days. During an interview on 8/19/20 at 8:30 a.m., Staff D, CNA, stated Resident #3 would come out of their room with staff assistance while pushing in a wheelchair and would come to the dining room with no face mask. During an interview on 8/19/20 at 8:50 a.m., Staff C, CNA, stated Resident #3 needed extensive assistance with all activities of daily living and that staff would push the resident out to the dining room and also devotions and that no mask was used during meal times or devotion. During an interview on 8/19/20 at 9:35 a.m., Staff E, (Licensed Practical Nurse) stated Resident #3 needed extensive assistance to come out of their room and needed to be pushed in a wheelchair to the dining room and to devotions and that no mask put on the resident. If the resident would of been told they needed to stay in their room for 14 days due to facility policy that the resident had been out of the facility, the resident would of complied with the facility policy. During an interview on 8/19/20 at 10:00 a.m., Staff F (CNA), stated Resident #3 needed extensive assistance with all aspects of activities of daily living and that staff needed to push the resident out of their room in a wheelchair and a mask was not used during meal times or during devotions and Staff F had seen another resident give Resident #3 a hug while out in devotions and no masks were on either residents. During an interview on 8/19/20 at 10:38 a.m., the Activity Assistant, stated Resident #3 would come out for devotions and a mask was not utilized when the resident was in the living room. During an interview on 8/17/20 at 3:10 p.m., the facility Medical Director explained he had gotten a telephone call from the facility Director of Nursing and Administrator stating the ARNP wants the residents and staff at the facility to be tested for COVID-19, he recieved an email also from the Infection Control Nurse to explain his rationale for wanting the residents and staff tested , and if he actually gave that order. The Medical Director stated that if knew Resident #3 had returned from the hospital on [DATE], it would of been expected to isolate for the 14 days, since the resident was not isolated than it would be expected to have the residents and staff that were within 6 feet of Resident #3 to have been tested to make sure they were not COVID-19 positive. The Medical Director also explained the facility was told to get ahold of the Public Health in the state and follow the recommendations that are given to the state that they are in. The Medical Director explained if the facility needs to test all the resident and staff in the facility that the orders will be given and then the facility can proceed from there. Covid-19 Policy and Procedure dated 3/1/20, documented the purpose of this policy is to identify and isolate symptomatic residents and prevent the potential contamination of facility population with Novel Coronavirus. Resident will be assessed every shift for elevated temperature and noted change of condition. Should residents exhibit any of the following symptoms the facility shall intitate droplet isolation precautions for symptomatic residents and room mates if applicable *fever greater than 100.4 *sore throat *cough *Decreased oxygen saturation *difficutly breathing or painful respirations. *fatigue, body aches, headache or any other flu-like symptom Facility shall notify primary medical provider or their designee of symptoms. Residents will be placed into droplet isolation along with their roommate. Follow up testing shall occur per the order of the primary medical provider. Residents and roommate will remain on droplet isolation precautions until test results are returned with definitive diagnosis. Should the resident require transfer to hospital and is hospitalized roommate will continue on droplet isolation precautions until test results are confirmed or 14 day isolation period has been completed with no noted symptoms of illness. During active covid-19 out break period facility shall halt all group activites and community dining. Residents will be offered activities in the location of their room or an area where there is no more than 5 residents or staff located with observed social distancing. All residents and staff will practice social distancing. No residents will be seated closer than within 6 feet of another resident. All direct care staff will wear appropriate PPE while providing care to residents 2. During record review of the facility's Covid-19 Employee sign in tracking logs, the facility failed to accurately and consistently record and document all staff and visitors entering and exiting the facility were negative for Covid-19 symptoms. An audit of the facility's surveillance logs from 7/26/20 to 8/14/20 revealed there were no temperatures completed on clock out for these dates, 7/26/20, 7/28/20, 7/31/20, 8/10/20, and 8/13/20. The facility failed to consistently record and verify with another staff's signature, that the Covid-19 screening questions had