STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to develop a care plan for 1 of 3 (Resident #1) residents reviewed. The facility reported a census of 54 residents. Findings include: The Resident Elopement Policy and Procedure dated 3/11/20 documented the residents care plan shall be updated accordingly to prevent repeated incidents. The Minimum (MDS) data set [DATE] for Resident #1 documented [DIAGNOSES REDACTED]. The MDS also documented the resident required staff supervision for transfers and ambulation (walking) The Wander Risk Assessment form dated 5/12/20 documented the resident as at high risk for wandering. The Progress Notes dated 5/23/20 documented the resident eloped (left the facility without staff knowledge) on the evening of 5/22/20. The Care Plan for the resident lacked any documentation that showed the resident engaged in wandering behavior or had eloped in the past. In an interview on 6/8/20 at 3:30 PM, the Director of Nursing stated the resident had been known to wander and staff had applied a wander guard to his person as an intervention. She stated that she expected staff to identify the resident as at risk of wandering on the care plan.
F 0689 **Level of harm** - Minimal harm or potential for 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** Based on record review and staff interviews, the facility failed to ensure the resident remained free from accidents and hazards for 1 of 3 residents reviewed. The facility reported a census of 54 residents. Findings include: The Minimum Data Set assessment tool dated 4/22/20 identified Resident #1 had [DIAGNOSES REDACTED]. The MDS documented the resident required staff supervision for transfers and ambulation (walking). Review of the Door Alarm Policy and Procedure dated 3/11/20 revealed: When a door alarm sounds, at least one and two if staffing allows will exit the door of the alarm and search the perimeter of the property remaining outside until a staff from the inside reports to them all residents are accounted for. Staff will not silence the alarm on the assumption of seeing someone who may have just entered the facility without confirming that person was responsible for the alarm activating. The Wander Risk Assessment form dated 5/12/20 documented the resident is at high risk for wandering. The Progress Notes dated 5/23/20 documented the resident eloped (left the facility without staff knowledge) on the evening of 5/22/20. During the interview with the Director of Nursing (DON) on 6/8/20 at 1:35 PM she stated staff called her on 5/22/20 at 10:23 PM and reported the resident was missing. She reported Staff E shut off the door alarm and went about her work, however Staff D arrived at the facility at 9:55 PM and did respond to the alarm. She stated that Staff E did not follow the facility policy and had to be re-educated. During the interview with the night shift Certified Nursing Assistant (CNA) Staff D on 6/8/20 at 2:15 PM, she stated that she got to work on 5/22/20 around 9:55 PM and got report. Around 10:10 PM the alarm sounded and it was activated at the dining room door according to the p;panel at the nurse's station. She stated that she immediately went to investigate and found the stop sign that had been across the door was down and the door had been open. She stated that she went out the door and looked both ways but didn't see anyone. She then went back and was told to check Resident #1's room. She reported she ran to his room and he was not in there so she alerted her nurse Staff E right away and she started head count. She went to look for the resident with help of another aide and they found him around 10:45-10:50 PM. During an interview on 6/8/20 at 3:35 PM, of Staff E reported she did not respond to a door alarm on 5/22/20 at around 9:55 PM because she thought it had been someone that went outside to smoke. She stated Staff D alerted her that Resident #1 may be missing around 10:15 PM so she and another nurse started head count.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, CMS QSO letters, CDC guidelines and staff interviews, the facility failed to ensure staff utilized proper infection control protocols for 6 of 6 residents reviewed. The facility also failed to ensure appropriate amount of PPE was readily available for staff use and that staff were properly screened for infection control. The facility reported a census of 54 residents. 1. During an observation on June 6/8/20 at 10:12 AM, the facility did not have anyone at the front of the facility to check surveyors' temperatures. The facility had surveyors fill out a questionnaire, however, nobody checked the surveyors' questionnaire or temperatures to allow admittance into the facility. In addition, the screening log for staff dated 6/8/20 had 4 staff names listed with no check-in temperatures documented. Two of the staff with no check-in temperatures documented were the Director of Nursing (DON) and Administrator. The CMS QSO 20-14 letter directed facilities to actively check staff temperatures at the beginning of staff shifts and assess for signs and symptoms of COVID 19. Review of the CMS QSO 20-20 letter showed facilities should provide temperature checks and ask about fever before admittance into the facility. In an interview with the Director of Nursing on 6/8/20 at 10:20 AM and she reported the thermometer did not work so she took her temperature later, but had not gotten back to the log to chart it. In a subsequent interview on the same day at 12:10 p.m., the DON reported there are no staff designated to sit at the front to check visitors and staff in. She stated the door is locked and visitors and staff must ring the doorbell to be allowed in. She stated she expected staff to complete the questionnaire, sign in, and check their temperatures. 2. The Minimum Data Set (MDS) for Resident #2 revealed resident [DIAGNOSES REDACTED]. The MDS documented Resident #2 displayed moderately impaired cognitive status and exhibited wandering behavior. The MDS identified the resident as independent for transfers and toilet use but required supervision for bed mobility and eating. The Care Plan for Resident #2 identified the the resident as at risk for infection and elopement (leaving the facility without staff knowledge). The Care Pan also revealed the resident was on isolation for 14 days due to being in the community and directed staff to encourage the resident to stay in the isolation area and redirect him if he wanders out of the quarantined area. The resident's progress notes revealed the resident exhibited signs of behaviors and attempts to leave the facility frequently. Due to these factors. Resident #2 required close observation and has a staff member with him often. During an observation on June 8th at 10:35 AM, the designated hall for residents in quarantine for COVID 19 had three disposable gowns were not utilized by staff and were not in the waste bin. One gown was seen hanging on the door stop, and two more were placed on the side railing. During the observation, at 10:45 AM, the nurse who was one on one with Resident #2 walked out of the quarantined area with the resident. The resident refused to stay in the quarantined area. The resident had his mask below his nose. The staff member left the quarantined area with the gown on. The resident and the staff stayed out in the front dining area, while staff attempted to speak with resident about staying in the quarantine area. Later, the staff who was one on one with the resident, came back, and placed their gown on the door inside the quarantined area and left to be back with the resident.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) During an observation on June 8th at 10:50 AM, staff C, housekeeping, was cleaning a resident's room and had the surgical mask pulled down to chin line. During an interview on June 8th at 12:56 PM, the administrator and DON reported they felt there were enough supplies now because the facility recently received a FEMA drop of PPE supplies. They reported staff are expected to reuse their masks and place them in ziplock bags and fold them the mask so the inside of the mask doesn't touch the outside of the mask. Staff are to take their masks home and bring them back to reuse them for their next shift. During an interview on June 9th at 12:10 PM, the DON reported the gowns staff use were washable and must be taken to the laundry after use, unless it is a disposable gown. The DON reported there are no designated staff for the COVID hall due to there not being any positive COVID-19 cases. She reported all residents have been screened and tested negative for COVID-19. She reported if there were to be a positive case then there would be designated staff for the hallway.