STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on clinical record review, family and staff interviews, and health care provider interviews, the facility failed to notify a resident's primary care provider when the resident tested positive for COVID-19 for 1 of 3 residents reviewed for physician notification (Resident #10) as well as 3 additional residents revealed in interviews. The facility also failed to notify residents' families of the diagnosis of their family member with COVID-19 for 3 of 4 residents reviewed (#3, #10, and #13). The facility reported a census of 45 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 showed a Brief Interview for Mental Status (BIMS) score of 6 indicating severely impaired cognition. Review of Progress Notes revealed Resident #3 tested positive for COVID-19 on [DATE]. The Progress Notes failed to contain documentation regarding notification of the resident's family. During an interview on [DATE] at 10:10 a.m., the resident's Power of Attorney (POA) for Healthcare / Emergency Contact #1 reported staff did not notify her of the resident's positive COVID-19 test. Staff had only notified her of a room change on [DATE]. 2. The MDS assessment dated [DATE] for Resident #10 recorded the resident as rarely understood but with OK long- and short-term memory. The MDS revealed Resident #10 with diagnoses of paraplegia, diabetes, and stroke. Review of Progress Notes revealed Resident #10 tested positive for COVID-19 on [DATE]. The Progress Notes stated the POA expressed a concern to the Social Services Director on [DATE] regarding being unaware of the COVID-19 diagnosis. The progress notes failed to document notification of the resident's primary care provider of the COVID-19 diagnosis. The resident died on [DATE]. Review of a clinic Encounter Summary revealed a clinic Advanced Registered Nurse Practitioner (ARNP) visited and assessed Resident #10 at the nursing facility on [DATE]. She documented being unaware until the visit of his positive COVID-19 test and so he was outside the window for monoclonal antibody treatment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:25 p.m., Resident #10's POA / Emergency Contact #1 stated the facility had not notified her of the positive COVID-19 test. She spoke to the Social Services Director on [DATE] who told her Resident #10 had tested positive on [DATE]. No family member knew. The POA reported receiving general automated voice messages about the number of positive tests in the facility. She said staff had told her if a family member tested positive, the facility would call. During an interview on [DATE] at 8:10 a.m., the physician listed as a second Primary Care Provider (PCP) for Resident #10 reported he had not been seeing Resident #10 and had not been aware of the COVID-19 diagnosis until the ARNP visit on [DATE]. He would have expected the facility to notify the PCP and let her know about the positive COVID-19 test so she could make the decision about whether to order treatment at that time. During an interview on [DATE] at 2:00 p.m., Resident #10's PCP / Physician stated that her Clinic ARNP arrived at the facility on [DATE] for rounds and found out four of the residents scheduled to be seen had tested positive for COVID-19. The PCP / Physician stated the facility had not notified her of Resident #10 testing positive for COVID-19 until the Clinic ARNP found out on [DATE]. The window for monoclonal antibody infusion is 3 days since a positive test and 10 days since symptom onset so at 6 days post-positive test, he likely did not qualify. The PCP/Physician stated she could not speculate whether she would have ordered the monoclonal antibodies infusions or whether the resident's outcome would have changed, but at the clinic they do regularly order the monoclonal antibodies, which have been shown to have better outcomes. During an interview on [DATE] at 3:20 p.m., the Clinic ARNP who visited Resident #10 on [DATE] reported being unaware of Resident #10 and three other residents having tested positive for COVID-19 until her visit. She stated she would expect the facility to notify the clinic when residents test positive for COVID-19. On [DATE] at 3:30 p.m., Staff H, Licensed Practical Nurse (LPN), stated the nurses are responsible for notifying the PCP of residents when residents test positive for COVID-19. Nurses can call, fax, or use the clinic's portal to communicate. On [DATE] at 3:35 p.m., Staff G, ARNP, reported testing all residents during the facility's COVID-19 outbreak in November and December. Nursing staff is responsible for reporting the positive cases to the individual resident's PCP. On [DATE] at 3:50 p.m., the Administrator stated staff have done proper notification of physicians. The ARNP may not have known, but the physician would have. 3. The MDS assessment dated [DATE] for Resident #13 showed a BIMS score of 11 indicating moderately impaired cognition. Review of Progress Notes revealed Resident #13 tested positive for COVID-19 on [DATE]. The Progress Notes failed to document any family notification of the positive test. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:40 p.m., the Resident Representative / Emergency Contact #1 stated the facility failed to notify her of the resident's COVID-19 diagnosis. The representative found out during a phone call with Resident #13 on [DATE] when the resident told her she had COVID-19. The representative reported talking to the Social Services Director who stated the facility had sent an automated voice message about positive cases. The representative stated the transcript from the recording stated nothing about Resident #13 having COVID-19. The facility provided policy, Novel Coronavirus COVID-19 revised [DATE], stated the administrator or Director of Nursing (DON) will notify the physician, nurse practitioner, and dietician of COVID-19 in the facility. The facility policy titled Novel Coronavirus COVID-19 revised [DATE] documented weekly updates would be sent to Resident Representatives via Cliniconex-Automated Voice Messaging. It did not address Resident Representative notifications when their resident had COVID-19. The facility policy titled Notification of a Change in a Resident's Condition dated [DATE] documented Licensed Nursing Personnel should document the resident's change in condition, the physician/physician extender notification, and notification of the resident's representative. On [DATE] at 10:40 a.m., Staff H, Licensed Practical Nurse (LPN), reported being unsure of who notified families when their resident had COVID-19. No one had instructed Staff H to notify families. On [DATE] at 10:20 a.m., Staff D, Registered Nurse (RN), reported uncertainty with who notified families when their resident had COVID-19. The Admissions Coordinator notified some families. On [DATE] at 12:50 p.m., the Administrator stated the Social Services Director and maybe the Activities Director had notified families when their resident had COVID-19. Nurses knew to call families with updates. It was a group effort at times, with others involved also. On [DATE] at 10:00 a.m., the Social Services Director stated she thought the automated voice messaging system let families know their resident had COVID-19. She had discovered with audits that the recording sent to families stated families would receive