Compliance Tips from IHCA's Survey Results Committee
October 2020

Total Number of Survey Reports: 34

Survey Composition:

Annual:	1 Surveys	1 Deficiency Free
Complaints:	34 Surveys	13 Unsubstantiated
Self-Reports:	12 Surveys	2 Unsubstantiated
Mandatory Reports:	0 Surveys	0 Unsubstantiated
COVID-19 Infection Control Survey:	42 Surveys	14 Deficiency Free

State Fines: $43,750
State Fines in suspension: $ 115,250

Most Commonly Cited Iowa Tags:

F 880 – Infection Prevention and Control (18)

F 689 – Free from Accidents and Hazards (11)

F 684 – Quality of Care (8)

F 656 – Develop/Implement Plan of Care (6)

F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers (5)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers	**1 J Level Tag & 1 G Level Tag**
F 689 – Free from Accidents and Hazards	**3 J Level Tags & 4 G Level Tag**
F692 – Nutrition/Hydration Status Maintenance	**1 G Level Tag**
F760 – Residents are Free of Significant Med Errors	**1 J Level Tag**
F 880 – Infection Prevention and Control	**3 K Level & 2 L Level Tag**

Top 10 National F-Tags*

Citation Frequency Report

National Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers=15451		Total Number of Surveys=60583
F0880	Infection Prevention & Control	4,659	23.5%	7.7%
F0884	Reporting - National Health Safety Network	2,513	7.7%	4.1%
F0689	Free of Accident Hazards/Supervision/Devices	1,527	8.6%	2.5%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	1,136	6.9%	1.9%
F0684	Quality of Care	1,118	6.3%	1.8%
F0656	Develop/Implement Comprehensive Care Plan	1,004	6.0%	1.7%
F0761	Label/Store Drugs and Biologicals	802	5.0%	1.3%
F0609	Reporting of Alleged Violations	704	4.0%	1.2%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	647	3.8%	1.1%
F0657	Care Plan Timing and Revision	606	3.6%	1.0%

*Additional detailed national, regional, state and facility-specific CMS regulatory data can be found S&C's Quality, Certification, and Oversight Reports (QCOR).

<u>**Deficiencies and Fines**</u> (sorted ascending by F-tag number)

F554 – Resident Self-Admin Meds-Clinically Appropriate

- Resident was allowed to self-administer not in presence of nurse when not clinically appropriate due to cognitive level. D

F561 – Self-Determination

- Facility failed to ensure resident rights were met due to resident was not allowed to have family visit during end of life. Resident on hospice, declining, began to mottle and passed away next day. Daughter was allowed window visit but was not allowed in facility. No COVID screening log documentation noted for window visit. **G $2,000**

F580 – Notify of Changes (Injury/Decline/Room, Etc.)

- Facility failed to provide notification of residents change of condition physician and family. Failed to notify family and physician of significant weight loss and overall decline in transfers, ambulation and eating and new open area. D
- Failed to notify responsible party of medication change. **D $6,000**
- Failed to immediately notify physician of change in condition. Resident had an increase in pain in left ankle after foot was hit while moving resident through doorway in wheelchair. Physician and family were not notified until two days later. D

F584 – Safe/Clean/Comfortable/Homelike Environment

- Not maintain clean homelike environment, dark brown drips on door and dried to wall, stains on curtains and floor. Multiple other issues**. D $8,500**
- Facility failed to maintain safe clean homelike environment. Lots of water damage to various ceilings and continued leaks, water on floor near residents, multiple resident rooms with wet floors, no wet floor signs, resident with multiple full trashcans. E

F600 – Free from Abuse and Neglect

- 6 or 7 residents were not free from abuse. CNA was calling residents molesters, expletives, spraying periwash in their face, being too rough with them during cares, and embarrassing residents. CNA had had one counseling and was terminated on day of incident. E

F604 – Right to be Free from Physical Restraints

- Failure to adequately document seatbelt restraint for one resident and release of seatbelt. D

F607 – Develop/Implement Abuse/Neglect, etc. Policies

- One of three surveyed staff did not have documentation of dependent adult abuse training. D

