STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165265	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QHC FORT DODGE VILLA , LLC	2721 10TH AVENUE NORTH FORT DODGE, IA 50501

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

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F 0553 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** Based on clinical record review, staff and resident interview the facility failed to included residents in the care planning process for 3 of 3 residents reviewed. (Resident #4 and Resident #5) Facility census was ninety-three (93) residents. Findings include: 1. Resident #4's most recent Minimum Data Set (MDS) identified the resident with a Brief Interview for Mental Status (BIMS) score of 14 (no cognitive impairment). On 9/14/20 at 1:25 PM, Resident #4 revealed she is not aware of care plan meetings and the facility did not ask her to attend a care plan meeting. 2. Resident #5's most recent Minimum Data Set (MDS) identified the resident with a Brief Interview for Mental Status (BIMS) score of 14 (no cognitive impairment). On 9/14/20 at 1:35 PM, Resident #5 revealed she has never been invited to a care plan meeting. 3. On 9/14/20 at 3:30 PM, the Administrator acknowledged staff did not complete quarterly and annual care conferences. The facility initiated a Performance Improvement Plan (PIP) dated 9/14/20 with the objective and goal identified as care conferences.
F 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** Based on clinical record review and staff interview, the facility failed to notify and document a resident room change for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 93 residents. Findings include: 1. On 9/15/20 at 10:15 AM the Administer revealed the facility did not have a written protocol/policy for resident room and roommate changes. The Administrator further revealed resident room and roommate changes included talking to the resident and if unable to make the decision for the room change, then the facility would notify the power of attorney (POA)/responsible party. The Administrator identified Resident #3 with a recent room change and a new roommate after coming out of quarantine as the previous roommate no longer wanted to reside with Resident #3. On 9/15/20 at 12:45 PM Staff T, Social Services Designee revealed the protocol for resident room changes is a conversation with the resident, call family if the resident is not able to understand and document in resident's record. Review of Resident #3's clinical record did not reveal notification of the room or roommate change. The facility could not produce a document signed by Resident #3 or responsible party in regards to the room and roommate change.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, record review, resident interview and staff interview, the facility failed to maintain a clean, comfortable and homelike environment. The facility reported a census of 93 residents. Findings include: 1. Resident #4's most recent Minimum Data Set (MDS) identified the resident with a Brief Interview for Mental Status (BIMS) score of 14 (no cognitive impairment). The resident admitted to the facility 9/5/19. On 9/14/20 at 1:25 PM, Resident #4 revealed she would like to look out a clean window and she never observed staff clean her room windows. The resident stated she was hopeful when it rained and it was windy, that it would remove some of the debris from her window. Observation at that time of Resident #4's window revealed cob webs, dead flies, spots on the window and fecal matter from birds. 2. Observation on 9/15/20 at 8:10 AM revealed spider webs and dead flies on the interior window seals in the Villa Dining Room. 3. Observation on 9/15/20 at 1:30 PM of the windows in the main dining room revealed spots on the windows, dead flies and spider webs on the interior window seals and cobwebs throughout the screens. 4. On 9/14/20 at 11:00 AM, the Administrator revealed housekeeping cleaned the facility windows in the early spring, this summer and will clean them again this fall. The Administrator further revealed housekeeping will clean the windows as needed.
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to investigation 2 instances of alleged misappropriation of property for 1 of 6 residents reviewed. (Resident # 3) Facility census was ninety-three (93) residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 identified a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate impairment. The MDS recorded the resident exhibited no behavioral symptoms during the 7-day assessment period. Review of Resident #3's record failed to identify the resident missed two watches. On 9/14/20 at 11:00 AM, the Administrator acknowledged Resident #3 had 2 Apple watches reported missing in the past year; one watch reported missing prior to the Administrator's employment at the facility (Administrator began employment 3/23/20) and one reported missing in April or May of 2020. The Administrator revealed there wasn't any follow-up documentation or investigation in regards to the two missing Apple watches. Facility form titled QHC Grievance Policy, documented the Facility Administrator is the Grievance Official and is responsible for any necessary investigations and the facility will immediately report all alleged violations including misappropriation of the resident property. On 9/22/20 at 2:00 PM, the Administrator revealed she did not know she was the Grievance Officer for the facility and initiated a Performance Improvement Plan dated 9/22/20 with the objective and goal grievances and missing items.
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** Based on staff interview and record review, the facility failed to provide services that met professional standards of quality for 1 of 7 residents reviewed (Resident #3). The facility reported a census of 93 residents. Findings include: Records for Resident #3 included an appointment at the Veteran's Administration behavioral unit in Des Moines on 8/18/20 at 12:45 PM. Family interview indicated the facility did not supply a medication list and did not send the medication with Resident #3 to the appointment. Review of Medication Administration Record [REDACTED].) for mood at noon on 8/18/20 as ordered as he was out of the facility. In an interview with the Director of Nursing (DON) on 9/14/20 at 11:00 AM she revealed it is an expectation when a resident is sent to another facility, the facility will supply a face sheet, medication list and Iowa Physician order [REDACTED].
