STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165264	A. BUILDING _____ B. WING _____	**05/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QHC MITCHELLVILLE, LLC	**114 CARTER STREET SW MITCHELLVILLE, IA 50169**

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 0684 **Level of harm -** 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** Based on observation, record review, staff and resident interviews, the facility failed to complete ongoing nursing assessments for residents identified with changes in medical condition for 8 of 8 residents reviewed. (Resident #2, #3, #1, #13, #12, #4, #6, #7). The facility failed to complete daily respiratory assessments during a COVID-19 infection outbreak in order to monitor residents' potential need for higher level of care. The facility reported a census of 41 (forty-one) residents. Findings include: 1. An admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 11 without signs/symptoms of [MEDICAL CONDITION]. A score of 11 indicated moderate cognitive impairment. The MDS recorded the resident spoke clearly and able to understand others and make herself understood. The MDS revealed the resident as totally dependent upon 1 person for eating. The MDS coded functional limitations in range of motion (ROM) on both sides of upper and lower extremities. The MDS recorded the presence of indwelling catheter and ostomy for bladder and bowel elimination. The MDS documented [DIAGNOSES REDACTED]. The BIMS assessment dated [DATE] recorded a score of 15. A score of 15 indicated intact cognition. The care plan focus areas initiated [DATE]6/20 identified the resident had a suprapubic catheter (tube put through the skin into the bladder), bilateral nephrostomy tubes (a thin tube put through the skin into the kidney), and a cecostomy (a thin tube placed through the skin into the first part of the large bowel). The care plan identified a self-care deficit related to impaired mobility and need for assistance with ADL (Activities of Daily Living). The care plan noted the resident totally dependent upon staff for all cares and able to verbalize her needs and preferences. The care plan interventions directed staff to monitor and provide for the resident's changing needs. On 4/24/20 the care plan identified a potential risk for COVID-19 infection related to a recent outbreak. The care plan directed staff to follow CDC updates and guidelines, follow CMS guidelines, monitor daily temperatures, and observe for signs/symptoms of COVID-19 infection such as temperature, cough, shortness of breath, chest pain, fatigue, and report to primary care physician. Review of the fluid intakes recorded [DATE]4/20 thru 4/24/20, revealed the intakes less than 720 mls (equivalent to 3 eight ounces glasses of water) on the following days: [DATE]4 thru [DATE]7, and [DATE]9 thru 4/23. Review of the outputs for urination recorded [DATE]4/20 thru 4/24/20 revealed the outputs less than 720 mls on the following days: [DATE]6, [DATE]7, and [DATE]9. The Progress Notes dated [DATE] at 3:20 p.m. documented the nurse assessed the residents nephrostomy tube as secured by clamps and the blue suture not in place at that time, however the tubes seemed to work effectively with urine return. The doctor directed if urine collection stopped or if the tube came out completely then the staff should contact the doctor. The Progress Notes dated 4/24/20 at 12:49 a.m. documented the resident complained of shortness of breath, felt warm, blood [MED]gen saturation (sats) reading 85% on room air, an order for [REDACTED]. The resident's temperature was 99.9 degrees, and [MED]gen sat still 87% on 3 liters [MED]gen per nasal cannula. The physician directed staff to transfer the resident to the ER (emergency room). At 10:36 a.m. the notes recorded the resident hospitalized for [REDACTED]. The Hospital Discharge Summary recorded the resident admitted to the hospital 4/24/20 and discharged [DATE]. The summary documented the principal problem as nephrostomy tube with clots and no longer secured. The Hospital Course section documented the resident presented with a chief complaint of shortness of breath with onset ten days prior to arrival. The entry recorded the resident did not have an order for [REDACTED]. At 4:45 p.m. the notes documented an assessment of the resident. The Admit/Readmit Screener dated effective 4/28/20 at 6:14 p.m. documented a full nursing assessment. On 5/8/20 at 1:48 p.m. Staff C, Registered Nurse (RN), reported working with just 1 nurse and 1 aide on the 2 p.m. to 10 pm. shift 5/1/20 and 5/3/20, and on 5/3/20 from 11:00 p.m. until 5/4/20 at 1:30 a.m. she was the only staff member in the building. Staff C reported she knew Resident #2's cares not done timely and needs not met. Staff C stated she could not perform rounds, as she had to make calls for help and answer call lights. Staff C commented she felt many residents declined overall. The Progress Notes dated 5/6/20 at 8:57 a.m. recorded Staff L, CMA (Certified Medication Aide) administered [MEDICATION NAME] tablet for chest pain (medication used to treat chest pain in people with a heart condition). At 9:09 a.m. Staff L wrote the [MEDICATION NAME] ineffective, blood pressure medications also given, and the resident assessed by the DON (Director of Nursing). At 9:12 a.m. Staff L recorded administration of another [MEDICATION NAME] tablet. At 9:34 a.m. Staff L documented the [MEDICATION NAME] effective. At 10:06 a.m. Staff L recorded administration of [MEDICATION NAME] for nausea. At 10:46 a.m. Staff L documented the [MEDICATION NAME] effective. The clinical record lacked documentation of the DON's assessment of the resident or vital sign measurements on 5/6/20. On 5/7/20 at 4:30 p.m. the DON voiced she worked long hours on-call so she couldn't get anything done. The DON stated she was new with no training but she tried to provide the most care she could and focused on essential needs as a nurse. The DON commented they had bed-ridden, weakened residents with no one to help the residents. The DON stated staff should document respiratory surveillance in the MAR (Medication Administration Record) and also the residents' temperatures taken daily. The DON said she asked the questions from the checklist related to respiratory symptoms of all residents she personally encountered each day . The DON stated the goal was to keep the current healthy residents healthy. The DON commented staff provided the basic nursing needs and kept up on resident status. Review of the Progress Notes from 4/28/20 at 4:45 p.m. to 5/8/20 at 3:49 pm. revealed no nursing assessments documented. On 5/8/20 at 7:22 p.m. Resident #2 reported she would sweat badly and felt something wrong with her. Resident #2 stated she requested a nurse assess her but they never came in to assess that day (5/8/20). Resident #2 stated she hardly ever got fevers. Resident #2 said sometimes she never saw a nurse all day, even when she asked to. Resident #2 reported the day before she had nasal drainage rolling out of her nose, a shaking feeling, and felt something going on-a change in her health status. The late entry Progress Note created 5/9/20 at 3:56 p.m., dated for 5/8/20 at 3:49 p.m., revealed an assessment of the resident's open areas, nephrostomy tubes, suprapubic catheter, and cecostomy. The Progress Notes dated 5/10/20 at 5:08 a.m. documented a Transfer/Discharge Summary note. The entry recorded the resident complained of stabbing chest pain, crushing feeling in the chest, cold sweats, upset stomach, headache, and just not feeling right. The entry documented vital signs of a low blood pressure reading 92/64, pulse 84, respirations 16 per minute, blood [MED]gen reading of 93% on room air, and blood pressure reading up to a normal level at 117/81. The resident continued to complain of headache and crushing feeling in the chest and the facility received a physician order [REDACTED]. The Fire Department Prehospital Care Report dated 5/10/20 documented the care provided for Resident #2. The report recorded a blood pressure at 5:10 a.m. of 95/71 (low) and pain rating of 9 (on a 0 to 10 scale with 10 the worst pain imaginable). At 5:34 a.m. the blood pressure reading 191/108 (very high) and the resident received 4 liters of [MED]gen. The report documented the resident complained of chest pain and stabbing/crushing pain all over her body with an upset stomach. At 5:37 a.m. the resident's blood pressure even higher at 207/178 and nitro sublingual spray given ([MEDICATION NAME] liquid absorbed under the tongue). At 5:40 the blood pressure 173/147 and at 5:42 a.m. another [MEDICATION NAME] dose given. At 5:45 a.m. the blood pressure reading 185/153 (remained

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) very high). The ER After-Visit Summary printed 5/10/20 at 8:03 a.m. identified the reason for visit as chest pain and the end of visit vitals blood pressure reading of 113/72 (normal). The Progress Notes lacked documentation of when the resident returned to the facility 5/10/20 or a nursing assessment upon return. Observation on 5/10/20 at 5:52 p.m. revealed Resident #2 laid in bed. On 5/10/20 at 5:55 p.m. Staff H, CNA from temporary staffing agency, reported Resident #2 out to hospital that day; she thought the resident came back but she wasn't sure. On 5/11/20 at 9:53 a.m. Staff L, CMA, wrote the resident admitted to the hospital per nurse. However, at 6:11 p.m. Staff J, RN, documented the resident had a good day with no complaints of chest pain only muscle aches. Staff J recorded doing an assessment on the resident. On 5/13/20 at 1:08 p.m. Staff M, CNA, reported to Staff F, Licensed Practical Nurse (LPN), that Resident #2 complained of a severe migraine. Staff F commented something about Resident #2's behaviors to which Staff M responded she was just making sure to let Staff F (a nurse) know. Staff M stated she left Resident #2's call light on as she had not yet met the resident's need/request. On 5/13/20 at 1:27 p.m. Staff F sat at the nurses station and did not go to Resident #2's room. At 1:33 p.m. the DON said she would check on Resident #2. The Progress Notes lacked documentation on 5/13/20 from 3:06 a.m. to 7:00 p.m. of the report the resident complained of a migraine or of an assessment of the resident. At 7:00 p.m. an agency nurse recorded administration of [MEDICATION NAME] (pain medication). The entry contained no assessment of the pain location or characteristics. At 9:58 p.m. the notes recorded [MEDICATION NAME] administered but no reason given. At 11:36 p.m. the notes documented the [MEDICATION NAME] and [MEDICATION NAME] effective. Observation on 5/15/20 at 1:15 p.m. revealed a sign on Resident #2's door recorded the resident in 14-day precautions until 5/24/20. Review of the Assessments tab of the electronic medical record revealed only one nursing assessment listed from 4/28/20 thru 5/19/20. The list contained an Admit/Readmit Screener assessment dated [DATE] with status documented as In Progress. The Progress Notes dated 5/19/20 at 2:29 a.m. recorded the resident's call light on most of the shift and complained of feeling cold even with 4 blankets yet she sweated. The entry documented a focused nursing assessment of the resident with vital sign measurements. Review of the fluid intakes recorded 4/28/20 thru 5/20/20, revealed the intakes less than 720 mls on the following days: 4/28, 4/29, 5/1 thru 5/9, 5/13, 5/15, 5/16, and 5/20. Review of the outputs for urination recorded 4/28/20 thru 5/22/20 revealed the outputs less than 720 mls on the following days: 4/28, 4/29, 4/30, 5/3, 5/4, 5/8, 5/9, 5/12. The Progress Notes dated 5/20/20 at 2:30 p.m. documented the resident's left side nephrostomy tube not draining urine and only dark red blood. The entry recorded the resident stated she did not feel well and she felt light headed. The DON wrote vital signs measured and within normal limits (WNL) but no values documented. At 2:40 p.m. the DON wrote doctor notified of resident status and the resident sent to the ER. On 5/21/20 at 10:30 a.m. the DON stated she expected nurses to assess residents every day as part of quality of care, and nurses should complete assessments. In response to the CNA Staff M reporting Resident #2 had a severe migraine on 5/13/20, the DON said she hoped Staff M reported Staff F, LPN, if she did not assess the resident after Staff M's report. The DON acknowledged Staff F should have assessed Resident #2 and documented the assessment in the progress notes. The DON stated she expected Staff F to complete basic contact with Resident #2 after Staff M reported the migraine. The DON reported Resident #2 transferred to the hospital that day (5/21/20) due to blood present in her nephrostomy tubes. The DON stated she did not know Resident #2's hospital admitting [DIAGNOSES REDACTED]. The DON stated when staff documents items on the 24-hour nurse report sheet it means staff should complete hot charting morning and nights. The DON identified hot charting meant the nurse charts an assessment on the resident each shift, monitoring for things like fever, sore throat, shortness of breath, or changes in condition. The DON said assessments and documentation should continue for 72 hours (3 days) minimum. The Progress Notes dated 5/22/20 at 10:19 a.m. documented the resident returning from the hospital and tested positive for COVID-19 on 5/20/20 and 5/21/20. The entry revealed the resident showed no symptoms at that time. The Weights and Vitals Summary form identified the only vital sign assessments completed from [DATE]4/20 thru 5/13/20 for blood pressure, pulse, and respirations occurred on 4/21/20 and 5/12/20 and blood [MED]gen saturation values recorded on 4/21/20, 4/30/20, and 5/12/20. Review of the clinical record revealed it lacked documentation of daily respiratory assessments for signs/symptoms of COVID-19 screening as recommended by CDC and CMS guidelines (i.e. shortness of breath, sore throat, or cough) from [DATE]4/20 thru 5/20/20 except for the 4/28/20 readmission nursing assessment. 