a phone call if their family member had COVID-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42440 Based on clinical record review and staff interview, the facility failed to provide 1 of 3 sampled residents the required forms for Medicare Liability Notices and Beneficiary Appeals when skilled services were no longer covered (Resident #1). The facility reported a census of 45 residents. Findings Include: Record review for Resident #1 indicated she received skilled services from 10/21/21 to 11/11/21. The facility did not provide the resident or resident representative with the Notice of Medicare Provider Non coverage, CMS form #10123 or Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNFABN), CMS form #10055. On 12/29/21 at 3:40 p.m., the Admissions Coordinator reported she usually provided the notification when skilled services ended. She had been on vacation at the time the notification should have gone out, providing a 48-hour notice, and could not find any documentation of notification. When she is not available to give notice, the Social Services Director should. On 12/30/21 at 1:00 p.m., the Social Services Director reported she needed to look further for any notification and talk to the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on clinical record review, observation, and staff interviews, the facility failed to administer over-the-counter medications as ordered by a physician or practitioner for 3 of 3 residents reviewed (Residents #8, #9, and #10). The facility reported a census of 45 residents. 1. The MDS assessment dated [DATE] recorded Resident #8's BIMS as 15, indicating intact cognition. The MDS documented the resident had a diagnoses of chronic obstructive pulmonary disease (COPD), Parkinson's, and chronic kidney disease. The Progress Notes documented a positive COVID-19 test on 11/23/21 and the start of over-the-counter medications: guaifenesin (an expectorant) tablets 400mg twice a day for cough, zinc 50mg daily, vitamin C 1000mg daily, and vitamin D 500mg daily for 10 days. Staff documented none in cart for guaifenesin and zinc on 11/30/21, on order for guaifenesin and zinc on 12/1/21 and 12/2/21, and on order for guaifenesin the morning of 12/3/21. Review of the Medication Administration Records (MAR) for November and December 2021 revealed doses of guaifenesin not given on 11/30/21, 12/1/21, 12/2/21, and the morning of 12/3/21. Staff also failed to administer zinc on 11/30/21, 12/1/21, and 12/2/21. The Care Plan documented, on 11/5/21, that Resident #8 had asthma. Interventions included to give medications as ordered and encourage prompt treatment of any respiratory infection. An observation on 12/9/21 at 12:20 p.m. revealed Resident #8 cough and spit out blood-tinged sputum and reported continued cough. 2. The MDS assessment dated [DATE] recorded Resident #9 with memory impairment and a diagnosis of Huntington's disease. Review of the facility's undated Residents Positive list displayed a positive COVID-19 test on 11/29/21. Review of the resident's December 2021 MAR revealed Vitamin C 1000mg daily, Vitamin D3 50mcg daily, and zinc 50mg daily were ordered to start on 12/1/21. Staff did not administer the zinc on 12/1/21 or 12/2/21. Progress Notes dated 12/1/21 and 12/2/21 documented zinc as on order. 3. The MDS assessment dated [DATE] revealed Resident #10 with diagnoses of paraplegia, diabetes, gastro-esophageal reflux disease with esophagitis, and stroke. The MDS recorded the resident as rarely understood but with OK long- and short-term memory. The Progress Notes documented a positive COVID-19 test on 12/3/21. They also documented Mucinex (an expectorant) as out of stock and on order on 12/1 and 12/2 and Omeprazole as out of stock or on order December 1st, 2nd, 3rd, 4th, 6th, 7th, 8th, 9th, and 10th. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for December 2021 revealed the resident did not receive Mucinex 600mg twice daily on 12/1/21 or 12/2/21. Staff did not administer Omeprazole 200mg twice daily in the morning on December 1st, 2nd, 3rd, 4th, 6th, 7th, 8th, 9th, and 10th and in the evening on the 2nd, 8th, 9th, and 10th. On 12/15/21 at 10:40 a.m., Staff H, Licensed Practical Nurse (LPN) stated some stock (over-the-counter) medications have been on back order. Staff H reported the former Director of Nursing (DON) ordered the medications in the past; she is unsure who has placed orders recently. When she had no zinc, mucinex, guaifenesin, or omeprazole for COVID-positive residents, she informed Staff K, Advanced Registered Nurse Practitioner (ARNP). On 12/15/21 at 2:45 p.m., Staff M, Certified Medication Aide (CMA) stated she took over ordering for central supply last week. She has placed two orders for stock medications and has taken petty cash to Wal-Mart for over-the-counter medications. The former DON ordered stock medications before she left the facility several weeks ago. On 12/15/21 at 3:45 p.m., Staff G, Advanced Registered Nurse Practitioner (ARNP), reported being aware that zinc, guaifenesin, mucinex, and omeprazole were not available. She stated she informed staff the residents really needed them. On 12/20/21 at 3:45 p.m., Staff N, Interim DON, stated staff order over-the-counter medications through a formulary. The medications can be stat-ordered. If not arriving timely, staff can go to the store and purchase medications if equivalent to what is ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on clinical record review, observation, Centers for Medicare and Medicaid (CMS) guidance, and resident and staff interviews, the facility failed to increase assessments of residents diagnosed with COVID-19 for 3 of 3 residents reviewed (Residents #8, #9, and #10). The facility also failed to assess neurological status following a fall with head injury for 1 of 2 residents reviewed (Resident #1). The facility reported a census of 45 residents. Findings include: CMS Memorandum QSO-,d+[DATE]-NH dated [DATE] and revised [DATE] stated facilities should follow the Centers for Disease Control and Prevention (CDC) guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. The CDC guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated [DATE] stated Healthcare Personnel should wear eye protection (i.e. goggles or a face shield that covers the front and sides of the face): a. When entering a room of a patient with suspected or confirms [NAME]-CoV-2 infection b. During all patient care encounters in facilities located in counties with substantial or high transmission of COVID-19 The CDC guidance Interim Infection Prevention and Control Recommendations to Prevent [NAME]-CoV-2 Spread in Nursing Homes updated [DATE] documented: a. Actively monitor all residents upon admission and at least daily for fever and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. b. Increase monitoring of residents with suspected or confirmed [NAME]-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation, and respiratory exam, to identify and quickly manage serious infection. 