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.**

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide restorative care for 1 of 6 residents reviewed. The facility reported a census of 93 residents. Findings include: The Minimum Data Set (MDS) assessment tool dated 7/7/20 identified Resident #3 with a Brief Interview for Mental Status (BIMS) of 8 indicating moderately impaired cognition. The MDS revealed he required extensive assistance of 2 persons with transfers and toilet use and limited assistance of 1 person with bed mobility and personal hygiene. The MDS further indicated he utilized a wheelchair as a mobility device. The MDS included [DIAGNOSES REDACTED]. On 10/5/20 via email, the Administrator identified the resident's admitted as 10/2/19. Resident #3's Care Plan completed 2/14/20 included a focus area for Impaired Physical Mobility related to the aging process with a goal that he will participate in activities of daily living this quarter. The Nursing Restorative Care Program form dated April 2020 identified Resident #3 with a goal to increase strength with approaches that included Nu-step 2-3 times a week as he tolerated and allowed and exercise class as he tolerated and allowed. Review of the Nursing Restorative Care Program form further indicated the last time staff offered the resident the restorative approaches was 4/3/20. On 9/14/20 at 3:20 PM the Director of Nursing (DON) indicated the facility's Restorative Nursing Aide (RNA) pulled from providing restorative services for the residents in March 2020 due to staffing issues and restorative care for residents was not initiated again until August 2020.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to address a significant weight loss for 1 of 7 residents reviewed (Resident #6). The facility reported a census of 93 residents. Findings include: The Minimum Data Set (MDS) assessment initiated 8/19/20 for Resident #6 identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. The MDS revealed the resident required extensive physical assistance of 2 persons for bed mobility and transfers with limited 1 person physical assistance with eating. The MDS documented [DIAGNOSES REDACTED]. The care plan focus area initiated 8/18/20 identified a potential for altered nutrition related to aging process. The care plan revealed the facility would identify the resident's significant loss/gain with proper interventions. The care plan revealed the dietician is to consult on admission, quarterly and as needed and directed staff to notify doctor/family of any significant weight loss/gain. On 8/30/20 at 1:36 PM, Staff S, Registered Dietician (RD), documented Resident #6 had a current body weight of 167.6 pounds. On 9/6/20 at 2:57 PM, Staff L, Licensed Practical Nurse (LPN), documented Resident #6 had a weight of 156.9 pounds. Nutritional assessment data completed 8/13/20, indicated Resident #6 did not receive supplements and had an appetite pattern of 50-75%. Review of facility form titled Nutrition/Hydration Process, upon significant change in condition the RD will complete nutrition/hydration assessment of resident and make recommendations to the physician and interdisciplinary team (IDT). Clinical record review indicated the doctor/family was not notified and the RD (registered dietician) not consulted in regards to the significant weight loss of 10.7 pounds in 7 days. The clinical record further revealed no additional or revised interventions put in place related to the weight loss. On 9/15/20 at 3:10 p.m. the Director of Nursing stated the facility was aware of the weight loss on 9/6/20 and the RD should assess the resident this week.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Observe each nurse aide's job performance and give regular training.** Based on personnel file reviews and staff interview, the facility failed to assure staff received yearly performance reviews for 4 of 4 sampled staff employed greater than 1 year (Staff I, K, L and M). The facility identified a census of 93 residents. Findings include: 1. The personnel file for Staff I, Certified Medication Assistant (CMA) documented a hire date of 7/12/18. The personnel file did not contain a yearly performance evaluation. 2. The personnel file for Staff K, Certified Nursing Assistant (CNA) documented a hire date of 8/21/18. The personnel file did not contain a yearly performance evaluation. 3. The personnel file for Staff L, Licensed Practical Nurse (LPN) documented a hire date of 12/21/10. The personnel file did not contain a yearly performance evaluation 4. The personnel file for Staff M, Cook documented a hire date of 8/12/19. The personnel file did not contain a yearly performance evaluation. On 9/8/20 at 11:20 AM, the Administrator revealed continuous turnover in leadership at the facility resulted in the facility not completing annual evaluations.