2. Resident #3's quarterly MDS assessment dated [DATE] revealed severe cognitive impairment with continuous behavior of inattention, disorganized thinking, and fluctuating level of consciousness. The resident was totally dependent upon 2 persons for bed mobility, transfers, dressing, toilet use, and totally dependent upon 1 person for eating. The MDS revealed [DIAGNOSES REDACTED]. The care plan focus area initiated 10/16/17 identified a potential for dehydration/fluid deficit related to unable to drink independently requiring staff assistance. The interventions included to educate the resident, family, and caregivers on the importance of fluid intake; monitor vital signs as ordered per protocol, record, and notify the physician of significant abnormalities; and monitor, document, and report as needed any signs or symptoms of dehydration. The care plan focus area initiated 4/24/20 identified a potential risk for COVID-19 infection related to a recent outbreak and reflected the resident tested positive for COVID-19 infection on [DATE]7/20. The care plan directed staff to follow CDC updates and guidelines, follow CMS guidelines, monitor daily temperatures, and observe for signs or symptoms of COVID-119 infection such as temperature, cough, shortness of breath, chest pain, fatigue, and report to the primary care physician. The facility line listing for the public health department related to COVID-19 provided on 5/8/20 documented Resident #3 resided in room [ROOM NUMBER]-A, illness onset [DATE]3/20 of shortness of breath, cough, fever, and fatigue; tested positive [DATE]9/20, and status hospitalized , returned 4/27/20. Review of the clinical record revealed no documentation of daily respiratory assessments for signs/symptoms of COVID-19 screening as recommended by CDC and CMS guidelines from 4/2/20 thru [DATE]4/20. The Progress Notes dated [DATE]4/20 at 11:53 a.m. recorded a Nutrition/Dietary note written by the Registered Dietician (RD). The RD wrote the resident did not feel well and per nursing, the resident ran a fever last reported to be 100.6 degrees and nursing pushed fluids. The Progress Notes dated [DATE]5/20 at 12:45 p.m. recorded the resident continued to gag on solids and liquids after taking approximately an ounce of fluids at lunch, started to gag with small emesis, lung sounds slightly diminished in the bases, no cough or increased difficulty breathing, temperature 101 degrees, and no evidence of increased pain. The entry revealed the facility sent a fax to the doctor to notify of the resident's condition and new orders requested. The physician fax form dated [DATE]5/20 and signed by the physician [DATE]9/20 revealed the following: a. on [DATE]4/20 the resident's temperature 100.6 degrees with pulse 96 (beats per minute), respirations 18 (per minute), and blood [MED]gen level 92% b. on [DATE]5/20 temperature 100.9 degrees with pulse 103, respirations 20, and blood [MED]gen level 90% c. the resident had episodes of choking/aspiration at meals and experienced labored breathing with short, quick respirations; lung sounds clear to auscultation with bilateral lung bases diminished d. order for portable chest x-ray The Progress Notes dated [DATE]5/20 at 1:21 p.m. identified a call to the doctor at 12:53 p.m. related to the resident's declining status, increased temperature to 101.2 degrees with fever reducers administered, and the resident continued to choke, vomit on food and fluids. A new order received for a portable chest x-ray. At 3:30 p.m. the chest x-ray completed. The Progress Notes lacked documentation of the resident's labored breathing and quick respirations as reported to the physician on the fax form. The chest x-ray results dated [DATE]5/20 documented the indication for the diagnostic test as: elevated temperature with vomiting. The chest x-ray identified mild patchy opacification (consolidation) in the left lower lobe, which could represent a developing infiltrate (associated with pneumonia) or [CONDITION] (collapse of air spaces). The Progress notes dated [DATE]6/20 at 3:38 a.m. documented the resident's temperature 101.1 degrees, then down to 99.8 after administration of [MED]. The nurse assessed a productive cough and noted the chest x-ray results. The entry lacked a full assessment of the resident's respiratory status. At 12:57 p.m. of the same date, the facility updated the physician of the following the resident's temperature 102.5 degrees, pulse 104, respirations 20 with audible wheezing, and blood pressure 180/90, and [MED]gen level 92% on 2 liters. The physician responded by ordering a clear liquid diet and [MED] (antipyretic) suppository as needed every 4 hours. Progress Notes on [DATE]6/20 did not contain any other nursing assessments. A late entry Progress note created by the DON on 4/20/20 at 9:30 a.m., dated effective [DATE]7/20 at 10:24 a.m., documented the facility contacted the resident's family to inform them of a positive COVID-19 test result from another resident. At that time, the family received a report on the resident's status of continued decline, short labored breathing, audible wheezing throughout (lungs), bilateral (lungs) diminished in the bases, and increased respirations, blood pressure, and pulse with declining O2 ([MED]gen level). The facility also reported low intake of food and fluids and continued climb of fever even with fever reducers. The DON asked the family if they would like to send the resident out for further evaluation and COVID-19 testing. The COVID 19 testing results would be completed slightly quicker than what the facility could provide by sending the test to a lab. The resident's family stated they would like the resident sent out for more rapid evaluations and testing due to the resident's rapid, continued decline. The Progress Notes dated [DATE]7/20 at 11:00 a.m. documented the facility updated the physician of resident's symptoms of

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) temperature 103.4 degrees, pulse 92, blood pressure 92/66 (low) and respirations 22. The physician directed staff to transfer the resident to the ER for evaluation and treatment of [REDACTED]. The Transfer/Discharge Report dated [DATE]7/20 at 11:15 a.m. documented a temperature of 103.4 degrees, blood pressure of 92/66 (low), pulse 92, respirations 22, and the resident nauseated- unable to take meds or keep down any liquids. The nurse assessed rales (abnormal rattling sound) in the upper and lower lungs. The Progress Notes dated [DATE]9/20 at 10:24 a.m. recorded the resident admitted to the hospital with [REDACTED]. The hospital Discharge Face Sheet recorded the resident tested positive for [DIAGNOSES REDACTED]-CoV-2 (COVID-19) infection on [DATE]8/20. The hospital History and Physical Consultation printed 4/27/20 documented the resident presented to the Emergency Department (ED) on [DATE]7/20 with a fever that started the previous night and persisted. Evaluation revealed mild [MEDICAL CONDITION] (low blood [MED]gen level) and [MEDICAL CONDITION] (high blood sodium level) with lab result critical at 160 mEq/liter (milliequivalents per liter). High sodium levels can indicate dehydration. The Assessment/Plan subsection recorded [DIAGNOSES REDACTED]. The kidney consultation identified the resident as hypernatremic with an estimated fee water deficit of 6.1 liters and treatment included giving 2 liters of IV fluids in the emergency room . The Progress Notes dated 4/27/20 at 5:41 p.m. recorded the resident readmitted to the facility and a nursing assessment completed. The Admit/Readmit Screener dated effective 4/27/20 at 5:14 p.m. documented a full nursing assessment. The Progress Notes lacked documentation of any further nursing assessments from 4/27/20 thru 5/15/20. Review of the Assessments tab of the electronic medical record (EMR) revealed only one nursing assessment listed from 4/2/20 thru 5/13/20. The list contained an Admit/Readmit Screener assessment dated [DATE] with status documented as In Progress. Review of the resident's fluid intakes dated [DATE]2/20 thru 5/20/20, revealed the intakes recorded less than 720 mls on the following days: [DATE]2 thru [DATE]7, ([DATE]8 thru 4/27 the resident hospitalized), and 4/28 thru 5/20. The Weights and Vitals Summary documented the only vital sign assessments completed from [DATE]/20 thru 5/13/20 for blood pressure, pulse, and respirations occurred on [DATE]4 and 4/27 and blood [MED]gen saturation values recorded on [DATE]7, 4/27, 4/30, and 5/1. The temperature summary included values on 4/9 of 99.8 degrees, on [DATE]5 of 101.1 degrees, and on [DATE]7 of 103.4 degrees. 3. An annual MDS assessment dated [DATE] for Resident #1 identified a BIMS score of 15 (no cognitive impairment) without signs or symptoms of [MEDICAL CONDITION]. The MDS documented [DIAGNOSES REDACTED]. The care plan focus area initiated 4/24/20 identified a potential risk for COVID-19 infection related to a recent outbreak. The care plan directed staff to follow CDC updates and guidelines, follow CMS guidelines, monitor daily temperatures, and observe for signs/symptoms of COVID-119 infection such as temperature, cough, shortness of breath, chest pain, fatigue, and report to primary care physician. On 4/25/20, the care plan updated to reflect the resident tested positive for COVID-19 infection. The facility line listing for the public health department related to COVID-19 provided on 5/8/20 documented Resident #1 resided in room [ROOM NUMBER]-B, illness onset 4/20/20 of low grade fever, cough, and runny nose; tested positive 4/25/20, and status hospitalized , returned 4/28/20. Review of the clinical record revealed it lacked documentation of daily respiratory assessments for signs/symptoms of COVID-19 screening as recommended by CDC and CMS guidelines from 4/2/20 thru 4/20/20. The Progress Notes dated 4/20/20 at 10:57 a.m. documented information given to the doctor's office the resident not positive at that time for COVID-19 but with a low grade fever that morning of 99.6 degrees. The Progress Notes dated 4/21/20 at 5:43 a.m. documented the resident continued with a low grade fever of 100.1 degrees, denied cough or feeling bad, and more tired that shift sleeping through completion of a blood sugar check. At 2:12 p.m. the notes revealed the resident with no complaints of a sore throat, increased difficulty breathing, cough, or pain; temperature 97.3 degrees with clear lung sounds. The Progress notes documented the next assessment occurred on 4/22/20 at 3:04 p.m. and the resident still presented with a slight cough, but no fever or other complaints. The entry lacked documentation of a full respiratory nursing assessment. The Progress Notes dated [DATE] revealed no documentation and no nursing assessments completed. The shift summary Progress Notes dated, 4/25/20 at 7:17 a.m., documented at 9:30 p.m. the resident's blood [MED]gen level reading of 85% while the resident slept and when awakened the reading up to 91 to 92%. The entry recorded the resident without fever. At 1:00 a.m. the [MED]gen level measured 82% with temperature 99.8 degrees. Staff applied [MED]gen at 2 liters per cannula due to the [MED]gen reading not improving when the resident awakened. After applying the [MED]gen, the resident [MED]gen saturation increased to 92%. Staff contacted the physician and the resident transported to the hospital and admitted to the hospital with [REDACTED]. The resident rested easy without complaints other than feeling tired. An assessment of the resident;s lungs revealed the lungs diminished in the bases. The entry lacked a full respiratory nursing assessment. Progress Notes dated 4/28/20 at 12:15 p.m. documented the resident readmitted to the facility after hospitalization for COVID-19 positive with complications. The entry recorded a completed nursing assessment. The resident stated she felt tired and ready to rest. The Admit/Readmit Screener dated effective 4/28/20 at 2:00 p.m. documented a full nursing assessment. The Progress Notes lacked documentation of any further nursing assessments from 4/28/20 thru 5/15/20. Review of the Assessments tab of the EMR revealed only one nursing assessment listed from 3/3/20 thru 5/13/20. The list contained an Admit/Readmit Screener assessment dated [DATE] with status documented as In Progress. The Weights and Vitals Summary documented the only vital sign assessments completed from [DATE]2/20 thru 5/13/20 for blood pressure, pulse, and respirations occurred on 4/20. Blood [MED]gen saturation values recorded only on 4/20, 4/24, and 5/1. On 5/12/20 at 3:00 p.m. Resident #1 reported she was hospitalized due to the COVID-19 infection but felt much better that day. Resident #1 stated she wondered if she could get re-tested . 