F609 – Reporting of Alleged Violations

- Failed to report an allegation of abuse to DIA within 24 hours who reported missing valuables. A missing item tracking reported dated 11/5/2019 completed by staff on-line abuse or incident reporting revealed the facility notified DIA. D
- Facility failed to report 3 of 9 incidents reviewed involving 4 of 5 residents. Staff saw one resident put their hands around another residents neck and push them against the wall and they then feel to the ground on their buttock. Staff reported to nurse and administrator, but it was not reported to the state. Nurse was called to resident room by the CNA who found resident sitting next to the residents bed with their pants pulled down to the knees, exposing the groin area and was not reported. D

F610 – Investigate/Prevent/Correct Alleged Violation

- Facility failed to thoroughly investigate allegations of resident to resident altercations. D

F656 – Develop/Implement Plan of Care

- Facility failed to complete a comprehensive care plan to accurately reflect care required for pressure ulcer. D
- Failure to follow care plan. Resident should have had a urinal at bedside and did not. Resident fell out of bed due to no urinal being on his walker - he was trying to get up to go to bathroom. D
- Failed to document care plan interventions. Fall occurred on 7/10 and sustained a skin tear, staff did not list an intervention on the care plan until 8/12. Fall interventions not put into place to address falls. D
- Facility failed to establish and implement accurate and appropriate care plan interventions. Resident had order for heal protector for pressure sore relief for right foot and they only had a gripper sock on the right foot. Care plan also directed staff to document the progress of the ulcer on his ankle weekly and there were only 2 entries containing wound measurements. Care plan lacked instruction regarding daily weights, the need for suctioning of secretions, the use of pressure reduction adaptive

equipment to assist with healing of sacral wound, supplemental oxygen use or PEG tube daily retention. D

- Facility failed to follow an update a care plan to effectively treat a resident. Resident with 10% weight loss, who needed help to eat and drink and staff who offered to help said they would be right back, and did not return. The care plan lacked documentation related to the use of pressure reduction boots, and also lacked documentation the resident was receiving Hospice level of care. D
- Facility failed to update and implement care plan for two residents. D

F657 – Care Plan Timing and Revision

- Failure to update care plans for two residents. One care plan stated resident was total body lift but also independent with pivot transfers in room. Another resident's care plan stated required extensive assistance with transfers and toileting and did not ambulate but Kardex stated resident to be independent with walker in her room. D

F658 – Services Provided Meet Professional Standards

- Facility failed to get equipment required to prevent residents decline and failed to get orders within an appropriate time frame. Resident went without compressions stockings for five weeks after a hole in one made it unusable, resident declined, got edema. Another resident had 10% weight loss and failed to get order from physician for extended period of time relating to increasing med pass. D
- Facility failed to provide professional standards of care by accurately documenting and transcribing admission and transfer orders. D
- Facility failed to receive/and or implement physician orders for 3 residents.

F675 – Quality of Life

- Facility failed to meet the needs of current residents reviewed when they failed to provide access to the call light during meal service. D

F677 – ADL Care Provided for Dependent Residents

- 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. Staff report not enough staff or supplies to adequately meet the resident's needs. Staff report running out of linen and pads. Lack of baths being completed 2x/week while in isolation. E
- Facility failed to ensure staff provided oral care/personal hygiene. Pushed resident to the dining room for lunch resident's hair stuck out in the back and both sides staff did not offer or provide any personal hygiene(washing of face, hands, chest, arm pits deodorant hair grooming or oral care. D
- Facility failed to ensure that 7 residents received grooming and personal hygiene. One resident chart had no documented bath or shower for month of July. Multiple

instances of residents going weeks or a month without shower or bath. Resident with unkempt appearance, food on gown and beard. E