1. The Minimum Data Set (MDS) assessment dated [DATE] recorded Resident #1's Brief Interview for Mental Status (BIMS) as 10, indicating moderately impaired cognition. The MDS documented the resident had a diagnoses of stroke, heart failure, and diabetes. On [DATE], the Care Plan addressed the resident being a fall risk. The Progress Notes described a fall on [DATE] at 3:30 p.m. resulted in a bruise around the left temporal area the size of a goose egg. The resident's record failed to contain any neurological assessment outside of one done at the time of the fall on [DATE] at 3:30 p.m. documented in the electronic health record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 - Some	On [DATE] at 10:30 a.m., Staff O, Registered Nurse (RN), stated nurses complete neurological assessments if a resident falls and hits their head or may have hit their head. The assessments should be documented in the assessment area of the electronic health record. On [DATE] at 2:05 p.m., Staff D, RN reported completing a head-to-toe assessment on Resident #1 following her fall with bruising to the forehead. She reported being pretty sure she had completed neurological assessments on a paper. The facility's Fall Management Guideline Practice Guidelines dated [DATE] documented to complete the neurological record per instructions for a resident with a potential head injury. On [DATE] at 3:20 p.m., Staff N, Interim Director of Nursing (DON) stated the expectation, when there is a fall with head injury, is for nurses to complete and document a neurological assessment every 15 minutes for an hour, then every 30 minutes, hourly, and so on. 2. The MDS assessment dated [DATE] recorded Resident #8's BIMS as 15, indicating intact cognition. The MDS documented the resident had a diagnoses of chronic obstructive pulmonary disease (COPD), Parkinson's, and chronic kidney disease. The Progress Notes documented a positive COVID-19 test on [DATE]. The Care Plan failed to address COVID-19 prevention or diagnosis. Review of the resident's record revealed no assessments or vital signs completed from [DATE] to [DATE] when isolated for COVID-19 except for Staff G, Advanced Registered Nurse Practitioner (ARNP), assessing on [DATE] and [DATE]. The Progress Notes documented the ARNP ordered an antibiotic for a productive cough on [DATE]. On [DATE] at 12:20 p.m., Resident #8 reported no recall of staff assessing her and checking vital signs while on the COVID-19 wing. While talking, the resident coughed and spit out blood-tinged sputum and reported continued cough and lack of appetite. 3. The MDS assessment dated [DATE] recorded Resident #9 with memory impairment and a diagnosis of Huntington's disease. The Progress Notes documented a positive COVID-19 test on [DATE]. The Care Plan failed to address COVID-19 prevention or diagnosis. Review of the facility's undated Residents Positive list displayed a positive COVID-19 test on [DATE]. Review of the resident's record revealed no assessments or vital signs completed from [DATE] to [DATE] except for Staff G, ARNP, assessing on [DATE] and [DATE]. The Progress Notes documented Staff H, Licensed Practical Nurse (LPN) and Staff G, ARNP, assessed Resident #9 on [DATE] prior to her admission to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 - Some	The Hospital Discharge Summary documented Resident #9 admitted on [DATE] with COVID Pneumonia and discharged back to the facility on [DATE] with a hospice referral. 4. The MDS assessment dated [DATE] revealed Resident #10 with diagnoses of paraplegia, diabetes, and stroke. The MDS recorded the resident as rarely understood but with OK long- and short-term memory. The Progress Notes documented a positive COVID-19 test on [DATE]. The Care Plan, dated [DATE], instructed staff to: a. Follow CDC guidelines and recommendations for COVID-19 and nursing centers b. Monitor for increased temperature and respiratory symptoms Review of the resident's record revealed no assessments or vital signs from [DATE] until [DATE]. Review of a clinic Encounter Summary revealed an Advanced Registered Nurse Practitioner (ARNP) from the clinic of the resident's primary care provider visited and assessed Resident #10 at the nursing facility on [DATE]. The ARNP documented being unaware until the visit of the resident's positive COVID-19 test. The Progress Notes revealed the resident died on [DATE]. An observation on [DATE] at 8:15 a.m., revealed Staff I, Certified Medication Aide (CMA), entering the facility's partitioned-off COVID-19 unit wearing personal protective equipment. On [DATE] at 1:30 p.m., Staff I, CMA, stated she worked the COVID-19 unit routinely with another nurse aide. The nurse would come from the non-COVID area of the facility to pass medications and assess residents. The designated nurse aides had not been checking vital signs on COVID-19-positive residents. On [DATE] at 10:10 a.m., Staff D, RN, stated she would be working on the COVID-19 wing today for the first time. Assessments on the COVID-19 positive residents are the same for everyone with daily vital signs and assessment in the electronic health record. On [DATE] at 11:35 a.m., Staff K, RN, reported being contracted through a staffing agency and so did not work the COVID-19 wing. On [DATE] at 10:00 a.m., Staff J, CMA, reported the COVID-19 wing had designated nurse aides on it, and a nurse would float from the regular floor to give medications and check on the residents. Staff J reported being given a vital signs documentation sheet on [DATE] to record the COVID-19 wing's vital signs on; otherwise, she had not been asked to check vital signs. She stated Resident #10 had an elevated pulse that day which she reported to Staff K, RN. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 - Some	On [DATE] at 10:40 a.m., Staff H, Licensed Practical Nurse (LPN), reported working the COVID-19 wing, spending a couple of hours or more there each shift to give medications and assess residents. Staff H reported not knowing of any protocol for how often to check vital signs and assess. Skilled residents are to have vital signs, and she reported not always completing them due to being the only nurse in the facility some shifts. On [DATE] at 1:55 p.m., Staff L, CMA, reported either two nurses or a nurse and CMA work the morning and evening shifts. Agency nurses do not work on the COVID-19 wing so the CMA would pass meds, check on residents, and report any concerns on the COVID-19 wing to the nurse. Agency staff could assess a COVID-19 resident in an emergency. Staff L never had any concerns to report when working with an agency nurse. On [DATE] at 2:45 p.m., Staff M, CMA, stated she passed medications to COVID-19-positive residents when the only nurse in the facility was an agency nurse. She never had a concern to report to the agency nurse requiring her to come onto the COVID-19 wing. On [DATE] at 3:25 p.m., Staff E, LPN, reported she usually checked oxygen saturations and temperatures on COVID-19-positive residents as giving them their medications. She did not record these anywhere. On [DATE] at 3:45, Staff G, facility ARNP said she assessed residents with COVID-19 on Tuesdays and Fridays if staff reported concerns or she observed concerns. She had not observed any concerns with Resident #10. The facility provided policy, Novel Coronavirus COVID-19 revised [DATE], stated: a. Charge nurse to complete a Respiratory Infection Screen each shift b. Follow CDC updates and guidance regarding COVID-19 On [DATE] at 10:30 a.m., Staff F, Corporate Senior Director of Nursing (DON), reported the expectation that staff assess COVID-19-positive residents every shift. On [DATE] at 