been answered, and the temperatures recorded were accurate. Review of the facility's Employee COVID-19 Screening dated 4/1/20, documented Employees of the facility will utilize the time keeping system to respond to COVID-19 questions. The employee will respond to three pre-programmed questions about the employees overall health prior to each shift. In the event that the employee responds yes to any of the COVID-19 questions it will trigger a report that is sent to the QA Nurse and Human Resources department. They will in turn contact the building to have that employee evaluated. If the employee answered yes in error a COVID-19 question document will be filled out and kept with the daily sheets. The employees are also required to sign in on the sheet at the front nurses station. The employee will have their temperature checked upon clock in and out, indicate if they have symptoms, perform hand hygiene per facility protocol and utilize PPE. If at any point in an employees shift they begin to feel symptomatic. They are to immediately report to

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) the nurse to have an assessment done. Observation on 8/17/20 at 1:50 p.m., revealed staff came into the facility via the front door and took their own temperature and did their own screening process for which included answering their own screening questions. Observation on 8/17/20 at 2:00 p.m., revealed one staff member screened themselves out of the facility after their shift was completed. Observation on 8/18/20 at 8:30 a.m., revealed three day shift staff came into the facility and proceeded to take their own temperature and screened themselves and answered the screening questions, and then proceeded to go to the nurses station. Observation on 8/18/20 at 2:05 p.m., revealed staff taking their own temperature and screening themselves in and answering the screening questions. Observation on 8/19/20 at 1:55 p.m., revealed staff coming into the facility and took their own temperature and screened themselves and answered their own screening questions. During an interview with the DON on 8/24/20 at 2:15 p.m. the DON confirmed and verified staff are to have another staff member screen them in and take their temperature before and after their shift is completed. 3. Observation on 8/12/20 at 3:50 p.m., revealed two male resident sitting at the dining room table not wearing masks and not [MEDICATION NAME] social distancing. Observation on 8/13/20 at 10:35 a.m., revealed a male resident in a wheelchair at the nurses station with no mask on covering their nose or mouth. Observation on 8/13/20 at 1:03 p.m., revealed a male resident propelling himself in a wheelchair around the nurses station with no mask covering their nose or mouth, and another male resident ambulating throughout the facility without a mask covering their nose or mouth. Observation on 8/17/20 at 1:10 p.m. revealed two resident in their wheelchairs across from the nurses station with no masks on propelling themselves throughout the facility Observation on 8/17/20 at 1:20 p.m., revealed two resident at the nurses station with no masks on covering their nose or mouths. Observation on 8/17/20 at 2:05 p.m., revealed a male resident sitting in a wheelchair in front of the activity directors office with no face mask on covering their nose or mouth. Observation on 8/17/20 at 2:20 p.m., revealed a male ambulating in the hallway with the face mask in the right hand and not over their nose or mouth. Observation on 8/17/20 at 2:30 p.m., revealed three males sitting in the dining room around a square table within 6 feet from each other, no social distancing and no face masks worn to cover their nose and mouth. Observation on 8/18/20 at 9:56 a.m., revealed a male resident sitting in a wheelchair with mask below his nose and mouth. Three men sitting in the dining room at a square table drinking coffee with no masks on and not [MEDICATION NAME] social distancing. Observation on 8/18/20 at 11:22 a.m., revealed 2 residents sitting outside the facility on the cement patio not [MEDICATION NAME] social distancing. Observation on 8/18/20 at 11:30 a.m., revealed a male resident at the nurses station with a mask that is not on his face and in his right hand, not covering his mouth or nose. Observation on 8/18/20 at 1:10 p.m., revealed 3 residents sitting outside smoking not [MEDICATION NAME] social distancing. One male resident in the dining room with no mask on at the table. One male resident at the nurses station with a mask below their nose and chin. Observation on 8/18/20 at 1:44 p.m., revealed a staff member sitting outside with a male resident not [MEDICATION NAME] social distancing and the staff member with the mask below the staffs chin and not covering the nose and mouth. Observation on 8/18/20 at 1:50 p.m., revealed a male ambulating out of the dining room with the mask down underneath the chin. Observation on 8/18/20 at 3:00 p.m., revealed two male residents sitting at the nurses station not [MEDICATION NAME] social distancing and no face masks covering their nose or mouth. Observation on 8/19/20 at 8:10 a.m., revealed 3 residents sitting in the dining room at a square table drinking coffee and not [MEDICATION NAME] social distancing and wearing no masks to cover their nose or mouths. Observation on 8/19/20 at 1:30 p.m., revealed two male residents sitting in the dining room having coffee and not [MEDICATION NAME] social distancing and no face masks on that cover their nose or mouths. Observation on 8/19/20 at 1:55 p.m., revealed the two male residents continue to sit in the dining room with no mask on their face covering their nose or mouth and not [MEDICATION NAME] social distancing. 