4. A readmission MDS assessment dated [DATE] for Resident #13 identified the resident's original admitted as 10/9/18 with the most recent entry dated 3/34/20. The MDS coded the presence of an indwelling catheter. The MDS documented [DIAGNOSES REDACTED]. The MDS coded special treatments of [MED]gen therapy and isolation or quarantine for active infectious disease while a resident. The care plan focus area initiated 2/1/19 identified altered urinary elimination related to [DIAGNOSES REDACTED]. On 2/22/19, the care plan identified a risk for infection related to recent hospitalization [MEDICAL CONDITION] and catheter use. The care plan directed staff to monitor encourage fluids unless contraindicated and frequently monitor for signs or symptoms of infection and notify the doctor if changes found. On 4/24/20, the care plan identified a potential risk for COVID-19 infection related to a recent outbreak. The care plan directed staff to follow CDC updates and guidelines, follow CMS guidelines, monitor daily temperatures, and observe for signs/symptoms of COVID-119 infection such as temperature, cough, shortness of breath, chest pain, fatigue, and report to primary care physician. The facility line listing for the public health department related to COVID-19 provided on 5/8/20 revealed Resident #13 resided in room [ROOM NUMBER]-B, asymptomatic in the facility; and tested negative 4/28/20. Progress Notes dated 3/21/20 at 8:39 a.m. identified the resident with an elevated temperature of 101.1 degrees during a routine assessment. The vitals measured: blood pressure 149/60, pulse 90, respirations 20, and blood [MED]gen reading of 92% on room air. The nurse assessed even, unlabored respirations with no acute distress, complaints of coughing and wheezing during the night, and denied shortness of breath. A telephone order dated 3/21/20 contained physician orders [REDACTED]. Progress Notes dated 3/23/20 at 12:32 a.m. revealed the resident admitted to the hospital for UTI (urinary tract infection) and other low electrolytes. Progress Notes dated 3/24/20 at 3:53 p.m. revealed the resident readmitted from the hospital and staff completed a full nursing assessment. Progress Notes dated 3/25/20 at 3:49 a.m. documented the resident continued [MEDICATION NAME] (antibiotic) every day and the foley catheter patent and draining. At 3:20 p.m. the notes included the resident readmitted on antibiotic for UTI treatment, foley catheter intact and patent, and an occasional dry non-productive cough present. Progress Notes contained documentation of nursing assessments on 3/26, 3/27, 3/28, and 3/30 related to the resident's urinary status. The Progress Notes included only the following documentation pertaining to urinary assessments 3/31/20 thru 5/10/20: a. On 4/4/20 at 2:25 a.m., the foley catheter plugged and leaked so staff inserted a new catheter with urine present in the new drainage bag and no complaints from the resident. b. On [DATE]0/20 at 6:51 p.m., the resident refused the catheter flush. c. On [DATE]1/20 at 1:09 a.m., the resident's catheter would not flush and staff inserted a new catheter. At 1:10 a.m. the notes added staff changed the catheter per sterile technique due to previous catheter clogged with no output for 3 hours. d. On [DATE]3/20 at 7:49 p.m., staff changed the resident's foley catheter using sterile technique due to inability to flush the catheter. After insertion of the new catheter staff observed immediate return of a thick yellow mucus clot then light clear urine in tubing and into the down drain bag. The resident denied any urinary pain or discomfort at that time. e. On [DATE]4/20 at 1:17 p.m., while assisting with peri-care, staff noted the bulb of the foley catheter crowning (coming out of the entrance to the body). The nurse deflated the bulb, removed the catheter and replaced it with a new catheter without difficulty with immediate return of clear yellow urine. Late entry Progress Notes dated [DATE]7/20 at 8:38 a.m. documented the DON informed the family of another resident testing positive for COVID-19 infection. The DON wrote she reassured family the resident did not show any signs or symptoms of COVID 19 at that time and appeared in good health. The late entry Progress Notes dated 4/28/20 at 11:08 a.m. documented the resident's COVID-19 test results negative. Review of the clinical record revealed it lacked

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	165264	A. BUILDING _____ B. WING _____	**05/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QHC MITCHELLVILLE, LLC	**114 CARTER STREET SW MITCHELLVILLE, IA 50169**

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 -** Actual harm **Residents Affected -** Some	(continued... from page 3) documentation of daily respiratory assessments for signs/symptoms of COVID-19 screening as recommended by CDC and CMS guidelines from 4/2/20 thru 5/10/20. Review of the Assessments tab of the EMR revealed no nursing assessments listed from [DATE]/20 thru 5/10/20. The Weights and Vitals Summar
F 0692 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, staff and family interviews, the facility failed to ensure residents received adequate and timely dining assistance to avoid weight loss of greater than 5% in 1 month or 10% in 6 months for 7 of 7 residents reviewed for significant weight loss (Resident #2, #3, #6, #7, #8, #10, #12). Two additional residents reported not receiving fluids and assistance devices for drinking (Resident #4 and Resident #1) The facility failed to complete nutritional assessments for residents who showed weight loss. The facility failed to offer adequate hydration and failed to monitor residents for dehydration when dietary services decreased the amount of fluids given at meals, from 720 milliliters (mls) to 240 mls consistently, and stopped offering drinks with snacks between meals at the onset of a COVID-19 outbreak in the facility. Significant weight loss occurred for 7 residents and a serious adverse outcome likely due to the ongoing lack of timely dining assistance for dependent residents led to the potential for more weight loss. In addition, the lack of sufficient hydration for all residents led to increased risk of UTIs (urinary tract infection) and dehydration. Resident #3 received hospitalization for signs/symptoms of dehydration. An immediate jeopardy concern identified on 5/11/20. The facility abated the concern on 5/14/20. The facility reported a census of 41 (forty-one) residents. Findings include: 1. An admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 11 without signs/symptoms of [MEDICAL CONDITION]. A score of 11 indicated moderate cognitive impairment. The MDS revealed the resident spoke clearly and could understand others and make herself understood. The MDS identified the resident as totally dependent upon 1 person for eating. The MDS coded functional limitations in range of motion (ROM) on both sides of upper and lower extremities. The MDS documented [DIAGNOSES REDACTED]. The MDS recorded a weight of 153.0 lbs. (pounds). A discharge summary for a hospital admitted d 4/24/2020 through 4/28/2020 identified the reason for the admission as problem with urinary catheter-nephrostomy tube with clots and no longer secured. The resident's BUN (blood urea nitrogen) was 8 (normal) and creatinine 0.53. A BIMS assessment dated [DATE] recorded a score of 15. A score of 15 indicated intact cognition. Care Plan: Care plan focus areas initiated [DATE]6/20 identified the resident utilized a suprapubic catheter (tube put through the skin into the bladder), bilateral nephrostomy tubes (a thin tube put through the skin into the kidney), and a cecostomy (a thin tube placed through the skin into the first part of the large bowel). The care plan identified a self-care deficit related to impaired mobility as manifested by need for assistance with ADL (Activities of Daily Living) and the resident on quarantine/isolation precautions for 2 weeks due to being a new admit. The care plan interventions informed staff the resident needed fed by staff assist. On 4/24/20, the care plan identified a potential risk for COVID-19 infection related to a recent outbreak. The care plan directed staff to shelter in place and provide in-room meal service. On 4/28/20, the care plan identified a nutrition risk related to picky preference, mental status as evidenced by reported poor intakes from staff, and medical history of [REDACTED]. Care plan interventions directed staff to: assess nutritional status quarterly and as needed; assist with meals as needed; honor likes and dislikes; monitor and provide for resident's changing needs; monitor and record intakes; monitor weights as ordered; notify the doctor and dietary of significant weight changes; obtain weight weekly x 4 weeks then monthly, and as needed if stable, at the same time of day, document accordingly; provide house supplement as ordered 60 mls (milliliters) per day, mix with ice cream as needed; RD (Registered Dietician) to review quarterly and as needed; and serve the diet ordered. Record Review: Progress Notes dated 4/22/20 at 11:03 p.m. revealed a meeting held with dietary on 4/21/20 concerning the resident's medical condition, dependency on staff for repositioning and transfers, and pressure sores upon admission located on the right and left gluteal creases with delayed wound healing. The note recorded the resident denied wanting breakfast so she did not receive adequate nutrition intake regularly. The facility sent a facsimile (fax) to the physician requesting orders for supplements and continue weekly weight measurements. Physician orders [REDACTED]. Progress Notes dated 4/28/20 at 11:22 a.m. revealed a Nutrition/Dietary Note. The entry revealed a current weight of 153.0 lbs with no weight history available and no meal intakes recorded. The RD documented the resident reported she did not like the food and did not eat much on her regular diet. The entry documented the resident had two stage 2 pressure ulcers with a recent hospitalization for UTI (Urinary Tract Infection) from 4/24/20 to 4/28/20. The RD directed staff to contact the RD with any new nutrition concerns. A Nutritional Risk assessment dated [DATE] categorized the resident as a medium nutritional risk. The assessment recorded a weight measurement done on [DATE]4/20 of 153.0 lbs. The assessment documented interventions that included: continue house supplement 60 ml per day mixed with ice cream if needed, continue weekly weight checks, once quarantine lifted encourage to come to dining room for meals, record all meal/snack intakes, encourage high protein choices at meals/snacks, and contact the dietician with any new concerns. Review of the clinical record revealed a lack of documentation pertaining to weekly weight measurements as care planned and per dietician recommendations. The Weights and Vitals Summary dated 5/27/20 documented only 2 weights: a. [DATE]4/20 - 153 lbs b. 5/4/20 - 144.6 lbs Comparison of the 2 weight values showed a significant weight loss of -5.5% or -8.4 lbs in less than 1 month. Review of the clinical record revealed a lack of a nutrition assessment by the Registered Dietician on or after 5/4/20. Progress Notes dated 5/6/20 at 4:04 p.m. documented the Activities Director assisted the resident to obtain hot tea as the resident preferred it when she was sick. The note recorded the resident reported CNAs refused to get her tea and one aide told her she already had water, drink the water. An ED (emergency department) note dated 5/10/2020 identified the resident's weight as 145 pounds. The resident's BUN measured 12 (normal) and creatinine 0.53 (normal) Progress Notes dated 5/12/20 at 3:03 p.m. identified a new order received to discontinue med pass (house supplement) as the resident refused it stating she was allergic to it. Progress Notes from 5/4/20 thru 5/27/20 contained no documentation pertaining to the weight measurement obtained on 5/4/20 or that it showed a significant weight loss. Review of the fluid intakes recorded [DATE]4/20 thru 5/20/20, revealed the intakes less than 720 mls (equivalent to 3 eight ounces glasses of water) on the following days: [DATE]4 thru [DATE]7, [DATE]9 thru 4/23, 4/28, 4/29, 5/1 thru 5/9, 5/13, 5/15, 5/16, and 5/20. Review of the outputs for urination recorded [DATE]4/20 thru 5/22/20 revealed the outputs less than 720 mls on the following days: [DATE]6, [DATE]7, [DATE]9, 4/28, 4/29, 4/30, 5/3, 5/4, 5/8, 5/9, 5/12. On 5/8/20 at 1:48 p.m. Staff C, Registered Nurse (RN), confirmed she worked Friday 5/1/20 from 6:00 p.m. to 6:00 a.m. Staff C reported she worked with just 1 CNA (Certified Nurse Assistant) from 2 p.m. to 10 p.m. and also from 10 p.m. to 6:00 a.m. Staff C voiced when she arrived on 5/1/20 at 6 p.m. she was told it was a rough day and the kitchen staff did not pass trays. Staff C stated she and the 1 CNA passed the meals. Staff C stated she knew who needed assistance as one of the nurses kept a list due to the facility utilizing so many agency staff. The list contained at least a dozen resident names. Staff C stated that on 5/1/2020 an additional 3 residents on the 100 hall needed assistance who normally fed themselves. Staff C stated Resident #2 wanted pizza instead of the main meal, but Staff C could not get it for her right away. Staff C said around 8:00 p.m. she took Resident #2 the pizza and when Staff C came back later to administer medicine, she realized the resident needed assistance to eat so Staff C helped her eat at that time. Staff C stated she ran around crazy and reported some residents did not receive dining assistance. Staff C confirmed she also worked 6:00 p.m. to 6:00 a.m. on Sunday 5/3/20 into Monday 5/4/20. Staff C reported again only 1 CNA, Staff D from a temporary staffing agency, worked from 2:00 p.m. to 11:00 p.m. Staff C stated when she arrived on-duty at 6:00 p.m. 5/3/20, Resident #2 reported she did not drink all day. Staff C stated Resident #2 had four different drainage tubes, and could not use her hands to drink so Staff C made her a big jug to drink. Staff C commented during normal circumstances (prior to the COVID-19 outbreak) residents ate in the dining room at 6:00 p.m. when she arrived to work. Staff C said now the dietary staff just gave trays to residents and left the building by 6:15 p.m. Staff C identified issues with trying to document intakes for Resident #2. On 5/8/20 at 6:22 p.m., Resident #2 complained staff gave her milk and she was allergic to it. Resident #2 reported she asked for a substitute and they brought her cottage cheese. Resident #2 stated she did not think they gave food she could tolerate and without enough calories causing a 10 pound weight loss in 3 weeks. Observation revealed the resident's supper tray container sat on her bedside table and Resident #2 reported it sitting there for 15 to 20 minutes. Resident #2 identified herself as hungry and wanting to eat but could not as she required assistance from staff. The resident stated she could not move her own extremities. Resident#2 reported staff brought in her food container and told her they would return. Staff informed the resident that needed to eat last because she took a long time to eat. Resident #2 identified her food as always cold by the time staff could assist her. Continuous observation on 5/8/20 revealed at 6:29 p.m. no staff assisted Resident #2 with eating. At 6:39 p.m. Staff G, CNA from temporary staffing agency, entered to assist Resident #2 to eat and Resident #2 reported her food was cold. Staff G left the room and said she would