11:50 a.m., the Administrator reported staff assessed but did not document. She verified that agency nurses are only to work with COVID-19-positive residents in an emergency but stated the nurse aides get vital signs and reported concerns. An interim DON had educated staff on completing vital signs on all residents on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on clinical record review, resident interview, facility staff interview, and wound clinic staff interview, the facility failed to assess and measure pressure ulcers weekly and provide treatment as ordered by a physician for 3 of 3 residents reviewed with pressure ulcers (Residents #2, #5, and #7). The facility reported a census of 45 residents. Findings include: The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 with diagnoses including peripheral vascular disease, coronary artery disease, and muscle weakness. The MDS documented the resident had 4 unstageable pressure ulcers when admitted on [DATE] and received pressure ulcer care. The Care Plan, dated [DATE], stated Resident #2 had pressure ulcers to both heels and listed interventions: a. Administer treatments as ordered and monitor for effectiveness (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Monitor dressing to ensure it is intact and adhering. Report loose dressing to nurse. Review of a physician Order Entry revealed a treatment order obtained [DATE] to cleanse the coccyx and cover with a silicone dressing, changing 3 days per week. Review of the [DATE] Treatment Administration Record (TAR) from [DATE] to [DATE], when the resident died , revealed no documentation schedule for the treatment. 2. The MDS assessment dated [DATE] revealed Resident #5 with diagnoses that included dementia and muscle weakness. The resident had long- and short-term memory impairment. The MDS failed to document any pressure ulcer. The Care Plan contained a focus area for potential of skin integrity impairment on [DATE]. It stated to follow facility protocol for treatment of injuries. It failed to document an actual pressure ulcer. A Weekly Wound Observation assessment dated [DATE] documented a new coccyx pressure ulcer. The TAR for [DATE] and [DATE] indicated a treatment order starting [DATE] and ending [DATE] for hydrogel impregnated gauze 3 days a week to the coccyx. During this timeframe, nursing initialed the treatment as completed only once. Review of a Wound Evaluation & Management Summary physician note dated [DATE] revealed new treatment orders: alginate calcium daily and zinc ointment twice daily and as needed. Review of a Wound Evaluation & Management Summary physician note dated [DATE] revealed a change in the alginate calcium to 3 days a week and zinc ointment to continue twice daily and as needed. Review of the TAR for [DATE] revealed the [DATE] order on the TAR to start [DATE] and end [DATE] and the [DATE] order documented to start [DATE]. Nursing staff failed to initial the treatment as completed on [DATE] and [DATE]. In addition, the zinc oxide twice daily only appeared on the TAR on Mondays, Wednesdays, and Fridays to complete. 3. The Minimum Data Set (MDS) assessment dated [DATE] recorded Resident #7's Brief Interview for Mental Status (BIMS) as 14, indicating intact cognition. The MDS documented the resident had a diagnosis of quadriplegia, pressure ulcer of the sacral region stage 4. It further documented 2 stage 3 pressure ulcers in addition to the stage 4 pressure ulcer. The Care Plan contained a Focus area, revised [DATE] of pressure ulcers of the sacrum, right upper thigh, and left anterior upper thigh with interventions: a. Administer treatments as ordered and monitor for effectiveness, revised [DATE] b. Assess/record/monitor wound healing weekly and as needed. Measure length, width, and depth where possible. Assess and document the status of wound perimeter, wound bed, and healing process. Report improvements and declines to the MD, dated [DATE] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Monitor dressing to ensure it is intact and adhering. Report loose dressing to nurse. Revised [DATE] Review of the clinical record for Resident #7 revealed no pressure ulcer assessments with measurements from [DATE] to [DATE]. Review of a Wound Evaluation & Management Summary physician note dated [DATE] revealed new treatment orders: alginate calcium with silver daily to all pressure ulcers. Review of the TAR for [DATE] revealed no order for daily alginate calcium with silver until [DATE]. From [DATE] to [DATE], staff failed to initial the treatment as completed on the 8th, 9th, 10th, 15th, and 16th. On [DATE] at 12:13 p.m., Resident #7 stated staff had not done her pressure ulcer treatments at times, maybe missing one or two in the last week or so. On [DATE] at 2:05 p.m., Staff D, Registered Nurse (RN) stated the floor nurses are responsible for wound treatments if no wound nurse is scheduled. The wound nurse has typically been responsible for entering treatment orders into the electronic health record, but the facility has been without a wound nurse. On [DATE] at 11:30 a.m., Staff O, RN, reported taking over doing the wound treatments a week ago since it could be difficult for nurses to provide all the ordered treatments with all their other duties. She stated a wound clinic physician has recently been seeing residents weekly at the facility except for last week when on vacation. On [DATE] at 1:15 p.m., Staff H, Licensed Practical Nurse (LPN), reported a nurse went with the Wound Clinic Physician each week on rounds and was responsible for entering new treatment orders into the electronic health record. Based on clinical record review, observation, resident interview, facility staff interview, and wound clinic staff interview, the facility failed to assess and measure foot wounds weekly and provide treatment as ordered by a physician for 2 of 2 residents reviewed with foot wounds (Residents #4 and #6). The facility reported a census of 45 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 with diagnoses including diabetes, morbid obesity, and dementia. The resident scored 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. A Care Plan focus area, revised [DATE], recorded Resident #4 as having a nonstageable pressure injury to his left plantar foot related to diabetes with interventions dated [DATE]: a. Administer treatments as ordered and monitor for effectiveness b. Assess and record wound healing weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress c. Check dressing to ensure it is intact and adhering; report loose dressing to nurse (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Wound Evaluation & Management Summary physician note dated [DATE] revealed documentation of the left foot wound as a diabetic wound. The physician ordered a treatment of alginate calcium with silver daily. A Confidential Fax signed by the resident's primary care provider on [DATE] and noted by nursing staff on [DATE] documented agreement of the [DATE] order. Review of Wound Evaluation & Management Summary physician notes dated [DATE], [DATE], and [DATE] revealed all stated to continue the alginate calcium treatment daily. The Treatment Administration Record (TAR) for [DATE] contained no order for alginate calcium. It documented a treatment to the left foot of a Prisma dressing every other day from [DATE] to [DATE]. The TAR for [DATE] documented the daily alginate calcium treatment started [DATE] and ended [DATE] then started again on [DATE]. From [DATE] through [DATE], staff only initialed the treatment as completed 3 times. Review of the resident's clinical record revealed no assessment and measurement of the foot wound from [DATE] to [DATE]. During an observation on [DATE] at 11:30 a.m., Staff O, Registered Nurse (RN), provided wound treatment to a wound on the bottom of Resident #4's left foot near the base of the 5th toe. 2. MDS assessment dated [DATE] revealed Resident #6 with diagnoses including stroke and foot ulcer. The resident scored 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. A Care Plan focus area, revised [DATE], recorded Resident #6 as having venous wounds to both lower extremities. Interventions documented [DATE] included: a. Provide a weekly wound assessment and documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. b. Administer treatments as ordered and monitor for effectiveness Review of a Wound Evaluation & Management Summary physician note dated [DATE] revealed a new lymphodemic wound on the resident's right foot with treatment orders of metronidazole (an antibiotic) 500mg crushed on the wound 3 days a week. The TAR for [DATE] contained no order for the metronidazole until [DATE]. Review of the resident's clinical record revealed no assessment and measurement of the foot wound from [DATE] to [DATE]. On [DATE] at 7:45 a.m., Resident #6 reported having wound treatment on Mondays, Wednesdays, and Fridays. Open areas tend to come and go to his legs and feet. Until recently, staff did not always complete the treatments 3 times per week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:05 p.m., Staff D, RN stated the floor nurses are responsible for wound treatments if no wound nurse is scheduled. The wound nurse has typically been responsible for entering treatment orders into the electronic health record, but the facility has been without a wound nurse. On [DATE] at 11:30 a.m., Staff O, RN, reported taking over doing the wound treatments a week ago since it could be difficult for nurses to provide all the ordered treatments with all their other duties. She stated a wound clinic physician had recently been seeing residents weekly at the facility except for last week when on vacation. On [DATE] at 1:15 p.m., Staff H, Licensed Practical Nurse (LPN), reported a nurse went with the Wound Clinic Physician each week on rounds and was responsible for entering new treatment orders into the electronic health record. She had gone with the physician on [DATE] but had not entered orders in until the following week. If the Wound Clinic Physician is not through to assess the wounds, the facility nurses should complete the assessments. On [DATE] at 3:00 p.m., the Wound Clinic Physician reported knowing the facility had not been getting the ordered treatments onto the TAR timely. She had rounded with a different nurse each time she had come to the facility and had seen that the newest ordered treatments were not always on the wounds. She stated she is not responsible for the weekly assessment of the wounds. Nursing should be ensuring assessments with measurements are completed. The facility's Skin Management Guidelines Overview revised ,d+[DATE] stated residents with wounds and/or pressure injury are identified, assessed, and provided appropriate treatment to encourage healing. On [DATE] at 3:20 p.m., Staff N, Interim Director of Nursing, stated staff assessed the wounds last week with the Wound Clinic Physician out; they just did not measure them. She is training all staff on entering physician's orders into the electronic health record and assessing wounds. She has been reviewing all wound orders to ensure they are properly in the electronic health record. On [DATE] at 3:00 p.m., the Wound Clinic Physician reported knowing the facility has not been getting the ordered treatments onto the TAR timely. She has rounded with a different nurse each time she has come to the facility and saw that the newest ordered treatments were not on the wounds. She stated she is not responsible for the weekly assessment of the wounds. Nursing should be ensuring assessments with measurements are completed. The facility's Skin Management Guidelines Overview revised ,d+[DATE] stated residents with wounds and/or pressure injury are identified, assessed, and provided appropriate treatment to encourage healing. On [DATE] at 3:20 p.m., Staff N, Interim Director of Nursing, stated staff assessed the wounds last week with the Wound Clinic Physician out; they just did not measure them. She is training all staff on entering physician's orders into the electronic health record and assessing wounds. She has been reviewing all wound orders to ensure they are properly in the electronic health record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on clinical record review, observation, resident interview, facility staff interview, and wound clinic staff interview, the facility failed to assess and measure foot wounds weekly and provide treatment as ordered by a physician for 2 of 2 residents reviewed with foot wounds (Residents #4 and #6). The facility reported a census of 45 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 with diagnoses including diabetes, morbid obesity, and dementia. The resident scored 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. A Care Plan focus area, revised 5/11/21, recorded Resident #4 as having a nonstageable pressure injury to his left plantar foot related to diabetes with interventions dated 4/20/21: a. Administer treatments as ordered and monitor for effectiveness b. Assess and record wound healing weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress c. Check dressing to ensure it is intact and adhering; report loose dressing to nurse Review of a Wound Evaluation & Management Summary physician note dated 11/17/21 revealed documentation of the left foot wound as a diabetic wound. The physician ordered a treatment of alginate calcium with silver daily. A Confidential Fax signed by the resident's primary care provider on 11/23/21 and noted by nursing staff on 11/25/21 documented agreement of the 11/17/21 order. Review of Wound Evaluation & Management Summary physician notes dated 12/1/21, 12/8/21, and 12/15/21 revealed all stated to continue the alginate calcium treatment daily. The Treatment Administration Record (TAR) for November 2021 contained no order for alginate calcium. It documented a treatment to the left foot of a Prisma dressing every other day from 10/29/21 to 12/7/21. The TAR for December 2021 documented the daily alginate calcium treatment started 12/8/21 and ended 12/18/21 then started again on 12/21/21. From 12/8/21 through 12/20/21, staff only initialed the treatment as completed 3 times. Review of the resident's clinical record revealed no assessment and measurement of the foot wound from 12/15/21 to 12/29/21. During an observation on 12/28/21 at 11:30 a.m., Staff O, Registered Nurse (RN), provided wound treatment to a wound on the bottom of Resident #4's left foot near the base of the 5th toe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. MDS assessment dated [DATE] revealed Resident #6 with diagnoses including stroke and foot ulcer. The resident scored 