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on observation and staff interview, the facility staff failed to ensure they secured and locked medication carts and a treatment cart while unattended in resident care areas. The facility reported a census of 93 residents. Findings include: Observation on 9/1/20 at 10:35 AM revealed a medication cart and treatment cart unlocked between the 100 and 200 hallway on the outside of the nurse's station near the main entrance without staff present. At 10:40 AM Staff H, Nurse Manager, notified of unlocked medication and treatment cart and proceeded to lock both carts. Observation on 9/2/20 at 11:00 AM revealed Staff I, Certified Medication Aide (CMA) walked away from an unlocked medication cart located in the 500 resident hallway, enter a resident's room with her back to the resident's doorway and perform a blood glucose monitoring procedure. Observation on 9/2/20 at 11:15 AM revealed a medication cart unlocked on the outside of the nurse's station near the 300 hallway without staff present. Director of Nursing locked cart after notification of observance of unlocked cart. In an interview with the Director of Nursing on 9/2/20 at 11:15 AM, she revealed she expects staff to lock medication and treatment carts unless the carts are within the peripheral vision of the staff person responsible.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to document in a resident's clinical record for 1 of 6 resident's reviewed (Resident #3). The facility reported a census of 93 residents. Findings include: A Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #3 with a Brief Interview for Mental Status (BIMS) of 8 indicating moderate cognitive impairment. The MDS included [DIAGNOSES REDACTED]. Resident #3's progress notes did not reveal that he was out of the facility on 8/18/20 for an appointment including the time he left the facility and the time he returned to the facility. In an interview on 9/15/20 at 3:20 PM, after reviewing the schedule of appointments for 8/18/20, the Director of Nursing (DON) indicated Resident #3 left the facility for an appointment scheduled for 12:45 PM at the Veteran's Administration in Des Moines on 8/18/20 and returned from the appointment on the same day prior to receiving his scheduled 7 PM medication. She further indicated she expected staff to document when a resident leaves for an appointment outside the facility and the time the resident returns to the facility.
F 0880 **Level of harm** - Immediate jeopardy **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 and staff interview, the facility failed to implement proper infection control practices/procedures when providing care and when screening staff prior to commencing work with residents. The facility failed to ensure resident safety related to infection control by allowing staff to take their own temperatures and complete their own screenings related to COVID-19 at the beginning of their shift and take their own temperature at the end of the shift. The facility allowed staff to work with symptoms consistent with COVID-19. The facility was notified of the 1st COVID-19 positive resident on 8/21/20. On 8/30/20, 19 more residents tested positive for COVID-19. 1 resident passed away from COVID-19. 8 staff tested positive for COVID-19 from 8/21/20-8/28/20. This resulted in an immediate jeopardy situation for the facility. The facility reported a census of 93 residents. Finding include: 1. Review of facility form titled, Start of Shift to Prevent COVID-19 Employee Screening Log, Staff N, Licensed Practical Nurse (LPN) intermittently documented she had symptoms of cough, vomiting and/or diarrhea, muscle pain, headache and new loss of taste or smell at the beginning of her shift from 7/27/20-8/17/20 and was not asked to go home. On 8/23/20, Staff N documented at the beginning of her shift that she had a cough, sore throat, muscle pain, headache and new loss of taste of smell and was not asked to

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) go home. Staff N documented a temperature of 100.0 at the end of her shift. On 8/24/20, Staff N was tested for COVID-19 with positive results. Review of time card punch detail for Staff N revealed she worked from 8/23/20 at 7:16 PM until 8/24/20 at 7:42 AM. 2. On 9/2/20 at 3:05 p.m. the Administrator stated staff screen themselves and take their own temperature. She stated if staff have symptoms they come to the Administrator in regards as what to do and the Administrator calls a nurse on the phone for further assessment of the staff member. 3. Review of facility form titled, Start of Shift to Prevent COVID-19 Employee Screening Log, Staff O, Certified Nursing Assistant (CNA) revealed she did not take her temperature at the beginning or end of her shift on 6/30/20 as no thermometer available. Records reveal Staff O was tested for COVID-19 on 8/21/20 with positive results on 8/24/20. Review of time card punch detail for Staff N revealed Staff O worked 8/24/20 6:04 AM-3:18 PM. 4. Review of facility form titled, Start of Shift to Prevent COVID-19 Employee Screening Log, Staff P, CNA revealed she had a sore throat and muscle pain at the beginning of the shifts 7/19/20 and 7/20/20 and was not asked to go home. On 8/24/20, Staff P documented she had a cough at the beginning of her shift. Time card punch detail revealed she worked from 1:43 PM 8/24/20 until 2:30 AM 8/25/20. Staff P was tested for COVID-19 8/27/20 with positive results 8/27/20. 5. Review of facility form titled, Start of Shift to Prevent COVID-19 Employee Screening Log, Staff Q, CNA revealed she had new shortness of breath, vomiting and/or diarrhea, chills and headache intermittently from 7/26/20-8/23/20 and was not asked to go home. On 8/24/20, Staff Q documented symptoms that included new shortness of breath or difficulty breathing and headache. At the end of the shift on 8/24/20, Staff Q documented a temperature of 99.3. Time card punch detail revealed Staff Q worked 5:31 PM 8/24/20 until 6:46 AM 8/25/20. Staff Q was tested for COVID-19 on 8/28/20 and the results were positive. 