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F 0692 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) tell the nurse. On 5/8/20 at 7:22 p.m., Resident #2 sat up in her wheelchair in her room. Observation revealed two green water pouches with tubes and mouthpieces for drinking with both placed in a straight back chair out of reach of Resident #2 and one of the tubes/mouthpieces in contact with the floor. Observation revealed the push pad call light not clipped to the resident's gown and falling down out of reach on the left side of the resident's arm. Resident #2 commented the call light needed clipped to her right side in order for her to activate it with her fist. Observation revealed both of the resident's arms contracted. Resident #2 became tearful and upset that she could not reach her water pouches to take a drink or call for help to drink. In addition, Resident #2 voiced she did not know when or if staff ever cleaned the water pouches and now the mouthpiece was dirty from the floor. Resident #2 stated the staff constantly talked about her in front of her about the resident eating slowly and taking an hour to assist with eating. Resident #2 stated due to not getting fluids she got dehydrated. She did not know if the water pouches got moldy, as she did not know when they washed the pouches. Resident #2 reported because she was starving she just ate the cottage cheese for supper that night and Staff G reheated her food. Resident #2 responded she was not sure if the food was the same originally served. Resident #2 said she only ate breakfast twice by choice and identified lunch experience as worse. Resident #2 responded nursing management never come to assist her to eat. Observation on 5/10/20 at 5:52 p.m. revealed Resident #2 laid in bed. At 5:55 p.m. Staff H, CNA from temporary staffing agency, reported Resident #2 out to hospital that day and came back. Staff H did not know if Resident #2 refused supper or if someone assisted her to eat yet. At 6:28 p.m. Staff G asked Staff H if she assisted Resident #2 to eat yet and everyone looked for the resident's food container but did not locate it. At 6:30 p.m. Staff Q, contracted Dietary Aide, responded if staff could not find Resident #2's food container then they had access to the snack container. At 6:36 p.m. Staff X, CNA from temporary staffing agency, went in to see if Resident #2 ate yet then went to the kitchen to request they get the resident some green beans. 2. A quarterly MDS assessment dated [DATE] for Resident #3 identified severe cognitive impairment with continuous behavior signs of inattention, disorganized thinking, and fluctuating level of consciousness. The MDS identified the resident as totally dependent upon 1 staff for eating. The MDS coded functional limitations in ROM on both sides of upper and lower extremities. The MDS documented [DIAGNOSES REDACTED]. The MDS recorded a weight value of 174.0 lbs. and indicated a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Care Plan: The care plan focus area initiated 10/16/17 identified a potential for dehydration/fluid deficit related to the resident unable to drink independently requiring staff assistance. The care plan interventions included to educate the resident, family, and caregivers on the importance of fluid intake. The care plan identified a self-care deficit related to impaired mobility, impaired cognition, incontinence, and the resident unable to voice wants/needs so staff must anticipate them. The care plan directed staff to assist the resident with eating. The care plan identified a potential for alteration in nutrition related to [DIAGNOSES REDACTED]. The resident required puree diet texture and nectar thickened liquids. A care plan update, dated April 2020, documented the resident with inadequate energy intake related to poor appetite, fever, and not feeling well as evidenced by not eating meals. Nursing reported the resident drank liquids. A weight loss of -13.8 lbs in 4 months and -17.8 lbs in 5 months recorded. Care plan interventions included to provide nutritional assistance with meals and the RD to assess nutritional status, quarterly, annually, and as needed. Progress Notes dated [DATE]4/20 at 11:53 a.m. recorded a Nutrition/Dietary note written by the RD. The RD wrote the resident did not feel well and ran a fever last reported as 100.6 degrees, Nursing pushed fluids. The RD identified the resident's current weight as 174.0 lbs with weight trending down and almost significant with -2.25% in 1 month, -7.35% or -13.8 lbs in 3 months, and -9.28% or -17.8 lbs lost in 6 months. The RD wrote meal intakes on pureed diet with nectar thick liquids presumed inadequate as the resident did not feel well and mainly drank fluids. The RD wrote with poor intakes, fever, and almost significant weight loss, the RD recommended house supplement 60 mls per day for 30 days, which would provide additional 118 kcal (calories), and weekly weight checks. Staff should the RD with any new nutrition concerns. A Nutritional Risk assessment dated [DATE] categorized the resident as a high risk for nutritional concerns. Interventions included: continue regular puree, nectar-thick liquids; RD recommended house supplement 60 mls per day for 30 days; RD recommended weekly weight checks; encourage the resident to eat meals in the dining room as able;encourage adequate hydration and intakes as able; record all meal and snack intakes; and contact the RD with any new concerns. A Significant Weight Change Notification to Physician form dated [DATE]4/20 revealed staff informed the physician that the resident weighed 174 lbs and lost -2.25% in 30 days, -7.35% or -13.8 lbs in 4 months, and -9.28% or -17.8 lbs in 5 months. The RD wrote recommendations to start weekly weight measurements and house supplement 60 mls per day for 30 days. The record lacked evidence the physician ever acknowledged the significant weight change form. Review of the clinical record revealed it lacked documentation of meal and snack intakes as recommended by the dietician. Review of the April and May 2020 Medication Administration Records (MARs) revealed the facility failed to initiate the RD's recommendation for 60 mls of house supplement until 5/12/20. Review of the clinical record revealed it lacked documentation pertaining to weekly weight measurements as care planned and per dietician recommendations. A hospital History and Physical (H&P) Consultation printed 4/27/20 documented the resident presented to the Emergency Department (ED) on [DATE]7/20 with a fever that started the previous night and persisted. The resident found to have mild [MEDICAL CONDITION] (low blood [MED]gen level), [MEDICAL CONDITION] (high blood sodium level) with lab result critical at 160 mEq/liter (milliequivalents per liter) (high sodium levels can be an indicator for dehydration), elevated BUN and dehydration. The Assessment/Plan subsection recorded [DIAGNOSES REDACTED]. The kidney consultation identified the resident as hypernatremic with an estimated free water deficit of 6.1 liters and treatment included giving 2 liters of IV fluids in the emergency room . The resident discharged back to the facility on [DATE]. The H&P identified the resident's weight as 185 pounds. A urinalysis identified the resident's urine specific gravity as 1.036 (high indicating dehydration), BUN 30 (high) and creatinine 0.52 (normal). A hospital discharge form dated 4/27/2020 identified the resident's BUN on discharge as 5, creatinine 0.48 and sodium 140 (normal). The resident returned to the facility 4/27/2020. Review of the fluid intakes recorded [DATE]2/20 thru 5/20/20, revealed the intakes less than 720 mls on the following days: [DATE]2 thru [DATE]7, ([DATE]8 thru 4/27 the resident hospitalized), and 4/28 thru 5/20. The Weights and Vitals Summary dated 5/27/20 documented only the following values for April/May: a. [DATE] - 174.0 lbs b. 5/1/20 - 168.4 lbs c. 5/9/20 - 154.0 lbs On 5/9/20, the summary documented a significant weight loss of -18% or -33.8 lbs since [DATE] when the resident weighed 187.8 lbs; a loss of -8.6% or -14.4 lbs when compared with 5/1/20 weight; and a -13.9% or -24.8 lbs lost since 2/28/20 when the resident weighed 178.8 lbs. On 5/8/20 at 1:48 p.m. Staff C, RN, stated on 5/1/20 she worked with just 1 CNA from 6 p.m. to 10 p.m. and 10 p.m. to 6:00 a.m. Staff C stated she went to Resident #3's room to assist her with eating and when she arrived, she observed the resident only had two little cups of food and no liquids. Staff C identified the kitchen staff as gone by 6:15 p.m Staff C could not find the key to the kitchen, and since Resident #3 needed thickened liquids, Staff C could not provide the drinks. Staff C said she used the fluids already in Resident #3's room, which were not fresh. Staff C thought the fluids remained in the room from a previous meal -probably lunch. Staff C stated the next day she asked Staff Y, contracted Dietary Aide, why the resident did not receive liquids. Staff Y informed her she should use the water in Resident #3's room. Staff C identified dietary staff as upset due to staff taking glasses out of the kitchen when they should use all paper products. Progress Notes dated 5/12/20 at 10:33 a.m. recorded a Nutrition/Dietary note written by the RD. The RD revealed the resident experienced a significant weight loss with current weight 154.0 lbs and that the resident tested positive for COVID-19 on [DATE]9/20. The resident exhibited a poor appetite for quite some time, lost -20 lbs or -11.79% in 1 month, and -24.8 lbs or -13.87% in 3 months, and -37.8 lbs or -19.71% in 6 months. The RD documented on her last note [DATE]4/20 she recommended house supplement 60 ml per day with weekly weights but it was not ordered. The RD now recommended house supplement 60 mls twice a day, weekly weights, and contact the RD about any other nutrition concerns. Observation on 5/13/20 at 12:32 p.m. revealed Resident #10 sat in a wheelchair at table in the dining area by himself. At 12:55 p.m. Staff N, CNA, assisted Resident #3 and Resident #10 to eat. Staff N stood to assist with the residents with dining and went back and forth between the two residents. Staff L, CMA, entered and offered to sit with Resident #10 to ensure Staff N could focus on Resident #3. 3. A quarterly MDS assessment dated [DATE] for Resident #6 identified a BIMS score of 0 with signs of fluctuating inattention and disorganized thinking. A score of 0 indicated severe cognitive impairment. The MDS revealed the resident independent with eating. The MDS documented [DIAGNOSES REDACTED]. The MDS recorded a weight value of 175 lbs. Care plan focus areas initiated 10/9/14 identified altered thought processes related to impaired cognition manifested by the need for assistance with decision-making and a potential for alteration in nutritional status. The interventions included: monitor and provide for changing needs; monitor intakes, if less than 50% for greater than 3 days, alert the RD and physician; monitor weight as ordered monthly and as needed; and RD to assess nutritional status quarterly and as needed to provide recommendations as needed. On 4/7/20 a care plan update directed staff to honor the resident's likes, dislikes, and offer alternatives as needed. Progress Notes dated 4/7/20 at 12:41 p.m. recorded a

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F 0692 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 5) Nutrition/Dietary note written by the RD. The RD identified the resident as doing well nutritionally with a weight of 175.2 lbs. The resident's weight trended up overall in the past 6 months with -1.13% lost in 1 month, +1.62% gain in 3 months, and +4.53% gain in 6 months. The RD wrote staff did not record the resident's meal intakes so intake information unknown. Staff reported no concerns and he ate well. The RD made no recommendations at that time. A Nutritional Risk assessment dated [DATE] categorized the resident as a medium nutritional risk. The assessment revealed interventions included: continue regular diet; continue monthly weight checks; encourage to come to dining room for meals as able; record all meal and snack intakes; encourage adequate intake and hydration; honor likes, dislikes, offer alternative as needed; and contact RD with any new nutrition concerns. Review of the clinical record revealed it lacked documentation of all meal and snack intakes as recommended by the dietician. The Weights and Vitals Summary dated 5/27/20 documented only the following values for March/April/May: a. 3/24/20 - 175.2 lbs b. [DATE]3/20 - 168.8 lbs c. 5/5/20 - 159.8 lbs d. 5/15/20 - 159.0 lbs On 5/5/20, the summary documented a significant weight loss of -5.3% or -9.0 lbs since [DATE]3/20 and a -9.8% or -17.4 lbs lost since 2/28/20 when the resident weighed 177.2 lbs. On 5/15/20, the summary documented a significant weight loss of -10.3% or -18.2 lbs since 2/28/20. Review of the fluid intakes recorded [DATE]2/20 thru 5/20/20, revealed the intakes less than 720 mls on the following days: [DATE]2, [DATE]5, [DATE]6, [DATE]7, [DATE]9 thru 4/24, 4/26 thru 5/4/20, 5/6/20 thru 5/11/20, 5/13, and 5/15/20 thru 5/18/20. Progress Notes dated 5/5/20 at 2:17 p.m. revealed a Nutrition/Dietary note written by the Registered Dietician. The RD identified the resident with a significant weight loss as he lost -9.0 lbs or -5.33% in 1 month and lost -17.4 lbs or -9.82% in 3 months. The RD wrote the resident tested positive for COVID-19 infection and was not used to the change in protocols including not eating meals with other residents in the dining room. The RD noted staff reported inadequate meal intakes. The RD recommended house supplement 60 mls twice a day for 30 days, weekly weight checks, and contact RD with any new nutrition concerns. The Significant Weight Change Notification to Physician form dated 5/5/20 notified the physician the resident weighed 159.8 lbs and lost -5.33% in 30 days, -9.82% in 90 days, and -4.65% in 180 days. The RD recommended house supplement 60 mls twice a day for significant weight loss. Review of the May 2020 Medication Administration Record [REDACTED]. Progress Notes dated 5/19/20 at 2:05 p.m. revealed a follow up Weight Change Note written by the RD. The RD wrote the resident lost another -0.8 lbs or -1.3% in the past week. The weight loss was not desired. The RD wrote the resident lost -9 lbs in the past month due to poor appetite, eating in room due to COVID-19 infection, and nursing reported he drank ordered house supplement sporadically. The RD documented the kitchen identified the resident's meal intakes as not great although he drank chocolate milk. The RD recommended chocolate milk mixed with whole milk for all 3 meals to start on 5/19/20, continue house supplement 60 mls twice a day, and weekly weights. Review of the clinical record revealed from 5/5/20 to 5/27/20 only one weight measurement documented on 5/15/20. The record lacked documentation of weekly weight measure measurements as recommended by the RD. 4. An annual MDS assessment dated [DATE] for Resident #7 identified a BIMS score of 15 without signs or symptoms of [MEDICAL CONDITION]. A score of 15 indicated intact cognition. The MDS identified the resident as independent with eating and only requiring set up help. The MDS documented [DIAGNOSES REDACTED]. The MDS recorded a weight value of 221 lbs with a weight gain of greater than 5% in 1 month or 10% in 6 months. A care plan focus area initiated 6/18/19 identified a potential for nutritional problem. The interventions included to monitor, record, and report to physician and RD signs or symptoms of malnutrition including significant weight losses of greater than 3 lbs in 1 week, 5% in 1 month, 7.5% in 3 months, or 10% in 6 months. On 3/17/20, the care plan contained an update that identified the RD would assess quarterly, annually, and as needed. Progress Notes dated 3/17/20 at 2:00 p.m. documented a Nutrition/Dietary Note written by the Registered Dietician. The RD revealed the resident weighed 220.8 lbs, significant for +10.80% gain in 6 months. The RD identified the weight as stable the last 3 months with +2.8% in 1 month and +4.26% in 3 months. The RD noted the resident drank a lot of fluid at meals and water in between meals. The RD gave no new recommendations. Progress Notes dated 5/12/20 at 2:03 p.m. documented a Nutrition/Dietary Note written by the Registered Dietician. The RD revealed the resident weighed 203.0 lbs on 5/5/20 with a significant weight loss of -19.6 lbs or -8.81% in 1 month and -17.8 lbs or -8.06% in 3 months. The RD identified the resident as positive for COVID-19 infection, no appetite or sense of taste or smell for quite some time with inadequate meal intakes. The RD recommended the resident start magic cup supplement 3 times a day and weekly weight checks. Review of the fluid intakes recorded [DATE]2/20 thru 5/20/20, revealed the intakes less than 720 mls on the following days: [DATE]2, [DATE]3, [DATE]5 thru 4/22, 4/24 thru 5/8, and 5/11 thru 5/20/20. 