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. A Care Plan focus area, revised 5/19/21, recorded Resident #6 as having venous wounds to both lower extremities. Interventions documented 2/26/21 included: a. Provide a weekly wound assessment and documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. b. Administer treatments as ordered and monitor for effectiveness Review of a Wound Evaluation & Management Summary physician note dated 12/15/21 revealed a new lymphodemic wound on the resident's right foot with treatment orders of metronidazole (an antibiotic) 500mg crushed on the wound 3 days a week. The TAR for December 2021 contained no order for the metronidazole until 12/22/21. Review of the resident's clinical record revealed no assessment and measurement of the foot wound from 12/15/21 to 12/29/21. On 12/28/21 at 7:45 a.m., Resident #6 reported having wound treatment on Mondays, Wednesdays, and Fridays. Open areas tend to come and go to his legs and feet. Until recently, staff did not always complete the treatments 3 times per week. On 12/27/21 at 2:05 p.m., Staff D, RN stated the floor nurses are responsible for wound treatments if no wound nurse is scheduled. The wound nurse has typically been responsible for entering treatment orders into the electronic health record, but the facility has been without a wound nurse. On 12/28/21 at 11:30 a.m., Staff O, RN, reported taking over doing the wound treatments a week ago since it could be difficult for nurses to provide all the ordered treatments with all their other duties. She stated a wound clinic physician had recently been seeing residents weekly at the facility except for last week when on vacation. On 12/28/21 at 1:15 p.m., Staff H, Licensed Practical Nurse (LPN), reported a nurse went with the Wound Clinic Physician each week on rounds and was responsible for entering new treatment orders into the electronic health record. She had gone with the physician on 12/15/21 but had not entered orders in until the following week. If the Wound Clinic Physician is not through to assess the wounds, the facility nurses should complete the assessments. On 12/29/21 at 3:00 p.m., the Wound Clinic Physician reported knowing the facility had not been getting the ordered treatments onto the TAR timely. She had rounded with a different nurse each time she had come to the facility and had seen that the newest ordered treatments were not always on the wounds. She stated she is not responsible for the weekly assessment of the wounds. Nursing should be ensuring assessments with measurements are completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Skin Management Guidelines Overview revised 07/2017 stated residents with wounds and/or pressure injury are identified, assessed, and provided appropriate treatment to encourage healing. On 12/29/21 at 3:20 p.m., Staff N, Interim Director of Nursing, stated staff assessed the wounds last week with the Wound Clinic Physician out; they just did not measure them. She is training all staff on entering physician's orders into the electronic health record and assessing wounds. She has been reviewing all wound orders to ensure they are properly in the electronic health record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on clinical record review, hospital record review, observation, mechanical lift User's Manual review, and staff interviews, the facility failed to provide a safe transfer during a full body mechanical lift transfer for 1 of 3 residents reviewed for transfers (Resident #11). The unsafe transfer resulted in the resident falling out of the sling onto the floor. The resident hit her head causing a subdural hematoma and subsequent death. The facility also failed to add and implement interventions for falls for 1 of 3 residents reviewed for falls (Resident #5). The facility reported a census of 45 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 with diagnoses that included dementia and muscle weakness. The MDS identified the resident transferred and walked with assistance of one staff. The resident had long- and short-term memory impairment. A Care Plan focus dated [DATE] identified the resident as at risk for falls. The Care Plan contained no interventions for falls after [DATE] except for two placed on [DATE]: a. Toilet after each meal due to resident wandering when needing to go to the bathroom b. Resident is to be settled in a recliner in the day area between meals so there are more people around to watch her to prevent her getting up on her own. Review of Facility Fall Reports revealed Resident #5 fell 13 times from [DATE] to [DATE], falling on , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. Review of the resident's Progress Notes revealed an intervention following the [DATE] fall to not have the footrest elevate on the recliner in the resident's room. On [DATE], the resident again fell out of her recliner with the footrest elevated. On [DATE] at 2:05 p.m., Staff D, Registered Nurse (RN), stated in the past the MDS Coordinator updated Care Plans. With changes in staff, all nurses will be responsible for some Care Plan updates in the future. The facility's Falls Management Guideline Practice Guidelines document dated [DATE] stated: a. The interdisciplinary team (IDT) will review all resident falls within ,d+[DATE] hours at the morning IDT meeting to evaluate circumstances and probable cause for the fall. b. The IDT modifies and implements a Care Plan and treatment approach to minimize repeat falls and the risk of injury related to the fall. The Care Plan will be reviewed and revised as indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0689 Level of Harm - Actual harm Residents Affected - Few	c. The At-Risk Review committee members will review weekly all residents with falls for documentation, compliance, and interventions to determine that interventions are appropriate. On [DATE] at 3:20 p.m., Staff N, Interim Director of Nursing (DON), stated the nurse should set an initial intervention at the time of the fall. Then the IDT meets within ,d+[DATE] hours, reviews the fall, and comes up with an intervention, which is placed on the Care Plan. 2. The admission MDS assessment dated [DATE] revealed Resident #11 with diagnoses that included stroke and reduced mobility. The MDS identified the resident transferred with total assistance of two staff and did not walk. The resident had long- and short-term memory impairment. A Care Plan focus dated [DATE] identified the resident with a problem of limited physical mobility related to stroke. The care plan revealed the resident did not bear weight or walk and transferred with the Hoyer (full body) lift and assistance of two people. The Invacare Reliant 450 User manual dated 2018 directed the operators to: a. Check to ensure the sling is properly connected to the hooks of the hanger bar when the patient is elevated a few inches off the surface of the stationary object (wheelchair, commode, or bed). b. Make adjustments for safety and comfort before moving the patient. c. Not use non-Invacare slings. Invacare slings are made specifically for use with Invacare Patient Lifts. For the safety of the patient, DO NOT intermix slings and patient lifts of different manufacturers. The undated facility document titled How to use a Hoyer Lift directed the operators to: a. Position