F684 – Quality of Care

- Facility failed to provide treatments as ordered by the physician. 15 days of omissions on the treatment sheet of a BID treatment for erythema and excoriation to buttock area. D
- Failed to timely asses and failed to administer insulin per manufacturers recommendations, failed to recheck blood glucose when requested by resident, resident found unresponsive with blood glucose of 30, sent to ER, record showed lack of food diary documentation as ordered by physician. One staff member had asked nurse to check but nurse informed multiple times that she was too busy. Facility failed to notify physician or carry out interventions for high glucose reading for same resident. G
- Failed to have timely complete, accurate and timely assessment and communication to physician for 2 residents. D
- Failure to provide adequate assessment and timely intervention on the resident who's foot hit the doorway. Staff did not stay ahead of the pain for the resident. An incident report was not completed. D
- Facility failed to document complete assessments on four out of seven resident who had tested positive for COVID-19. The care plan did not have documentation of the need to assess the resident's vital signs and for signs and symptoms of COVID-19. A review of the vitals section in the electronic medical record revealed no documentation of the following Temp or O2 sat on either the first or second shift on 6 days. On the day shift of temp or O2 sat on 3 days. A review of forms titled prevent COVID-19 and another with vital signs and untitled revealed no documentation on the second shift on 5 days. Sent a resident to the hospital on transfer form it said see Covid transfer form however no COVID transfer form found on the record. A review of the medication administration records, and physician order revealed an order to check vitals per facility policy. Policy all residents should be screened for COVID-19 by taking their temperature and oxygen saturation at least twice per day on first and second shifts and mor often if necessary. E
- Facility failed to follow professional standards with regards to documentation on the MAR. The MAR revealed missing documentation of Insulin administration and blood sugar readings. D
- Facility failed to identify and provide adequate interventions to ensure that residents were safe from harm from other residents. The facility continued to provide 15 minute checks for a resident, yet after the implementation, the resident had 4 more incidents/altercations with other residents. D
- Facility failed to complete accurate timely assessments, failed to communicate with physicians timely for 4 residents of 26. E

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Failed to provide necessary treatments to promote healing of pressure ulcers and avoid infection for 3 of 4 residents reviewed. G
- Facility failed to thoroughly assess and initiate interventions for residents with pressure sores for 4 of 4 residents. The facility failed to assess the residents blackened toe after first identifying the skin concern at time of admission, failed to notify the physician of the skin area, failed to obtain a treatment or consultation, and failed to intervene to prevent deterioration of the toes. The resident required hospitalization, amputation, and contributed to her death. Resident's discharge summary documented the resident with lower right leg in poor condition and some wounds on sacrum and right toes; edema to right hand. The summary failed to document under Course of Treatment any treatments to the left toes or coccyx. The clinical record lacked thorough pain assessment information for residents. Assessments lacked documentation of a full skin assessment, description of what the toes looked like, measurement of the wounds, location of the wounds, or notification to the physician. **J $10,000**
- The facility failed to provide appropriate nutrition and care to prevent pressure ulcers. Resident sat at the dining room table with socks on and no boots to the resident's feet. Residents chart noted they had 2 new pressure ulcer to bilateral heels. D
- Facility failed to notify the Dietician for nutritional interventions, and follow dietary recommendations when given, document skin assessments consistently and accurately to promote healing of facility acquired pressure sores. **G $4,000.**

F689 – Free from Accidents and Hazards

- Facility failed to provide adequate supervision to prevent accidents. During mechanical lift transfer, lift tipped over with resident in the air with lift landing on top of resident. Staff reported issues with carpet and room being too crowded to safely transfer. **G $4,000.**
- Failed to provide adequate supervision to prevent accident. Resident had not been toileted fo four hours, resident got up by herself (she was a two assist), was incontinent of urine and fell hitting her head. No major injuries. D
- Failed to provide adequate supervision to prevent elopement. Resident who had attempted elopement several times, disappeared out of his window in his room without staff noticing. There was no screen and no crank on his window. Resident was found two days later in the ER after being in two feet of water. Resident had been on 15-minute checks and those were done - he disappeared within an 11-minute frame time. **G $8.750.**
- Failure to provide adequate supervision, implement interventions per care plan and investigate incidents. All related to ankle injury from staff pushing resident in wheelchair and accidentally hitting foot on doorway. Incident report not done; resident did not receive pain medicine as ordered. Another resident was not seat

belted properly in her chair and fell onto floor requiring an ED visit. Another resident was left on the toilet as staff went to get wipes and resident fell off the toilet even though care plan stated someone should stay with her at all times when toileting. Lack of documentation of resident having another fall and no documentation of resident status between falls. Main entrance door and double doors were locked which prohibited anyone from leaving without a key and they are fire exits. **G $9.500.**