5. A quarterly MDS assessment dated [DATE] for Resident #8 identified severely impaired cognition for daily decision-making skills with continuous behavior of inattention and disorganized thinking. The MDS revealed the resident required supervision with setup help for eating. The MDS revealed [DIAGNOSES REDACTED]. The MDS recorded a weight value of 162 lbs. Care plan focus areas initiated 9/22/16 identified altered thought processes related to [CONDITION] dementia, delusional disorder, and need for assistance with decision-making and potential for alteration in nutritional status. The interventions included: assessing nutritional status quarterly and as needed; cue the resident to go to the dining room; monitor and provide for the resident's changing needs; and monitor and record intakes, cue and assist as needed. A Nutritional Risk assessment dated [DATE] categorized the resident as a medium nutritional risk and recorded a weight of 162.6 lbs on 2/28/20. The RD identified interventions that included: recording all meal and fluid intakes. Progress Notes dated 5/5/20 at 2:07 p.m. revealed nursing reported weight and intake concerns. The resident exhibited poor intakes due to lack of sense of smell and taste. The RD revealed the resident weighed 158.8 lbs and experienced a weight loss of -6.2 lbs or -3.76% in the last month, not significant. The RD recommended the kitchen provide ice cream with every meal to increase calories and she would continue to monitor weight as needed. A Significant Weight Change Notification to Physician form dated 5/5/20 notified the physician the resident weighed 158.8 lbs and lost -6.2 lbs or -3.76% in 1 month, not significant. The RD wrote recommendations as: kitchen to provide ice cream with every meal. The clinical record lacked documentation of the ice cream intakes with every meal. In an email correspondence dated 5/19/20 at 3:54 p.m., the Administrator clarified why the resident's clinical record lacked documentation of the intake of the recommended ice cream with every meal. The Administrator identified the ice cream as not necessarily an order but rather staff should just get the resident something she would actually eat. Review of the fluid intakes recorded [DATE]2/20 thru 5/20/20, revealed the intakes less than 720 mls on the following days: [DATE]2 thru [DATE]7, [DATE]9 thru 5/9, 5/11 thru 5/15, and 5/17 thru 5/20/20. The Weights and Vitals Summary dated 5/29/20 documented only the following values for April/May: a. [DATE]/20 - 165.0 lbs b. 5/5/20 - 158.8 lbs c. 5/12/20 - 152.0 lbs d. 5/27/20 - 147.8 lbs On 5/12/20, the summary documented a significant weight loss of -8.0% or -13.2 lbs since 3/24/20. On 5/27/20, the summary documented a significant weight loss of -6.9% or -11.0 lbs since 5/5/20 and -10.5% or -17.4 lbs since 3/24/20. Progress Notes dated 5/26/20 at 2:30 p.m. documented a Nutrition/Dietary Note. The RD revealed the resident weighed 152.0 lbs and experienced a significant loss of -13 lbs or -7.88% in the past month with weight trending down overall with -6.29% in 3 months and -7.43% in 6 months lost. The RD revealed inadequate meal intakes on the current regular diet with cut-up meats and ice cream with all meals. The RD revealed the resident no longer had dentures and could not eat meat, toast, and other regular foods. The RD wrote recommendations for a trial of mechanical soft diet; house supplement 60 mls twice a day, and weekly weights. Observation on 5/8/20 at 6:07 p.m. revealed Resident #8 sat in her room in a straight back chair. Resident #8 held her Styrofoam meal container half on the bedside table, half off, spilling down into her lap. Resident #8 made no effort to feed herself. Staff T, CNA, came down hall and noticed the resident spilling her food, entered, washed hands, and assisted the resident. At 6:11 p.m. Staff T asked Resident #8
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to provide a sufficient number of staff to meet the basic care needs for 6 of 7 residents reviewed for sufficient staffing (Resident #2, #5, #4, #3, #7, #12). During a staffing crisis, the facility failed to analyze staffing, resident acuity, and resources, to restructure accordingly to meet residents' essential needs. The facility reported a census of 41 (forty-one) residents. Findings include: 1. An admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 11 without signs/symptoms of [MEDICAL CONDITION]. A score of 11 indicated moderate cognitive impairment. The MDS revealed the resident spoke clearly and could understand others and make herself understood. The MDS documented the resident exhibited the behavior of refusing care on 1 to 3 days out of the 7-day look back period. The MDS revealed the resident required extensive physical assistance of 1 staff for personal hygiene; extensive physical assistance

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	165264	A. BUILDING _____ B. WING _____	05/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QHC MITCHELLVILLE, LLC	114 CARTER STREET SW MITCHELLVILLE, IA 50169

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) of 2 staff for bed mobility; total dependence upon 1 staff for eating; and total dependence upon 2 staff for transfers, toilet use, and bathing. The MDS coded functional limitations in range of motion (ROM) on both sides of upper and lower extremities. The MDS recorded the presence of indwelling catheter and ostomy for bladder and bowel elimination. The MDS documented [DIAGNOSES REDACTED]. The BIMS assessment dated [DATE] revealed a score of 15 (no cognitive impairment). Care plan focus areas initiated [DATE]6/20 identified the resident utilized a suprapubic catheter (tube put through the skin into the bladder), bilateral nephrostomy tubes (a thin tube put through the skin into the kidney), and a cecostomy (a thin tube placed through the skin into the first part of the large bowel). The care plan identified a self-care deficit related to impaired mobility and need for assistance with ADL (Activities of Daily Living). The care plan noted the resident often refused care if not on her terms/schedule and at times told the staff to schedule their day better. The care plan interventions informed staff the resident did not always use the call light, required a hoyer (mechanical lift) for transfers with the assistance of 2 staff, needed to be fed by staff assist, totally dependent upon staff for all cares, and able to verbalize her needs and preferences. Care plan interventions directed staff to assure the call light within easy reach in room at all times, monitor and provide for the resident's changing needs, assist with shower 2 times weekly, and communicate needs and cares with the resident to create a schedule that worked for both staff and the resident. Review Bath and Skin Reports from [DATE]4/20 to 5/20/20 identified the resident received showers on [DATE]6/20, 5/2/20, and 5/20/20 only. On 5/8/20 at 7:22 p.m., Resident #2 reported call lights took up to an hour to get answered, the times of day varied, and it occurred on a daily basis. Resident #2 said there were times she yelled to get help because it had taken and hour to hour and a half and it stressed her out. Resident #2 commented she should only be up a couple hours a day and turned every 2 hours when in bed due to a sore on her bottom. Staff did not adhere to the turning schedule and she often sat up longer than a couple hours. Resident #2 stated staff only repositioned her 1 to 2 times on the overnight shift. Resident #2 reported she thought staff had gotten her up around 5:00 or 5:30 p.m. that day and she never knew when she would get to bed, but usually she was one of the last to do so. Resident #2 said one of the aides who showered her that week did not let her get warm and rushed not drying her and put her in bed cold. Resident #2 stated she lived in the facility for 4 weeks and recalled only receiving 2 showers. Resident #2 said she only received bed baths after incontinence episodes and some staff did not do a good job cleaning her up. On 5/8/20 at 1:48 p.m. Staff C, Registered Nurse (RN), confirmed she worked Friday 5/1/20 from 6:00 p.m. to 6:00 a.m. and 6:00 p.m. to 6:00 a.m. Sunday 5/3/20 into Monday 5/4/20. Staff C reported she recalled not being able to assist Resident #2 to eat her supper until around 8:00 p.m. Staff C reported she knew Resident #2 did not have her needs met, specifically repositioning, as she told the resident she needed to wait because the resident needed assistance of 2 and Staff C worked with just 1 CNA (Certified Nurse Aide) and at times, by herself only. 2. A quarterly MDS assessment dated [DATE] for Resident #5 identified a BIMS score of 15 without signs or symptoms of [MEDICAL CONDITION]. A score of 15 indicated intact cognition. The MDS revealed the resident required limited physical assistance of 1 staff for bed mobility, dressing, and extensive physical assistance of 2 staff for transfers, toilet use, and bathing. The MDS documented [DIAGNOSES REDACTED]. The care plan focus area initiated 9/11/19 identified a [MEDICAL CONDITION] to the left lower extremity. The care plan directed staff to assist the resident with dressing changes and transfers to the wheelchair. Progress Notes dated [DATE] at 12:36 p.m. documented the resident called the administrator from his room demanding to have a shower immediately. The entry revealed the resident stated the aide offered to give him a shower after lunch but he wanted a shower immediately. The Administrator told the resident she was unfamiliar with staffing schedule that day and had not been on the floor. The Administrator offered to transfer the call to the Assistant Director of Nursing (ADON) and the resident refused. A late entry Progress Note dated 5/1/20 at 12:00 p.m. revealed staff found the resident on the floor of his room after he scooted on his back approximately 15 feet to the doorway. The resident's head laid in the hall and he yelled he wanted a shower. The resident reported he wanted a shower and when no one came, he tried to get out of bed by himself when his sock slipped on the floor and down he went. The resident stated he hit the back of his head and hurt his right knee and back. The resident refused an assessment by the nurse and staff immediately assisted him to the chair with the hoyer (mechanical lift) by 3 CNAs (certified nurse aides). The resident reported feeling upset he had to wait to have a shower as the staff passed lunch trays and would assist him as soon as lunch duties done. The resident refused further evaluation. At 12:40 p.m. the notes documented staff identified the resident as rude and yelled if they did not give him a shower to get out of his room. At 12:47 p.m., the resident called the Administrator again demanding a shower. The Administrator attempted several times to ask the resident to go to the hospital for evaluation for his fall but the resident refused stating all he wanted was a shower and he wanted it right then. At 1:00 p.m., the notes recorded the resident given a shower. On 5/7/20 at 2:20 p.m., Resident #5 reported the previous Friday he wanted a shower and staff said they would do it after lunch and he did not want to wait 2 hours as he gets up at 11:00 a.m. Resident #5 stated he fell out of bed and crawled to the door to get staff and they made him wait until Monday to get a shower. Resident #5 reported it took 1 hour to get his call light answered. Resident #5 said he gets up at 11:00 every day, his doctor ordered showers Monday/Wednesday/Friday, and its ridiculous it takes so long to get help with cares. Resident #5 stated the facility tried to sweep problems under rug and half the staff were from agency, as the facility could not keep regular staff working. Resident #5 said staff turned off call lights and say they will come right back, but he did not let them turn off his light until they helped him. Resident #5 reported management staff leaves at 2 to 3 p.m. daily and don't come back in after that to help. Resident #5 reported the previous weekend Staff C, a night shift nurse, worked 6 p.m. to 6 a.m. with only 1 CNA from 2 p.m. to 10 p.m. then at 10 p.m. to 1 a.m. no CNA, just Staff C, RN. Resident #5 said then management came. Resident #5 commented he knew this as he always stayed up until around 4 a.m. and got up each day at 11:00 a.m. Resident #5 said someone scheduled for third shift did not show up. Resident #5 said third shift aides got tired and quit. Resident #5 voiced management on-call turn off their phones and do not answer when staff call for help. Resident #5 stated he was in the halls and heard nurses on the phone or when going to smoke could hear the staff complaining about it that management not want to hear their problems. Resident #5 reported once recently an agency nurse had to stay for 24 hours to get relieved. Resident #5 reported last weekend as the first time there was only one staff (the nurse) working without an aide. Progress Notes dated 5/8/20 at 11:41 a.m. documented the resident activated his call light and stated he was ready for his shower. The note recorded staff discussed with the resident that staffing on the floor short, everyone busy, so he had to wait for his shower until staff available. The resident yelled at staff to get the shower chair as it was his doctor's order to have a shower every Monday, Wednesday, and Friday. Staff discussed they would follow his orders but he had to wait until a later time as his need was not time sensitive and they would provide a shower when staffing available. The resident stated he better get a shower before lunch and again staff told him there was minimal time until they served lunch. Staff would be assisting with passing meals, feeding residents, and there was no available staff to give the shower. The resident yelled to get the shower chair. Staff offered to assist the resident to get up and out of his bed for lunch but the resident refused saying he would only get up if going to the shower. On 5/10/20 at 5:18 p.m., Resident #5 complained staff told him no staff available to give baths. 