the sling under the patient b. Connect the sling to the lift c. When the patient is clear of the bed surface, swing their feet off the bed d. Move the lift away from the bed while turning the resident so that he/she faces the assistant operating the lift. A Progress Note dated [DATE] by Staff D, Registered Nurse (RN) revealed that at around 8:00 a.m. the resident slid out of a Hoyer sling during a transfer from the bed to the chair. Staff alerted Staff D, who arrived to the room and observed Resident #11 lying on her back on the floor with a pillow under her head. Resident #11 had no visible head injuries and reported her head hurt a little. The Certified Nurse Aide (CNA) onsite reported the resident might have hit her head on the floor. The sling was unhooked from the lift. Staff D checked the sling and documented it and the mechanical lift to be in good condition. An observation on [DATE] at 11:45 a.m., revealed Resident #11 lying in bed in her private room. A Geri (padded, reclining, wheeled) chair sat next to the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:00 a.m., Staff J, Certified Medication Aide (CMA) reported completing cares on Resident #11 around 8:00 a.m. on [DATE]. Staff I, CMA, then came in to assist with the transfer out of bed into the Geri chair. Together, they placed a full-body sling under the resident and attached sling loops to the lift, same colored loops for upper body and same colored loops for lower body. The distance from the top of the bed to the floor was approximately ,d+[DATE] feet. As Staff J pulled the lift with the resident away from the bed, Staff I moved the Geri chair into position for Resident #11 to sit in. Resident #11's bottom had just cleared the bed, and her feet were maybe just grazing the bed, when she suddenly came out of the lift and landed on the floor. The resident had not moved herself in the sling. Due to a stroke, the resident had a flaccid side. Staff J reported the fall occurred so quickly she could not say how the resident came out of the lift sling. She felt the resident landed hard on her bottom on the floor in more of a seated position and then may have hit her head on the floor. The four loops of the lift sling remained attached to the Hoyer lift. During a follow-up interview on [DATE] at 3:39 p.m., Staff J, CMA, stated she had not paused at any time during the transfer. She described the transfer as normal and stated once the resident had been raised in the bed so that she could move freely away without any friction against the bed, she pulled the lift away from the bed. On [DATE] at 10:20 a.m., Staff I, CMA, reported trying to move the Geri chair behind the resident when the resident suddenly fell out of the lift, landing hard on her bottom on the floor. The sling remained hooked to the lift, unsure if by all four loops. Staff I could not recall if she moved the resident's feet off the bed during the transfer. On [DATE] at 3:05 p.m., Staff D, RN, reported staff alerted her to Resident #11 falling from the Hoyer lift around 8:00 a.m. on [DATE]. When she arrived, she observed the resident lying on the floor with a Hoyer sling under her, not hooked to the lift. She checked the sling as rolling Resident #11 to assess her and reported no concerns with the sling or Hoyer lift. Staff used the same sling and Hoyer lift to transfer the resident off the floor and into bed. On [DATE] at 3:45 p.m. Staff G, Advanced Registered Nurse Practitioner, ARNP, reported going into Resident #11's room just prior to the Hoyer transfer around 8:00 a.m. on [DATE] to perform a COVID-19 test. Staff G observed the sling in place, hooked to the Hoyer lift without noted concerns. She reported being just outside the resident's door when the staff called for help moments later. When she walked into the room, she observed the resident lying on her back on the floor between the Hoyer lift legs with an aide holding the resident's head. Staff G recalled pushing the Hoyer lift out of the way, with the sling hanging from it, to assess the resident. She could not recall seeing if all four loops of the sling were attached the lift hooks. She met Staff D, RN, in the hall coming to the resident's room as she was leaving. A Progress Note dated [DATE] documented Resident #11 began vomiting around 10:30 a.m. and was taken via ambulance to the local emergency department. The hospital Discharge Summary dated [DATE] documented Resident #11 admitted on [DATE] for comfort cares following a diagnosis of acute subdural hematoma with herniation related to the fall from the Hoyer lift. The resident died on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0689 Level of Harm - Actual harm Residents Affected - Few	An observation on [DATE] at 12:40 p.m. revealed Staff I, CMA, and Staff J, CMA, transferring Resident #12 with a Hoyer lift from a Geri chair to bed. The lift was noted to be labelled Invacare Reliant 450. The label on the blue, solid, full body sling under the resident listed the manufacturer as Proactive. Staff I and Staff J reported the Hoyer lift and the full body sling used with Resident #11's transfer on [DATE] looked the same. On [DATE] at 2:40 p.m., Staff D, RN, described the lift sling used for Resident #11 as a blue, solid, full-lift sling, with unknown manufacturer. Staff did not remove the sling from circulation. The supply closet contained the slings not currently in resident rooms or laundry. The facility has three Hoyer lifts. An observation on [DATE] at 2:40 p.m. of the slings in the supply closet by the nurses station revealed 11 full body slings matching the description of the sling used for Resident #11's Hoyer transfer on [DATE]. One had manufacturer label of [NAME], nine contained Proactive manufacturer labels, and one label was worn and unreadable. The labels stated the useful life of the slings to be 6 months from the date of purchase. The slings had no dates. Observation of the three Hoyer lifts revealed all three labelled as Invacare Reliant 450 with sling instructions for Proactive slings attached. On [DATE] at 9:10 a.m., the Administrator stated having matching Hoyer lift and sling manufacturers is not a regulation. Laundry watches and removes any worn slings from circulation. The facility ordered new slings from Invacare last week after the fall from the Hoyer lift. On [DATE] at 12:45 p.m., the Administrator and Staff L, CMA reviewed lift slings in the facility. The facility reported around 15 to 20 blue, solid, full body slings, none manufactured by Invacare. The facility had Invacare U-Slings with straps that cross between the resident's legs. On [DATE] at 12:50 p.m., Staff L, CMA, reported staff used the full body slings on all residents and not the U-Slings because in the past some residents had not tolerated the straps between their legs. On [DATE] at 12:52 p.m., the Administrator directed staff to remove non-Invacare slings from circulation and use the Invacare U-Slings as tolerated until the new slings arrive. She directed Invacare sling instructions to be attached to the Hoyer lifts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - 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** 42440 Based on observation, policy review, and resident and staff interviews, the facility failed to ensure staff wore eye protection when providing care for residents without