2.Random observation on 8/13/20 at 9:30 AM revealed Resident #4 propelling self in wheelchair up the main hallway from the nurse's station to the front door to the facility, unlit cigarette in mouth, face mask worn under chin. Masked staff person and unmasked resident following within 6 feet. Staff person reminded Resident #4 to wear mask. Resident #4 responded that he couldn't propel own wheel chair, hold cigarette and propel own chair. Resident continued with no mask. Further observation at 9:35 AM on that same date, Resident #1 was observed in the hallway wheeling towards the nurse's station. Resident wore no mask, 5 residents were observed to be seated in the area around the nurse's station, 3 without mask covering mouth and nose. Resident #1 observed to come within 6 feet of residents seated at the nurse's station. Observation on 8/13/20 at 2:10 PM revealed 5 residents observed at the nurse's station. One resident with a mask on, 2 residents with mask on but worn on the chin not covering the mouth or nose, and 2 residents not wearing a mask. Residents were observed to be visiting with each other and the staff. Residents were seated within 6 feet of each other, and staff failed to remind or encourage to wear mask to cover mouth and nose. Observation on 8/13/20 at 2:15 revealed Staff J. CNA stopped at screening station just inside the front door and took own temperature and documented. Staff J reported she always takes own temperature and documents at the end of the shift. Further stated in the morning an RN is usually comes at the same time as other staff, but they still take own temperature and answer questions and document. Further observation at that same time Staff C CNA noted to self-screen by taking own temperature. Staff C stated always completes own screening.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on clinical record review, staff interview, and facility record review, the facility failed to inform all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed Covid-19 infection. Confirmation of a positive Covid-19 test for Resident #3 was reported to the facility 8/7/20. The facility census was reported to be 31. Findings include: A Nurse Note signed by Staff E, Licensed Practical Nurse (LPN) on 8/7/20 at 8:00 AM documented Covid-19 test result for Resident #3 came back positive, Covid-19 detected. Staff E notified the Quality Assurance Nurse, Iowa Department of Public Health, and provider to inform of positive results. Resident not in facility at that time, Resident at a local hospital. In an interview on 9/2/20 at 11:00 AM the Director of Nursing (DON) stated she had verbally informed all residents of possible exposure on 8/7/20 when aware of Covid-19 positive results for Resident #3. The DON further stated had failed to document at that time, and had recently documented a late entry in all facility residents chart. Examples provided revealed the late entry, which was undated when entered, was documented in the Nurse's Notes after 8/27/20. The DON was unable to provide a facility policy or protocol that directed notification of residents, their representatives, and families. The Administrator provided a computer generated document that listed all facility residents and their contacts. The Administrator indicated in writing on the document the date families and representatives were contacted. The document revealed the following resident representative or family were not contacted by 5:00 PM 8/8/20. Resident #17-Message left for emergency contact 8/10/20 Resident #2-Family contact 8/11/20 Resident #18-Family left phone message 8/11/20 Resident #19-Family phone call 8/11/20 Resident #4-Family phone call 8/10/20 Resident #13-Family called 8/10/20 Resident #20-Family left phone message 8/12/20 Resident #21-Family phone message and phone conversation 8/12/20 Resident #22-Family left message 8/10/20 Resident #7-Family phone message 8/10/20 In an interview on 9/2/20 at 11:20 AM the Administrator stated she was unaware that there was specific direction to notify residents, their families or representatives by 5 PM of the day following becoming aware of a positive Covid-19 infection. She further stated DON and Social Worker had assisted with notification of families and confirmed the time and date indicated on list provided was accurate.