3. A quarterly MDS dated [DATE] for Resident #4 identified a BIMS score of 15 without signs or symptoms of [MEDICAL CONDITION]. A score of 15 indicated intact cognition. The MDS revealed the resident required the limited physical assistance of 1 staff for transfers, dressing, personal hygiene, and extensive physical assistance of 1 person for toilet use and bathing. The MDS documented [DIAGNOSES REDACTED]. The MDS coded the used of [MED]gen therapy. Care plan focus areas initiated 10/11/19 identified an ADL self-care performance deficit and limited physical mobility related to increased weakness and the use of [MED]gen therapy with the resident having shortness of breath related to [MEDICAL CONDITIONS]. The interventions included: staff to provide assistance of 1 person with dressing, personal hygiene, toilet use, and transfers. On 5/12/20 at 3:00 p.m., Resident #4 said she had tremors and sometimes got up 3 times a day to the chair. Resident #4 stated most times staff helped her get to the bathroom but one lady left her in the bathroom. The incident occurred in the afternoon within the previous 2 weeks. Resident #4 stated she had to get herself back to the bed from the bathroom but she had been told by Staff A her dayshift CNA that she needed to have someone with her when she transferred. Resident #4 reported while using the toilet the aides left to help others and she got short of breath waiting. Resident #4 stated sometimes it took longer than 15 or 30 minutes and if it were just 2 aides working it was worse. Review of the Bath and Skin Reports from [DATE]/20 to 5/20/20 revealed staff completed showers on 4/2, 4/6, [DATE]3, 5/4 and 5/5 only. 4. A quarterly MDS assessment dated [DATE] for Resident #3 identified severe cognitive impairment with continuous behavior signs of inattention, disorganized thinking, and fluctuating level of consciousness. The MDS identified the resident as totally dependent upon 2 staff for bed mobility, transfer, dressing, toilet use, and 1 person for eating. The MDS coded functional limitations in ROM on both sides of upper and lower extremities. The MDS documented [DIAGNOSES REDACTED]. A care plan focus area initiated 10/16/17 identified a potential for dehydration/fluid

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) deficit related to the resident unable to drink independently requiring staff assistance. The care plan identified a self-care deficit related to impaired mobility, impaired cognition, incontinence, and the resident unable to voice wants/heeds so staff must anticipate. The interventions included to provide assistance of 1 person for eating. On 5/8/20 at 1:48 p.m. Staff C, RN, confirmed she worked Friday 5/1/20 from 6:00 p.m. to 6:00 a.m. and 6:00 p.m. to 6:00 a.m. Sunday 5/3/20 into Monday 5/4/20. Staff C reported she knew Resident #3's cares not done timely and needs not met specifically for repositioning and incontinence care on 5/1/20 and 5/3/20 as Staff C worked with just 1 CNA and at times by herself only. 5. A MDS dated [DATE] assessed Resident #7's Brief Interview for Mental Status (BIMS) score of 15 (no cognitive deficits). According to the MDS, Resident #7 had the ability to express his ideas and wants; he understood people and they understood him. The MDS also noted how Resident #7 required extensive assistance of 2 people for transferring, toileting and bathing. The resident required limited assistance of 1 person for most other activities of daily living (ADLs). An interview with Resident #7 on 5/12/20 at 3:00 p.m. revealed that he needed quite a bit of help; they used a mechanical sit to stand machine to transfer him. According to the resident, he spent most of his time in his wheelchair or recliner. The resident stated that Tuesdays and Fridays were his days to shower, but today was the first shower I've had in about 3 weeks. Resident #12 mentioned how it took staff up to a half an hour to respond to his call light. 6. The MDS dated [DATE] noted Resident #12's Brief Interview for BIMS score of 15 indicated he did not have any cognitive deficits. According to the MDS, Resident #12 had the ability to express his ideas and wants; he understood people and they understood him. The MDS also noted how Resident #12 required extensive assistance of 2 people for most ADLs. An interview with Resident #12 on 5/12/20 at 2:23 p.m. revealed that he needed help getting dressed and toileted, but he believed he did not get as much help as he needed. According to the resident, he slept in his recliner, but otherwise sat in his wheelchair all day. He said staff treated a sore on his bottom with ointment sometimes, but they probably only did it about half the time. Resident #12 mentioned how it took staff up to a half an hour to respond to his call light; he timed them. He said they did not always keep the water in his pitcher fresh either; he has found it empty before. Staff Interviews and Observations On 5/7/20 at 4:30 p.m., the Director of Nursing (DON) reported the facility tried to call everyone they could and utilized eight different temporary staffing agencies for emergency staffing. The DON stated since finding COVID-19 positive residents, agency staff did not want to come to help because if they did, they could not work in another facility for a while. The DON reported another nurse contacted the fire and police departments to see if they could help but they said short staffed also. The DON responded she would not say or agree it took 1 hour for staff to answer call lights. The DON responded she did not know what the contingency staffing plan was. The DON said the biggest thing was getting full-fledged showers done. The DON stated they did not have the staff to spend time scrubbing people; they completed 2 to 4 showers a day instead of the 7 scheduled. The DON stated the staff cleaned residents in their rooms, deodorant applied, hair combed, and they still met residents' basic needs. On 5/7/20 at 5:10 p.m., the Administrator answered questions derived from the Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and Other Long-term Care Settings (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html). The Administrator responded to the question of if a person assigned responsibility for conducting a daily assessment of staffing status and needs during the outbreak. The Administrator responded the ADON responsible for the scheduling. The Administrator reported the ideal staffing to meet resident needs would be: 2 nurses or 1 nurse and 1 Certified Medication Aide (CMA) for the 6 a.m. to 6 p.m. shift; 1 nurse for the 6 p.m. to 6 a.m. shift; 5 to 6 CNAs for 6 a.m. to 2 p.m. shift; 4 CNAs for 2 p.m. to 10 p.m. shift; and 2 to 3 CNAs for the 10 p.m. to 6 a.m. shift. The Administrator reported the facility consistently staffed only 4 CNAs on the 6 a.m. to 2 p.m. shift, 2 CNAs on the 2 p.m. to 10 p.m. shift, and 2 CNAs on the overnight shift 10 p.m. to 6 a.m. When asked what was not getting done for residents, the Administrator responded a couple complaints related to showers not getting done and minimal complaint about call lights not answered timely, and smoking times not on-time. The Administrator voiced showers were done, they just happened later in the day. The Administrator reported their staffing plan collaborated with local and regional planning and response groups to address health care staffing shortages during the crisis. On 5/8/20 at 1:48 p.m. Staff C, RN, reported she worked Friday 5/1/20 from 6:00 p.m. to 6:00 a.m. and 6:00 p.m. to 6:00 a.m. Sunday 5/3/20 into Monday 5/4/20. Staff C stated she worked once a week but picked up extra shifts due to the shortage of staff at the facility. Staff C explained CNAs worked 8-hour shifts 6 a.m. to 2 p.m., 2 p.m. to 10 p.m., or 10 p.m. to 6 a.m., and nurses worked 12-hour shifts, 6:00 a.m. to 6:00 p.m. or 6:00 p.m. to 6:00 a.m. Staff C stated the absolute minimum number of CNAs needed to meet residents' basic needs would be 3 aides on the 2 p.m. to 10 p.m. shift. Staff C reported on 5/1/20 and 5/3/20 the facility staffed with just 1 CNA from 2 p.m. to 10 p.m., 10 p.m. to 6:00 a.m., and just her as the nurse 6 p.m. to 6 a.m. Staff C stated when she arrived on 5/1/20 at 6 p.m. other staff described the previous shift as a really rough shift with kitchen not passing trays, and so she and the CNA had to do it. Staff C said she ran around crazy and residents did not receive timely repositioning or dining assistance. Staff C said she thought the 2 p.m. to 10 p.m. CNA completed rounds (go room to room and check needs of each resident and provide incontinence care) one time at around 9 p.m. to 10 p.m. Staff C said she personally informed Resident #2 and Resident #21 they needed to wait until later for help as both required assistance of 2 persons. Resident #3 did not receive not repositioning every 2 hours. Staff C reported she worked completely alone after 11:00 p.m. on 5/3/20 when Staff D, CNA, left the facility. Staff C stated she knew residents' needs not met from 11:00 p.m. to 1:30 a.m. as she answered what call lights she could and attempted to make phone calls for help. She could not reach anyone in management. Staff C reported at 1:30 a.m. the DON arrived to help and then Staff A, (CNA normally scheduled for 6:00 a.m.), came in early. Staff C reported Saturday morning 5/2/20 she called the DON about the schedule, needing people, and to let her know she felt frustrated working with just 1 CNA. Staff C reported the Administrator said they were working on it but Staff C never heard another thing the rest of the night, not even that they couldn't get anyone. Staff C stated she also told the DON the situation was terrible, medications passed 3 hours late, and it had been like that all week. On 5/12/20 at 2:50 p.m. Staff D, CNA from temporary staffing agency, reported he worked at the facility for 2 months. Staff D recalled working approximately a week prior. Staff D recalled feeling upset about the staffing levels as he worked by himself with just 2 other nurses in the facility. Staff D stated he was scheduled to work in the facility 2 double shifts; 2 p.m. to 10 p.m. and 10 p.m. to 6 a.m. Staff D reported his employer told him he did not have to stay for the overnight shift of his second double shift. Staff D said he reported to his employer that he had to work an entire shift by himself due to being the only CNA there and he could not finish the overnight shift by himself. Staff D stated from approximately 6 p.m. to 7 p.m. the other nurses left leaving only 2 staff in the building; him and Staff C, RN. Staff D stated the nurse instructed him not to reposition residents or get them up as they would not have time to get everything done. Staff D commented it was not possible for him to meet the basic needs of the resident's with staffing levels like that. On 5/8/20 at 5:10 p.m. Staff J, RN, stated she was supposed to be staffed with another nurse but the girl called off. Staff J said they tried to get a replacement without success. Staff J reported the overnight nurse Staff E, Licensed Practical Nurse (LPN), from temporary staffing agency, was supposed to come in early and Staff E worked in the facility before. Staff J reported things not done due to a skeleton crew during the pandemic. Staff J commented no one wanted to work and agency staff helped but were hard to find. Staff J said staff could only provide 2 to 4 showers during the daytime-that's the best they could do. Staff J reported they needed at least 3 aides on the 2 p.m. to 10 p.m. shift. Staff J stated the weekend before she came in overnight early, stayed late to cover, and put in many hours. Staff J said she called public health for assistance. Staff J said staff did not shave residents and they tried to get the residents who needed a hoyer lift up in a chair at least once a day. Staff J voiced she would love to give quality of care but she could not. Staff J stated they hurried to pass medications and give assistance. Staff J said since isolating residents in their rooms, many are getting weak. Staff J said if she had another nurse working with her she could have completed med pass earlier, likely by 6 p.m. Staff J commented the bottom line was they needed to increase staffing. Staff J stated every 2 hours the aides went around checking residents but did not provide care toto the extent she would like, though they do see the residents' faces. Staff J reported the previous weekend she just got home and received a call asking her to come back in. Staff J identified Saturday 5/2/20 as bad. She stayed as night nurse. Staff J commented she got no lunches, no breaks when she worked as the only nurse. Staff J voiced she did not know what to do as the only RN and only 3 aides on 5/2/20 dayshift, so they could not do showers. Staff J said management did not come to help when called. Review of the Daily Schedule for Friday 5/1/20 revealed the following staffing levels for the day: a. 1 RN (Staff J) and 1 CMA (Staff K) worked 6 a.m. to 6 p.m. b. 1 RN (Staff C) from 6 p.m. to 6 a.m. c. 1 CNA (Staff T) 2 p.m. to 10 p.m. (The schedule listed 3 other CNAs on the schedule for 2 p.m. to 10 p.m. but 2 circled as NCNS (no-call-no-shows) and 1 crossed off with a line thru it. Review of the Daily Schedule for Saturday 5/2/20 revealed the following staffing levels for that day: a. 1 RN (Staff J) 6 a.m. to 6 p.m. (However, per Staff J interview she stayed to work into the night shift.) b. 1 CMA (Staff K) 6