- staff responded to door alarm of front door and allowed resident to exit facility without supervision. Community member from town 10 miles away that resident was sitting on her front porch. Housekeeping let resident out the door as they thought she was a visitor. Resident was out of building for over 2 hours and staff did not know she was gone. **J $7,500**
- Failure to prevent elopement. Staff member came to work and noticed a resident sitting outside on sidewalk alone. Staff stated they did not hear the alarms. D
- Care plan stated resident needs extensive assistance of one for transfers ambulation and toilet use. Resident was found on bathroom floor, resident had fracture of leg and ankle. Bathroom emergency light was on. **G $8,500.**
- Resident moved while raised in a total mechanical lift and fell from the lift striking her head on the base of the lift and sustained a traumatic brain injury which resulted in death. The lift failed to contain safety clips on the hanger bar to prevent the lift sling from detaching from the lift. Facility failed to train staff on proper use of lift and what to do in the event a resident moves while in the lift. **J $8,500**
- Facility failed to provide adequate nursing supervision to protect residents injury by another resident. One resident was pushing another resident with their hands around their neck. One resident said they heard the other resident was heard saying they were going to kill them. Interventions were not put on residents' chart to help with the residents behaviors. D
- Facility failed to ensure door alarms were properly activated and resident #1 eloped from the facility. Resident who had exit seeking behavior did elope outside of building and was easily re-directed back into the building. That resident did again elope and was outside on the sidewalk with their clothes down and visitor told staff they were outside and the alarm from the first elopement was not properly reset. D
- Lack of adequate supervision for 3 of 5 residents that required staff assistance resulting in major injuries. In first case fall resulting in death after hospitalization. Resident was two person transfer with all mechanical full body lift. Used one staff and strap broke in lift. Second resident fell out of bed resulting in neck fracture ultimately resulting in death. Third reportedly fell during transfer with CNA when mechanical lift strap broke. Resident had multiple fractures. Resident in this case also a two person assist with one person transferring at time of incident. Last resident fell after reaching for water. Fracture of femur. J **$30,000.**

F690 – Bowel/Bladder/Incontinence, Catheter, UTI

- Facility failed to address symptoms of UTI for resident. G
- Failed to provide proper incontinence care. Staff wiped from back to front instead of front to back. D
- Failure to provide incontinent care in a manner to prevent infection. Staff did not wipe clean bottom and scrotal area. Staff wiped genital area with soiled wipe several times. D
- Facility failed to perform aseptic catheter care. Staff put on gloves and then touched multiple surfaces and emptied catheter bag into graduate and went into bathroom to empty graduate without changing gloves. D

F692 – Nutrition/Hydration Status Maintenance

- Facility failed to ensure that all resident receive sufficient fluid intake to maintain proper hydration and health. The facility admitted a resident with gastric tube feeding orders that did not meet his nutritional and fluid needs. The facility failed to follow up with the dietician to ensure the resident received adequate nutritional and fluid needs. **G $6,250.**
- Facility failed to compete and accurate nutritional assessment, weight a resident per protocol or identify a significant weight loss. Clinical record lacked identification of a 5% weight loss in less than 2 weeks and no other weights were recorded prior to resident discharge (30days later). Chart lacked a nutritional assessment and lacked identification of residents physician or family of the weight loss. Lack of documentation of offering a substitute for food not eaten. No documentation of resident likes, dislikes or preferences. Discharge summary did not include weight loss or use of supplements as resident reported drinking. D

F695 – Respiratory/Tracheostomy Care and Suctioning

- Facility failed to ensure that residents receive respiratory and oral care consistent with professional standards of practice. Transfer records revealed several orders that did not get transcribed int the residents record, which was to provide oral hygiene every 2 hours and Nystatin to be given 4X day orally for oral cares to prevent thrush. D