COVID-19 when community transmission rates were high and the facility had COVID-19 positive residents in the facility. The facility also failed to monitor residents for fever and symptoms of COVID-19 daily. This had the potential to affect all residents. The facility reported a census of 45 residents. Findings include: Centers for Medicare and Medicaid Services (CMS) Memorandum QSO-20-14-NH dated 3/13/20 and updated 3/10/21 stated facilities should implement active screening of residents for fever and respiratory symptoms. CMS Memorandum QSO-20-38-NH dated 8/26/20 and revised 9/10/21 stated facilities should follow the Centers for Disease Control and Prevention (CDC) guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. The CDC guidance Interim Infection Prevention and Control Recommendations to Prevent [NAME]-CoV-2 Spread in Nursing Homes updated 9/10/21 documented to actively monitor all residents upon admission and at least daily for fever and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry The CDC guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 9/10/21 stated Healthcare Personnel should wear eye protection (i.e. goggles or a face shield that covers the front and sides of the face): a. When entering a room of a patient with suspected or confirms [NAME]-CoV-2 infection b. During all patient care encounters in facilities located in counties with substantial or high transmission of COVID-19. The CDC COVID Data Tracker dated 12/8/21 revealed [NAME] County had a high community transmission. 1. The Minimum Data Set (MDS) assessment dated [DATE] recorded Resident #7's Brief Interview for Mental Status (BIMS) as 14, indicating intact cognition. The MDS documented the resident had a diagnosis of quadriplegia. The Care Plan, dated 12/31/20, instructed staff to: a. Follow CDC guidelines and recommendations for COVID-19 and nursing centers b. Monitor for increased temperature and respiratory symptoms Review of Progress Notes revealed the resident's roommate had a diagnosis of COVID-19 on 11/23/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's record revealed lack of daily temperatures or COVID-19 Coronavirus Risk Assessments over the thirty days from 11/15/21 to 12/14/21: a. Temperatures only recorded 12 of 30 days: November 22, 23, 25, 26, 27, 28, and December 1, 9, 10, 11, 12, and 14. b. COVID-19 Coronavirus Risk Assessments documented 7 of 30 days: November 23, 25, 27, and December 9, 10, 13, and 14. Review of Daily Skilled Summaries completed from 11/15/21 to 12/14/21 revealed completed forms on November 22, 23, 25, 27, 28, and December 1, 4, 8, 10, 13, and 14 and incomplete on December 3, 11, and 12. They contained no additional temperatures. On 12/9/21 at 12:13 p.m., Resident #7 reported never seeing staff wear eye protection. She stated staff do not ask about COVID-19 symptoms or take her temperature. 2. The MDS assessment dated [DATE] recorded Resident #8's BIMS as 15, indicating intact cognition. The MDS documented the resident had a diagnoses of chronic obstructive pulmonary disease (COPD), Parkinson's, and chronic kidney disease. The Progress Notes documented a positive COVID-19 test on 11/23/21. The Care Plan failed to address COVID-19 prevention or diagnosis. Review of the resident's record revealed lack of daily temperatures or COVID-19 Coronavirus Risk Assessments from 11/8/21 to 11/23/21. On 12/9/21 at 12:20 p.m., Resident #8 reported staff wore eye protection in the COVID-19 wing but not when caring for her outside of the COVID-19 wing. 3. The MDS assessment dated [DATE] recorded Resident #9 with memory impairment and a diagnosis of Huntington's disease. The Progress Notes documented a positive COVID-19 test on 11/29/21. The Care Plan failed to address COVID-19 prevention or diagnosis. Review of the resident's record revealed no documentation of temperatures or COVID-19 Coronavirus Risk Assessments from 11/8/21 to 11/29/21. 4. The MDS assessment dated [DATE] revealed Resident #10 with diagnoses of paraplegia, diabetes, and stroke. The Progress Notes documented a positive COVID-19 test on 12/3/21. The Care Plan, dated 2/23/21, instructed staff to: a. Follow CDC guidelines and recommendations for COVID-19 and nursing centers (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Monitor for increased temperature and respiratory symptoms Review of the resident's record revealed no documentation of temperatures or COVID-19 Coronavirus Risk Assessments from 11/8/21 to 12/3/21. An observation on 12/8/21 at 4:10 p.m. revealed Staff A, Certified Nurse Aide (CNA), walk into the room of Residents #7 and #8 without eye protection and exit at 4:15 p.m. without eye protection. An observation on 12/9/21 from 8:05 a.m. to 8:25 a.m. revealed Staff C, CNA, without eye protection on, feeding a resident in the dining room. On 12/9/21 at 12:25 p.m., Staff A, CNA, stated she does not wear eye protection since not given any by the facility. She does not work the COVID-19 wing. The nurse asked the CNAs to check vital signs on all residents today, which is new. An observation on 12/9/21 at 1:00 p.m., Staff C, CNA, revealed Staff C, CNA, without eye protection, assisting a resident with ambulation in the hall. Staff C had vital signs equipment and carried a paper labelled COVID Assessments East Hall with residents' names and vital signs listed. On 12/9/21 at 1:30 p.m., Staff B, CNA, reported staff do not need to wear eye protection outside of the COVID-19 wing. CNAs provided no formal screening of residents for symptoms of COVID-19. On 12/9/21 at 1:55 p.m., Staff C, CNA, said she had her own eye protection. She had not worked the COVID-19 unit or been told to wear it so had not brought it in the facility. CNAs do not check vital signs but nurses had asked CNAs to check them on all the residents today. On 12/9/21 at 3:45 p.m., the Administrator stated the facility has been in the red (high community transmission rate) for a long time. Staff wear eye protection on the COVID-19 unit, but it is not required off the unit. On 12/13/21 at 1:35 p.m., Staff D, Registered Nurse (RN), stated nurses recently began completing a daily COVID-19 assessment in the electronic health record on all residents to screen for COVID-19 symptoms. Vital signs may also be in a binder. Review of the binder labelled Resident Daily Vital Signs on 12/14/21 at 10:10 a.m. with Staff D, RN, revealed it contained sheets labelled COVID Assessment. The sheets had dates of 12/13/21, one undated day, and sheets from 10/22/21 or before. On 12/13/21 at 2:05 p.m., Staff E, Licensed Practical Nurse (LPN), reported staff are checking vital signs on all residents now due to the facility being in outbreak status. Staff E reported being new and unsure how staff monitored residents for COVID-19 symptoms prior to the outbreak. The facility's COVID Guideline document dated 5/21 listed to perform a risk evaluation with temperature check under screening. The policy Novel Coronavirus COVID-19 revised 2/8/21 stated: a. Complete a COVID Tracker daily on residents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Follow CDC updates and guidance regarding COVID-19 On 12/16/21 at 10:30 a.m., Staff F, Corporate Senior Director of Nursing, relayed the expectation that staff monitor residents at least daily for signs and symptoms of COVID-19, completing the COVID-19 Risk Assessment.