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) a.m. to 6 p.m. c. DON as floor nurse, 2 p.m. to 6 a.m. d. 3 CNAs for the 6 a.m. to 2 p.m. shift e. 2 CNAs for the 2 p.m. to 10 p.m. shift with 2 additional CNAs circled to indicate they did not come f. 2 CNAs for the 10 p.m. to 6 a.m. shift (The scheduled showed Staff D, CNA, worked a double shift 2 p.m. to 6 a.m.) Review of the Daily Schedule for Sunday 5/3/20 revealed the following staffing levels for that day: a. 1 RN (Staff I) 6 a.m. to 6 p.m. b. 1 CMA, who walked out, supposed to be 6 a.m. to 6 p.m. so DON worked 6 a.m. to 11:30 a.m. c. DON as on-call manager and floor nurse, 6 p.m. to 6 a.m. d. 1 RN (Staff C) 6 p.m. to 6 a.m. e. 4 CNAs for the 6 a.m. to 2 p.m. shift f. 1 CNA (Staff D) for the 2 p.m. to 10 p.m. shift; no other potential staff listed g. 2 CNAs listed for the 10 p.m. to 6 a.m. shift (Staff D and Staff A, but Staff D crossed off noting he could not work, and Staff A did not arrive until 1:30 a.m.) On 5/8/20 at 5:45 p.m., Staff U, CNA, voiced it took entirely too long to pass food. Staff U said she was very surprised to have 3 aides working that night as usually only 2 aides scheduled. On 5/9/20 at 12:38 p.m., Staff J reported because they had enough help that day, Resident #3 got up for the day, Resident #12 got shaved and showered, and staff worked with 1 resident at a time to get caught up on their hygiene. On 5/10/20 at 5:15 p.m., the staff in the building included 4 CNAs from temporary staffing agencies (Staff G, Staff X, Staff H, and Staff S) and 1 dayshift RN from temporary staffing agency (Staff I). Staff I stated the ADON said she would come to assist since Staff K, CMA, left early, however the ADON did not come to help. On 5/10/20 at 6:04 p.m., Staff I stated she felt there should be 2 nurses staffed if the facility had COVID-19 because if she needed to send a resident out to the hospital she would be in trouble as she was on her own. Staff I said the med aide left at 4:00 p.m. and the ADON did not show up so she was on her own for med pass. Staff I voiced she was new and felt it important to have another nurse who knew the facility to assist. Staff I said had she known she were going to be alone she could have prepared. On 5/10/20 at 6:23 p.m. Staff W, RN from temporary staffing agency, arrived. Staff W responded she worked in the facility since October 2019 the 6 p.m. to 6 a.m. shift. Staff W described the facility as a free for all with no leadership from management and she thought they were doing the best they could without the leadership. Observation on 5/12/20 at 1:00 p.m. revealed the staff on-duty included 3 CNAs 6 a.m. to 2 p.m. and 1 shower aide, Staff U, worked 10 a.m. to 2 p.m. Staff J stated she was having a much better day as they had 2 nurses working. On 5/12/20 at 1:30 p.m. Staff N, CNA, stated she worked for the facility for a year. Staff A, CNA, responded she worked at the facility for 3 years. Both staff voiced lately it was not doable to get the work done and they could not answer call lights within 15 minutes. Both reported some of the residents got up that day and others did not want to. Staff N commented they sometimes had to pick-and-choose whom they assisted. Both reported staffing levels difficult since March 2020. On 5/12/20 at 1:50 p.m. Staff S, CNA from temporary staffing agency, reported he averaged about 56 hours per week in the facility. Staff S stated since the lock down, he really only worked at this facility and he needed a break. Staff S stated this facility one of the more challenging facilities he worked in as a temporary nurse aide. Staff S said he was happy to see 4 CNAs scheduled for the 2 p.m. to 10 p.m. shift as his workload would now be doable. Staff S acknowledged less than 4 CNAs on that shift made it hard to meet resident needs. On 5/12/20 at 2:22 p.m., the DON and ADON reported typically they would staff 6 CNAs before the COVID-19 crisis: 4 CNAs assigned to hallways, 1 CNA as bath aide, and 1 CNA to work in the RA (Restorative Aide) role to complete the restorative maintenance program. The DON stated during the COVID-19 outbreak they pulled the RA to work the hallways and then they started pulling the bath aide. The DON stated the staff still completed bed baths if the resident did not get a shower. On 5/7/20, the Administrator provided a resident room roster that designated transfer status for each resident. The list identified 13 residents required the use of a hoyer (full body mechanical lift), 2 required an EZ stand (sit-to-stand mechanical lift, and 5 required assistance of 2 persons for transfers. On 5/13/20 at 1:08 p.m. Staff M, CNA, reported they were staffed that day with only 3 CNAs for the 6 a.m. to 2:00 p.m. shift: Staff A, Staff N, and Staff B. Staff M stated she herself was on light duty. Staff M stated she left Resident #2's call light on, room [ROOM NUMBER], as she had not yet met the resident's need/request. Observation on 5/13/20 at 1:10 p.m. revealed call lights on for rooms 105, 107, 109, 327, 330, 219 bath. The schedule for the day observed to list Staff F, Licensed Practical Nurse (LPN), and Staff L, CMA, for the 6 a.m. to 6 p.m. shift; a second nurse crossed off. The 2 p.m. to 10 p.m. shift scheduled to have 3 CNAs: Staff U, Staff T, and Staff S. From 6 p.m. to 6 a.m. Staff E, LPN, scheduled and 2 CNAs, Staff S and Staff Z, for 10 p.m. to 6 a.m. At 1:16 p.m. call lights on in rooms 105, 107, 109, 108, 327, 219, 221, and the service door alarming. At 1:20 p.m., Staff F reset the service entry door at the nurses station and said the maintenance man set it off. At 1:21 p.m. observation showed the DON at the medication cart. At 1:23 p.m., call lights on for room [ROOM NUMBER], 109, 108, 332, 329 bath, 327, and 329 bath. Staff L up from feeding in the dining room and said she would answer a call light once she washed her hands. Staff M out of the room to assist 300 hall and down the 100 hall. At 1:27 p.m., Staff F sat at the nurses station and had not gone down to Resident #2's room. At 1:28 p.m. call light for room [ROOM NUMBER] went off after being on for 18 minutes. At 1:29 p.m. call light for room [ROOM NUMBER] went off after being on for 19 minutes. At 1:31 p.m. the call light for room [ROOM NUMBER] went back on. At 1:33 p.m., the call light for room [ROOM NUMBER] remained on. Observation on 5/13/20 at 1:56 p.m. revealed Staff S arrived. At 2:02 p.m., Staff U arrived on duty. Staff T did not show up for the shift. At 2:35 p.m., Staff U reported Staff T still did not arrive to work. At 2:55 p.m., Resident #3 remained up in her wheelchair in her room. Staff did not reposition Resident #3 since she got up for lunch at noon. At 3:01 p.m. Staff B, CNA, remained in the building due to Staff T not showing up for work. At 3:03 p.m., observation showed Staff L on the 100 hall with the medication cart. At 3:06 p.m., Resident #22 walked up the hallway in a hospital gown, her bed without a fitted sheet on it, only a bed pad and flat sheet. Resident #22 ambulated to the nurses station. Staff S intervened and guided the resident back to her room. Resident #23 also wandered out of their room and Staff L encouraged the resident to go back to her room. Staff F charted and stated Resident #22 used to be independent with dressing herself. Staff provided no assistance or cues to the resident to get dressed for the day. At 3:08 p.m., Resident #22 again walked out of her room dressed only in a hospital gown. Staff L redirected the resident back to her room and again, no assistance given to get dressed. At 3:18 p.m., Staff B and Staff U transferred Resident #3 from the wheelchair to her bed. Staff B removed a soiled brief to reveal the buttocks reddened with imprinted wrinkles on buttocks from sitting that blanched readily when touched. Staff U decided to leave Resident #3 in bed and Staff U would get her back up at 4:30 p.m. The Daily Schedule for 5/15/20 revealed the following: Staff J, RN, and Staff K, CMA, worked 6 a.m. to 6 p.m.; CNAs Staff N and Staff M worked from 6 a.m. to 2 p.m.; Staff AA, CNA, worked 7:30 a.m. to 2 p.m.; and CNAs, Staff G and Staff H, worked from 8:00 a.m. to 2 p.m. So only 2 CNAs worked the dayshift 6:00 a.m. to 7:30 a.m. On 5/21/20 at 10:30 a.m., the DON stated she worked the floor a lot as the charge nurse due to short staffing levels and therefore was not updated on everything going on in the facility. The DON identified the day of the interview as the first day she did not pass medications. The DON identified Staff L (med aide) as ill, non-COVID-19 related. The DON reported she
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, observation, staff interview, and facility record review, the facility failed to implement a comprehensive infection control program to mitigate the risk of the spread of infection during a COVID-19 outbreak and failed to provide leadership and education to the facility and agency staff of the facilities infection control policies and procedures. The facility failed to develop a consistent system for the use of extended-use PPE (Personal Protective Equipment) to include: where to obtain PPE; what PPE required and when; how to properly don and doff PPE; where to put PPE when removed; how to sanitize PPE when reused; and competency checks for facility and agency staff. The facility failed to ensure all staff followed proper hand hygiene techniques. As of [DATE], the facility reported 22 positive cases of COVID-19 with 8 residents reported hospitalized during the outbreak and 2 of those residents expired associated with COVID-19 infection. An immediate jeopardy concern identified on [DATE]. The facility abated the concern on [DATE] when they developed a leadership committee to educate facility and agency staff on proper hand hygiene techniques; proper use of PPE; proper cleaning of contaminated surfaces; respiratory assessments for signs/symptoms of COVID-19; and overall infection control policies and procedures. The facility reported a census of 41 (forty-one) residents. Findings include: 1. A quarterly MDS assessment dated [DATE] for Resident #6 identified a Brief Interview for Mental Status (BIMS) score of 0 with signs of fluctuating inattention and disorganized thinking. A score of 0 indicated severe cognitive impairment. The MDS revealed the resident independent with no setup help for transfers, walking in room, and walking in corridor. The MDS documented [DIAGNOSES REDACTED]. Care plan focus areas initiated [DATE] identified altered thought processes related to impaired cognition manifested by the need for assistance with decision-making. The interventions informed staff the resident ambulated independently. On [DATE], the care plan identified a potential risk for COVID-19 infection related to a recent outbreak. The care plan directed staff to follow CDC updates and guidelines, follow CMS guidelines, monitor daily temperatures, and observe for signs/symptoms of COVID-119 infection such as temperature, cough,

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	165264	A. BUILDING _____ B. WING _____	**05/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QHC MITCHELLVILLE, LLC	**114 CARTER STREET SW MITCHELLVILLE, IA 50169**

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 9) shortness of breath, chest pain, fatigue, and report to primary care physician. On [DATE], a care plan update reflected the resident tested positive for COVID-19 infection. The facility line listing for the public health department related to COVID-19 provided on [DATE] identified Resident #6's illness onset as [DATE] with symptoms of fever and cough; he tested positive [DATE]; and status ill, feeling fine. Observation on [DATE] at 12:30 p.m. revealed Resident #6 wandered in the 100 hallway and the commons area with repeated vocalizations of something's wrong. The resident breathed in and out in shallow, huffing/puffing type breaths. The Administrator attempted to redirect Resident #6, who wore no facemask, to his room [ROOM NUMBER] without success. Resident #6 proceeded down the hall towards the commons area without further interventions to limit his contact with surfaces or other people. The Administrator identified Resident #6 positive for COVID-19 infection. Observation on [DATE] at 1:45 p.m. revealed Resident #6 wandered up on the 100 hall huffing and puffing with no staff visible. At 1:55 p.m. Resident #6 again in the hallway huffing with each breath indicating a sign of shortness-of-breath. At 3:46 p.m. Resident #6 out of his room again and at the dining room banister wall. Resident #6 breathed out repeatedly like huffing/puffing sound of huh, huh, huh and touching the top of the nurses station. The Director of Nursing (DON), Staff F, Licensed Practical Nurse (LPN), and Staff U, Certified Nurse Aide (CNA), present and none of them attempted to redirect Resident #6 or sanitize the contaminated surface after Resident #6 left the area. Observation on [DATE] at 6:24 p.m. revealed Resident #6 out of his room huffing and puffing with signs of shortness-of-breath. Resident #6 leaned bracing his arms against the covered clean linen cart. The Assistant Director of Nursing, (ADON), went down the hallway to redirect the resident to his room. The ADON did not cleanse or disinfect the outside flap of the clean linen cart, which Resident #6 breathed on directly within less than a foot (arm length) for several minutes. At 6:30 p.m. Staff G, CNA, exited a room with gloves on, touched and opened the contaminated flap of the 100 hall linen cart (which Resident #6 had breathed on), and obtained a brief. Staff G went into room [ROOM NUMBER] with Resident #3. Resident #6 again walked back and forth while making a huffing noise repeatedly from his room to hallway to room. At 7:02 p.m., Resident #6 came out of his room and stood at the banister in the dining room. Resident #6 huffed and puffed against the face shields lined up, which were stored as clean, and he touched the shields with his bare hands. Staff E, LPN, approached Resident #6 and asked him to go back to his room. Staff E failed to move or cleanse the face shields. 