F698 – Dialysis

- Facility failed to maintain CPAP equipment in a clean and sanitary manner for 1 of 3 residents

F712 – Physician Visits-Frequency/Timeliness/Alternate NPPs

- Failed to ensure residents had physician visit w/in 30 days for 2 of 5 residents. D

F725 – Sufficient Nurse Staffing

- Facility failed to ensure staff responded and answered residents call lights within 15 minutes to meet resident needs. Resident reports waiting up to 30-40 minutes for staff to answer lights. Call light report supported call light exceeded 15 minutes on 391 occasions. E

- Failure for staff to respond to call lights timely. 6 of 7 residents at risk for falls had call lights activated for 15 minutes or greater. Residents reporting that they are short staffed. E
- Failed to have adequate nursing staff to meet needs for six residents. Multiple reports residents not getting bath, changed clothes, responding to call lights in timely manner. One CNA One Nurse for entire building overnight. E

F726 – Competent Nursing Staff

- Failed to ensure nursing staff knew how to complete schedule treatment to manage a pressure ulcer for resident. D
- Failed to have nurse evaluation and implementation of care plan for 2 residents. D

F730 – Nurse Aide Perform Review- 12 Hr/Year In-Service

- Failure to complete annual performance reviews within 12 months. D
- Facility failed to provide documentation to show annual evaluations for staff members who had a hire date more than 12 months ago. B

F755 – Pharmacy Svcs/Procedures/Pharmacist/Records

- Facility staff failed to ensure the medication carts were locked while unattended in resident care area. D

F800 – Provided Diet Meets Needs of Each Resident

- Facility failed to implement infection control interventions during screening to enter the facility for residents in isolation, during meal service, and for resident with catheter. Door to room, with air borne precautions left open to hallway. Housekeeping staff took surveyors temp, touching the thermometer to surveyors head, did not ask about symptoms and did not document on screening log. Did not proceed to clean thermometer. Staff adjusted their mask and without performing hand hygiene took residents lunch tray to their room. 2nd staff person, touched their hear and mask and proceeded to deliver room tray without performing hand hygiene. Resident reports staff do not cleanse suprapubic site correctly. During cares staff wiped from abdomen towards catheter tubing and wiped several times at the insertion site without turning the wipe. Resident with previous ATB use with infection at site and UTI's. E

F804 – Nutritive Value/Appear, Palatable/ Prefer Temp

- Food served to residents was not at proper temperature - cold. E
- Failed to provide hot palatable meal for one resident. D

F812 – Food Procurement, Storage, Preparation, Sanitization

- Facility failed to serve food in accordance with professional standards for food service safety. Dietary staff wore gloves touching plates, utensils, steamer top, and using same gloved hands to pick up bread and butter to place on residents plates.

Meat was held on the plate with the gloves and touched items while food items with a knife. E

F836 – License/Comply w/ Fed/State/ Local Law/Prof Std

- 2 CNA staff records showed lack of documentation of physical before hire, Nurse lacked documentation of physical at time of hire or following. D

F842 – Resident Records- Identifiable Information

- Failure to complete incident reports, one was fall with fracture. D
- Facility failed to complete accurate resident records. Orders for residents with oxygen to change tubing weekly, which was not getting done. D

