

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 165234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2020
NAME OF PROVIDER OF SUPPLIER PARKVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP 516 THIRTEENTH STREET WELLMAN, IA 52356	
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 0684 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide treatments as ordered by the Physician for 1 of 5 sampled (Resident #1). The facility reported a census of 46. Findings include: According to the Minimum Data Set assessment dated [DATE], Resident #1 had a Brief Interview for Mental Status score of 5, indicating severe cognitive impairments. Resident #1 required limited assistance with mobility and transfers and extensive assistance with dressing, toilet use and personal hygiene needs. Resident #1 had [DIAGNOSES REDACTED]. A Hospital Discharge sheet dated 7/7/20 indicated Resident #1 had excoriation and [DIAGNOSES REDACTED] to her buttock area. The sheet contained a Physician order [REDACTED] #1's perineal and buttocks. The July 2020 Treatment Administration Record (TAR) revealed a physician's orders [REDACTED] #1's perineal and buttock area twice a day (7:00 a.m. and bedtime) for stool incontinence. The TAR revealed omissions in the morning treatment on 7/15 and 7/20 and omissions in the evening treatment on 7/7, 7/9, 7/10, 7/16, 7/17, 7/18, 7/27, 7/28, 7/29, 7/30, 7/31, 8/1 and 8/2. During an interview on 8/18/20 at 11:50 a.m., the Director of Nurses stated the facility had a supply of Dermaseptin on hand for the staff to complete Resident #1's treatments.		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the 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 the spread of COVID-19, effecting all 46 residents. The facility reported census was 46. Findings include: Observation on 8/12/20 at 11:00 a.m. revealed the facility had a designated quarantine hall. The hall had a census of 3 residents. The area outside the rooms failed to contain Personal Protective Equipment (PPE) supplies such as gowns and gloves. Resident #2 and Resident #3 who resided on 200 hall (not quarantine hall) had a quarantine status. The door to Resident #2 and Resident #3's room failed to contain any posted sign indicating quarantine status and precautions. The area outside Resident #2 and #3's room failed to contain a PPE supplies. During an observation on 8/12/20 at 5:09 p.m., Staff A and Staff B entered Resident #2's room and assist him with his call light and removed his meal tray. Staff A and B entered the room without donning a gown or gloves. Resident #2 recently returned from the hospital and had a quarantine status. During an interview on 8/12/20 at 5:09 p.m., Staff A (Nurse Aide) stated residents returning from the hospital, emergency room visits and appointments outside of the facility had a quarantine status for 14 days. The residents on quarantine status had direction not to leave their rooms or commingle with other residents. Staff A stated they wear a face mask and face shield or goggles as they would with any resident, but are not required to wear a gown or gloves for residents on quarantine status. During an interview on 8/20/20 at 11:45 a.m., the Director of Nurses (DON) stated the facility had no COVID-19 positive residents. The facility had a designated quarantine hall in which residents who return from the hospital, emergency room visits, appointments outside of the facility, and new admissions resided for 14 days. Residents on [MEDICAL TREATMENT] had an indefinite quarantine status. The designated quarantine hall contained private rooms and the residents on quarantine status were not allowed out of their rooms for meals or activities. The DON stated residents in quarantine status had no transmission based precautions other than the CDC required use of a mask and face shield. Staff are not required to wear a gown or gloves. During an interview on 8/12/20 at 12:55 p.m. Staff C (Restorative Aide) stated staff are required to wear a face shield and mask and use good hand hygiene practices when caring for all residents. Staff C stated there are some residents in quarantine, but they do not require any higher level of personal protective equipment (i.e. gowns, gloves) than any other resident. During an interview on 8/12/20 at 1:10 p.m., Staff D (Nurse Aide) stated staff are required to wear a mask and goggles or a face shield at all times and use good hand hygiene practices. Residents in quarantine do not require any additional PPE, but are required to remain in their rooms. According to the Centers for Medicare and Medicaid Services (CMS) QSO-20-29-NH dated 5/6/20, Summary COVID 19 Focused Survey for Nursing Homes protocol, residents on Contact Precautions (quarantine) require staff to wear gloves and isolation gown before contact with the resident and/or his/her environment. During an interview on 8/17/20 at 11:42 a.m., the Administrator stated on 6/13/20 stated an Agency Aide worked the overnight shift without using proper PPE (mask). The Administrator stated he was informed by the on-coming day nurse, Staff E. Out of precaution the facility had all residents placed on quarantine for 14 days. The Administrator identified the overnight aide as Staff F. During an interview on 8/17/20 at 1:12 p.m., the Director of Nursing (DON) stated on the morning of 6/13/20 she was informed of an aide not wearing her mask during her shift. The DON stated she contacted the agency and confirmed the aide had not worn her mask during the overnight shift on 6/12/20. The DON stated they requested the aide be tested for COVID 19 and placed all of their residents on quarantine for 14 days. During an interview on 8/17/20 at 12:47 p.m., Staff F (Nurse Aide) stated she worked multiple shifts at the facility and on overnight shift it was common practice to not wear a mask and when they did it was pulled down onto their chin. Staff F stated she was told to just make sure the mask is on when day shift arrives because they are real strict. Staff F stated on the overnight shift on 6/12/20 she arrived around 10:00 p.m. and filled out the screening sheet, noting there was no witness verifying her answers or checking her temperature. Staff F stated she didn't have a mask and the facility was hiding them because staff were taking them home. Staff F stated other staff on the overnight shift was also noncompliant with wearing the mask and she had witnessed the DON not wearing a mask as well. On the morning of 6/13/20, the on-coming nurse (Staff E) questioned her about not wearing a mask and she told Staff E she hadn't worn a mask all night. Staff F stated she left and later that morning was contacted by her supervisor noting the facility was requesting she get a COVID-19 test. Staff F stated she was not a priority and didn't get the test. Staff F stated she has not worked at the facility since. During a record review, the screening form Staff F filled out on 6/12/20 was examined. Staff F checked the box indicating she did not sanitize her hands and did not answer the questions related to the presence of signs and symptoms of COVID-19. Staff indicated she has worked with individuals with COVID and indicated she was instructed to wear a mask prior to resident contact and she had been educated on social distancing and hand hygiene. The form was signed by Staff G and dated 6/12/20. During an interview on 8/17/20 at 2:35 p.m., Staff G (Administrative Assistant) was asked about her signature on Staff F's screening form dated 6/12/20. Staff G admitted it was her signature and admits she was not at the facility on 6/12/20 at 10:00 p.m. Staff G had no explanation for why she would have signed a screening form in which she had not witnessed.		

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.