6. A Minimum Data Set (MDS) completed for Resident #2 dated 6/9/20 revealed a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. The resident required extensive assist with transfers, dressing and personal hygiene. [DIAGNOSES REDACTED]. A care plan intervention dated 4/27/20 revealed potential risk for COVID-19 infection related to recent outbreak with interventions in place to reduce the risk of exposure and infection including all staff, providers, vendors to enter the front door to have temperature taken and screen performed prior to entering the facility. Form titled Analytical Report from the State Hygienic Laboratory revealed Resident #2 had lab drawn for COVID-19 detection on 8/27/20, analyzed on 8/29/20, released on 8/30/20 with positive results. Review of progress notes indicated resident passed away on 9/1/20 at 4:30 AM. 7. In an interview with the Director of Nursing on 9/1/20 at 2:30 PM, she revealed on 8/21/20 the facility had their first resident test positive for COVID-19. On 8/21/20,(NAME)County Public Health Department sent COVID-19 testing kits to the facility for staff and residents that had close contact with Resident #1 to be tested . On 8/25/20 received results that 3 staff members tested positive. On 8/27/20, the owner requested the Director of Nursing to test all of the residents that hadn't recently been tested . On 8/30/20 received results that 19 additional residents had tested positive. Observations: 8. During initial tour of the facility on 9/1/20 at 10:40 AM, observation revealed Staff A, Certified Nursing Assistant (CNA), cleaning off a resident's face without goggles or a face shield in place. 9. Observation on 9/1/20 at 3:20 PM, revealed Staff B, Laundry and Staff C, Housekeeping, conversing while standing less than 6 feet apart in front of the time clock located in the hallway. Staff B wore a mask below her nose and goggles on top of her head. After observation, Staff B pulled up her mask while goggles remained on top of her head. Staff C wore her goggles on top of her head. After observation, Staff C removed her goggles from on top of her head and placed them over eyes. 10. Observation on 9/2/20 at 9:50 AM, revealed Staff D, Registered Nurse (RN) sitting behind the nurse's station between the 100 and 200 hallway working on the computer. Staff D had her face mask hanging from her right ear and goggles on top of her head. Two staff stood at the medication cart less than 6 feet from Staff D. 11. Observation on 9/2/20 at 11:00 AM, revealed Staff E, Certified Medical Assistant (CMA) stood at the medication cart in the hallway with resident's rooms with goggles on top of her head. 12. Observation on 9/2/20 at 4:20 PM, revealed Staff F, CNA stood at the nurse's station near the main entrance without goggles or a face shield in place. Staff G, RN sat at the nurse's station working on the computer without goggles or a face shield. 13. Observation on 9/14/20 at 1:20 PM, revealed Staff C, Housekeeping, cleaning in room [ROOM NUMBER] with her goggles on her forehead above her eyes and her face mask on her chin. Two residents were present in the room at the time without facemasks. After observation, Staff C pulled her goggles down over her eyes and pulled her face mask over her mouth. 14. Observation on 9/15/20 at 12:00 PM, revealed Staff Q, CNA in the dining hall pushing a resident in a wheelchair to the dining room table with her face mask below her nose and her face shield pushed up above her nose. After observation Staff Q pulled her face shield down however her face mask remained below her nose. 15. In an interview with the Director of Nursing on 9/2/20 at 10:10 AM, she revealed she expected staff to wear a face mask, goggles/face shield at all times unless outside the facility or on break and no else is around them. 16. Observation on 9/2/20 at 10:45 AM, Staff J, Certified Medication Aide (CMA), took an Accucheck blood glucose meter into a resident's room and placed the meter on the resident's side table without a barrier. Following the blood glucose monitoring procedure, Staff J returned the meter to the medication cart and placed it on the cart without a barrier. After placing the meter on the cart, Staff J used a Wipe Out antibacterial wipe to wipe down the meter and then immediately placed the meter on a barrier on top of the medication cart to air dry. On the facility form titled, Blood Sugar Monitoring, under procedure it stated to follow manufacturer's directions for the equipment used in the facility. Per the Accucheck manufacturer's disinfecting procedures, the meter is to be kept wet with disinfection solution contained in the wipe for a minimum of 2 minutes. 17. In an interview with the Director of Nursing on 9/2/20 at 11:00 AM she revealed the Accucheck machines are shared between residents. She expected barriers used at all times in resident rooms and on medication carts with the Accucheck machines and they are to be wrapped in antibacterial wipes for 2 to 5 minutes following use. Abatement: The facility abated the immediate jeopardy to a F level on 9/8/20 by beginning to actively check staff temperatures, implementing new forms that would identify the staff member actively checking temperatures and education to staff on the new screening policies and forms. The State agency notified the facility of the immediate jeopardy on 9/3/20.