F849 – Resident Records- Identifiable Information

- Progress notes did not include any hospice note or plan of care. D

F880 – Infection Prevention and Control

- Facility failed to maintain infection control standards while providing care for residents. Staff failed to wash or sanitize hands when entering or when leaving residents room. Drinks and desserts sitting on room tray carts without being covered, while maintenance worker was working on ladder in hall removing ceiling tiles above the room tray cart. Staff carrying multiple drinks with one centered in her chest, cup touching uniform and then assisted a resident to drink from the cup. E
- Facility failed to implement infection prevention and control protocols, including an effective screening process and adhering to transmission-based precautions established to mitigate the risk for spread of COVID19. Quarantined hall lacked PPE supplies outside of rooms. Room door failed to contain any posted sign indicating quarantined status and precautions. Staff entered quarantined room without donning a gown or gloves to answer call light and pick up meal tray. An agency C.NA worked many days without a mask and/or with mask pulled down under chin. Staff reported other staff members, did not always wear a mask appropriately. Lack of proper screening of verifying temps and questions when staff arrived to work. Staff signed screen form as verification, later discovered that staff person did not work on that particular day. F
- Facility failed to utilize appropriate infection control practices during resident care. Pericare provided, did not remove gloves after pericare and continued to put on brief, pull up pants and release wheelchairs locked brakes. Facility failed to consistently record and verify with staff members screenings. F
- Failed to follow CDC infection control practices to prevent spread of COVID for 4 of 8 residents on CCDI unit. Placed new admissions/readmissions in room with other residents. **K $7,250.**
- Lack of infection control. Staff wore mask but had face shield on upside down not covering face. Lack of hand hygiene during peri care. , Another staff with mask but no face shield, Resident on transmission based precautions in living room without

mask, Staff entering same room with only face mask and shield. Staff without face shield and mask below chin but pulled up to cover mouth (not nose) and no hand hygiene. Multiple instances of not wearing appropriate PPE in rooms with transmission based precautions. Multiple other staff with no face shield and inappropriate mask use. Isolation gowns reused without cleaning. **E $8,500.**

- Infection control not followed - one staff with no mask on, staff did not do hand hygiene after assisting a resident with eating then went and got a glass, nurse was talking to surveyor with mask down and when interview was over nurse never did put mask back on, 18 residents were eating in the dining room and 12 of them were eating within 6 feet, and aide was being interviewed by surveyor with mask down. E
- staff completed screening tool and answered yes to being exposed to COVID. Staff was allowed to work and then after having a test done that day, results came back two days later and the staff member was positive. The resident that the staff had worked with then tested positive. Nurse did sign off on staff's screening and said she didn't even look at it to see there was a yes answer. Therefore further screening was not done. **J $5,000.**
- Failure to follow recommendations of CDC. Staff were not wearing gowns when entering a presumptive positive resident room. Signs outside the resident door stated mask, goggles, face shield, gloves and gown were required. E
- Failure to implement comprehensive infection control program to mitigate risk of COVID-19 by failing to immediately isolate resident with symptoms. Resident was still in private room with no signage on door as staff "hadn't gotten around" to moving her yet to the cohort wing. Resident no wearing a mask and invited surveyor into room. Dietary aide was wiping down tables with just water and Dawn dish soap. E
- Failed to effectively screen staff prior to and after their shift for symptoms of COVID-19. D
- 12-14 residents were observed in the DR seated at 3 tables and a bar. Four to six residents were seated at the tabletops that measured 90 inches X 42 inches. Two to three were seated at the tabletops that measured 36 inches X 36 inches. No resident observed wearing masks and no masks were visible on the tables. The resident were not maintained at a distance of 6 feet apart to adhere to social distancing. Staff placed clothing protectors on several residents and touched each resident. When pouring juice and giving each resident a glass the LPN touched each resident on the shoulder or back while talking to them and failed to sanitize her hands and then touching the carafe and glass for each resident. E
- Failed to implement and monitor an effective screening process for staff to prevent COVID outbreak and failed to provide staff education. 7/21-7/28 6 staff came in to work with symptoms and instructed to continue to work on the positive COVID unit with no testing completed to determine if they were Covid positive and not sent home. No official screener consistently in place to monitor those coming through the front entrance when employees enter. 7/27 the surveyor entered the facility greeted

by administrator, DON, and Dietary Director and the surveyor had to prompt them to screen her. 7/28 surveyor entered the facility completed the screen form and took her own temp. no verification received from any staff on the information provided. Documentation lacked staff education on COVID 19 after April 2020 in human resources records. Facility failed to restrict visitors from entering the facility per CMS guidance. One residents spouse who lived in IL apartments was entering the building 6-7 times in a span of a month. The family of two other residents were allowed to visit the residents who had not been identified to be in the active phase of dying pr receiving hospice services. In a interview CNA reported the screening process is not consistent, staff are expected to take their own temperatures and answer the questions, however, there are people not doing this and nothing is done about it. Approximately 75% of the staff will forget to complete the screening process. Several people that work here that have tested positive and are allowed to work, they told her she could work with the residents who have already tested positive. 7/24 symptomatic staff allowed to work and not sent home at the start of the shift and not tested until 7/27. **L $7,750.**

- Staff completed a blood sugar she disposed of a used cotton ball and lancet obtained a disinfection wipe and cleansed the glucometer and a small tray , then removed her gloves. Housekeeper pushed a cart down the hallway by the resident rooms. Staff wore a mask over her mouth and had goggles on top of her head. Dietary cook served food from unit kitchenette staff wore a mask and hairnet but had no goggles or face shield on. CNA stood by resident in his room a quarantine sign hung on the resident's door staff B wore no gown and staff O wore no goggles or face shields.
- Facility failed to provide appropriate infection control to prevent the spread of COVID. Administrator worked while experiencing cough and allergy-like symptoms, later saw doctor who ordered COVID test which was positive. Surveyors watched staff wearing their masks under their nose and one nurse removed the mask form face while in nurses' station with other staff at the station. Business office staff greet surveyor with mask below nose and no shield on. **K $8,250.**
- Facility staff failed to wear face masks as instructed in common resident areas. D
- Failed to appropriately screen staff for symptoms of COVID. Some staff reported only temperature taken, others said not even temperature. Screening forms not completed. Facility had outbreak. Staff worked after positive tests. Screening sheet did not have symptoms of COVID. No screening of symptoms of surveyor. Staff wearing mask under nose. **K $10,000.**
- Facility failed to implement and monitor a complete and consistent screening process for staff and visitors to prevent a COVID19 outbreak. DON worked with runny nose and cough and continued to work, which was thought to be allergies, few days later was notified of positive COVID result. Lack of staff verifying answers and temps when employees entered the facility. (243 entries not verified). Staff entered isolation room without sanitizing hands prior to donning gloves. After cares doffed

gown, gloves and mask and disposed in a box without a hazard bag lining it. Staff did not sanitize or wash hands prior to putting on previous gown and gloves after leaving isolation room. Staff continued to self screen without other staff verifying during survey. **L $7,250.**

- Failed to maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Resident noted with an uncovered urinary drain bag on wheelchair and catheter tubing laying on the floor. During cares, staff donned gloves with performing hand hygiene and proceeded to pull a trash bag out from under trash bag in garbage can and with same gloves proceeded to empty the residents drain bag. Staff milked the cath tubing for 10min to drain the catheter tubing with the same gloves. Catheter bag was held above resident's bladder. While assisting resident with meal, staff touched residents toast with bare hands. C.NA touched garbage can with gloved hands, proceeded to provide pericare and without removing gloves continued to apply clean brief and reposition resident with same dirty gloves. D
- Facility failed to inform residents, their representatives, and families of those residing in facility by 5pm the day following the occurrence of a single confirmed infection of COVID19 or residents or staff. Staff member noted positive for COVID19, staff documented notifying resident, but no documentation of family notification. Staff reported if resident was their own POA, they did not need to notify family.

F885 – Infection Prevention and Control

- Facility protocol stated to notify residents, families, and staff and primary care provider of all positive test results by 5pm the following business day post notification of positive result. E
- Facility failed to notify residents/resident representatives and family of resident with confirmed COVID per reporting requirements by 5 pm next day. E

F947 – Required In-Service Training for Nurse Aides

- 3 C.NA's without the minimum (12hours) in-service training required per year. C

F948 – Training for Feeding Assistants

- The facility failed to provide documentation to show the required 12 hours per year of in-service training were completed. B

Nursing Facility Survey Frequency

As of October 29, 2020: CMS lists 160 Iowa facilities (37%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 32.9%. National average is 41.4%.

FFY 2020- October Totals - LTC Surveys				
Provider	**City**	**Survey End Date**	**Previous Date**	**Months Between**
St. Francis Manor	Grinnell	8/27/2020	5/23/2019	15.40