2. An admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 identified a BIMS score of 11 without signs or symptoms of [MEDICAL CONDITION]. A score of 11 indicated moderate cognitive impairment. The MDS revealed the resident spoke clearly and could understand others and make herself understood. The MDS revealed [DIAGNOSES REDACTED]. The MDS coded a special treatment of [REDACTED]. The BIMS assessment dated [DATE] recorded a score of 15. A score of 15 indicated intact cognition. A care plan focus area initiated [DATE] identified the resident on quarantine/isolation precautions due to new admit for 2 weeks. On [DATE], the care plan identified a potential risk for COVID-19 infection related to a recent outbreak. The care plan directed staff to shelter in place with room meal service policy, follow CDC updates and guidelines, follow CMS guidelines, perform frequent handwashing, monitor daily temperatures, and observe for signs/symptoms of COVID-119 infection such as temperature, cough, shortness of breath, chest pain, fatigue, and report to primary care physician. On [DATE] at 7:22 p.m., Resident #2 responded she did not see staff routinely wash their hands or use sanitizer when they entered her room but some put on gloves and some wore re-useable gloves. Resident#2 identified the day of the interview as the first day she observed staff starting to throw the gloves away. As for the facility educations, Resident #2 responded she did not receive education but looked online about COVID-19. 3. A quarterly MDS assessment dated [DATE] for Resident #5 identified a BIMS score of 15 without signs or symptoms of [MEDICAL CONDITION]. A score of 15 indicated intact cognition. Review of the census report revealed Resident #5 moved from room [ROOM NUMBER]-B to room [ROOM NUMBER]-A on [DATE]. The facility line listing for the public health department related to COVID-19 provided on [DATE] documented: a. Resident #30 resided in room [ROOM NUMBER]-A, tested positive [DATE], status hospitalized unrelated b. Resident #31 resided in room [ROOM NUMBER]-B, tested positive [DATE], status hospitalized - expired c. Resident #5 resided in room [ROOM NUMBER]-A, tested positive [DATE], status asymptomatic d. Resident #17 resident in room [ROOM NUMBER]-B, tested positive [DATE], status asymptomatic The Progress Notes dated [DATE] at 11:04 a.m. documented Resident #5 tested negative for COVID-19. On [DATE] at 2:20 p.m., Resident #5 reported the first facility case of COVID-19 was Resident #7 who came back from the hospital then a guy from Hall 2 got it and died . Resident #5 stated he used to live in room [ROOM NUMBER]-B but the facility moved him against his will without testing him. Resident #5 stated he did not want to move without knowing test results. Resident #5 stated there had been a guy in his new room sent out with a positive COVID test. Resident #5 said he was in his new room for less than 24 hours when his roommate hospitalized who since died . Resident #5 felt his new room barely got cleaned before they moved him into it. Resident #5 reported another resident who lived down a couple doors from him just passed away. Resident #5 commented he now knew some of the negative residents who moved rooms now positive for [MEDICAL CONDITION] and Resident #5 felt the facility put his life in danger. Resident #5 reported his COVID test came back negative and he did not show signs/symptoms. Resident #5 voiced he felt the deaths related to the facility putting negative residents in rooms with positive residents. Resident #5 reported he knew Resident #17 positive for COVID and staff let Resident #17 get into the ice chest by himself without wearing a facemask or gloves to get his own ice. Resident #5 complained Resident #6 positive for COVID, wandered, and staff did not contain Resident #6 while he touched everything, sat in the dining room, and facility not doing anything about it. Resident #5 repeated infected people should not walk around freely. Resident #5 voiced the laundry bin brought out and stunk up the hallway because dirty linens put straight into it without putting in little bags first, as the facility could not afford them. Resident #5 stated he asked for a new urinal and showed them his urinal was dirty and broken. Observation of 2 urinals labeled [DATE], one on the table and 1 hung on bedrail, appeared visibly dirty with brown lipped edges and broken handles. Resident #5 said his bedpan dirty, he requested a new one, but staff had not gotten back to him about it. Observation on [DATE] at 2:00 p.m. revealed Staff A, CNA and Staff B, CNA as they prepared to enter the room of a resident isolated for a positive [DIAGNOSES REDACTED].#7's door; which signified the Resident's positive [DIAGNOSES REDACTED]. Staff A failed to don the gown before she entered. Upon entering, both staff assisted Resident #7 to transfer from his wheelchair to his recliner with a mechanical sit to stand machine. Once Staff A and Staff B finished helping Resident #7, they took the sit to stand machine with them as they exited his room. Staff B doffed the yellow gown and hung it back up on the resident's door where she found it. Neither of the CNAs cleansed/sanitized the sit to stand machine before taking it out of Resident #7's room and entering into Resident #12's room to assist him with the same sit to stand machine. Staff A also wore the same attire into Resident #12's room that she wore in Resident #7's room. Once inside Resident #12's room, Staff A and Staff B used the machine to assist the resident to a standing position while they checked and changed the resident's disposable brief. Staff A provided peri care; cleansing the areas covered by the brief. Further observation revealed that Resident #12 had an open sore on his left buttock; the area cleansed by the CNA that previously failed to don protective attire in a positive COVID-19 resident's room before assisting Resident #12. After assisting the resident, the CNAs removed the sit to stand machine and stored it in the hallway outside of his room. Neither of the CNAs cleansed/sanitized the machine as they continued on with their duties. Staff Interviews and Observations Observation on [DATE] at 12:55 p.m. revealed the handwashing sink in the dishwashing room of the kitchen observed with a brown hand towel wadded up and placed on the hot water handle of the faucet. The paper towel dispenser empty with a used roll of paper towels sitting on top of the automatic dispenser. Staff O, contract Dietary Cook, entered and denied using the hand towel for drying hands and commented she just had not had a chance to replace the paper towel roll into the dispenser. Staff O acknowledged staff would have to handle the roll with wet hands to obtain paper towels. Observation showed another handwashing sink located across the room near the refrigerators. The second hand sink with personal pump hand soap and no garbage can close to be able to dispose of used paper towels after drying hands and turning off the faucet. Staff P, contract Dietary Cook, stated they worked for a contract company who provided them PPE. Staff P said masks worn outside of the kitchen, gloves, eye gear, but not allowed to go down the hallways as they deliver food. When asked about education related to COVID-19 and who taught them, both staff responded they got a letter informing them of positive COVID cases so they made sure to ask as the facility not the best at letting them know as they are not their employees. Staff O and Staff P showed an undated letter posted on the wall for education but no other education received from the facility. Both stated they thought they had a binder with information, and after a little searching, they were able to find the binder. Staff O stated the Dietary Manager always kept them updated as she was going to the facility meetings. The book titled and dated [DATE] COVID Readiness. Observation on [DATE] at 1:50 p.m. revealed the soiled utility room door on 300 hall propped open by a garbage can. The left side of the room contained a dirty linen barrel with lid on it right next to the hopper toilet. Then a double-sink present with 2 blue Rubbermaid totes sitting on it. A washbasin present in the left side of the double sink and 1 of the totes on the

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	165264	A. BUILDING _____ B. WING _____	05/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 10) right side of the sink. The totes contained PPE equipment in paper bags with names written on them. Three used/filled sharps biohazard containers leaning against one of the totes with PPE. A mob bucket present with dirty water stored next to 11 red biohazard containers stacked as clean. Both dirty and clean items present on the same side of the room. The right side of the room cluttered with mechanical lift batteries, box of red bags, box of black trash bags on the floor, 2 safety goggles hung visibly dirty, cupboard doors left open with items stored as clean inside the cupboards. Observation of the 300 hall revealed an overflowing trash bin next to 2 bind labeled for dirty linens. On [DATE] at 2:00 p.m., Staff B, CNA, reported she worked for the facility for a year but had been off for 5 weeks. Staff B said she just returned from leave of absence. Staff B worked on the hall with the trash on the floor. Staff B said yes, the doors with the yellow isolation gowns indicated isolation for COVID-19. Observation revealed room [ROOM NUMBER] with no stop sign, just white exclamation point in a red triangle approximately 3 by 5 inch size sign at the top of the room door. A yellow disposable isolation gown on the door; no indicators what to do, what precautions needed, and name plaque listed Resident #14. (The facility line listing for public health department related to COVID-19 provided [DATE] documented Resident #14 tested positive on [DATE] and recorded her status as ill, symptomatic.) The clean linen cart open to air with the closure flap flipped up on top of the cart. At 2:10 p.m., observation revealed name plaques for room [ROOM NUMBER], listed Resident #15 and Resident #27 (in hospital per Staff B). Staff B exited room [ROOM NUMBER] with a lunch Styrofoam container, bare hands, homemade cloth gown, face mask, and face shield on. Staff B pushed down the trash in trash bin to compact it with arms going in up to her elbows. Staff B then picked up a trash bag from the floor, put it in the bin, and pulled up the black trash bag higher than the bin to keep trash from overflowing to the floor. Wearing the same PPE and without performing hand hygiene, Staff B obtained gloves from the clean linen cart and entered room [ROOM NUMBER] after donning 1 of the 2 yellow disposable isolation gowns hung on the door over her homemade cloth gown. Resident #16 and Resident #29 (in hospital) resided in room [ROOM NUMBER]. Staff B again verified the gowns hung on the doors equaled a COVID-19 positive room. Staff B left the trash overflowing. Staff B out of isolation room [ROOM NUMBER] to the trash bin again and stuffed a trash bag into the over flowing trash with bare hands. Without performing hand hygiene, Staff B went to the clean linen cart, touched items then obtained a bed pad and carried it to the utility room. Staff B washed hands in room then exited with the same bed pad and entered another room. (The facility line listing for the public health department related to COVID-19 provided on [DATE] documented: a. Resident #15 tested positive on [DATE], status as ill, feeling fine. b. Resident #27 tested positive on [DATE] and recorded her status as ill, hospitalized . c. Resident #16 tested positive on [DATE] and recorded her status as ill, feeling fine. d. Resident #29 tested positive on [DATE] and recorded her status as ill, hospitalized .) Observation on [DATE] at 2:45 p.m. revealed the bag in 300 hallway filled with empty pop cans and on the floor at the end of the hall. The garbage now changed and full of trash in bin; strong smell of urine and the lid left open. Observation on the [LOC] revealed rooms 214 (Resident #18 and Resident #19), room [ROOM NUMBER] (Resident #7), room [ROOM NUMBER], and room [ROOM NUMBER], with yellow isolation gowns hung on the doors. (The facility line listing for the public health department related to COVID-19 provided on [DATE] documented: a. Resident #18 tested positive on [DATE], status as ill, feeling fine b. Resident #19 tested positive on [DATE], status as ill, feeling fine c. Resident #7 tested positive on [DATE], status as ill d. Resident #20 tested positive on [DATE], status as ill, feeling fine e. Resident #1 tested positive on ,[DATE]/ 20, status as hospitalized , returned [DATE] f. Resident #4 tested positive on [DATE], status as ill, feeling fine Observation on [DATE] at 2:49 p.m. revealed Staff U, CNA, exited room [ROOM NUMBER], Resident #20's room, wearing a disposable yellow isolation gown and N95 filtration mask. Staff U removed the yellow gown by pulling on the sleeves with hand, removed gown, shook the gown to straighten it, then hung the gown back up. Without performing hand hygiene, Staff U took a water mug from Resident #1 who stood in the doorway of room [ROOM NUMBER]; Resident #4 also resided in that room. Staff U reported she had been coming to work at the facility on and off for 6 years. Staff U filled Resident #1's water mug with ice then touched the lid where the straw and mouth hole were to replace the lid before handing back to Resident #1, who immediately took a drink from the contaminated mouthpiece. Staff U then walked back up the hall to the clean linen cart, lifted the box of gloves on the cart, threw the box back down, continued up the hall to the nurses station. Staff U grabbed a small, pocket-sized glass bottle with no label and performed hand hygiene with the hand sanitizer. On [DATE] at 2:52 p.m. Staff S, CNA, reported he worked the 2 p.m. to 10 p.m. shift and employed by a temporary staffing agency. Staff S took off 1 glove from his hand inside out, put the used glove on the nurses station counter, sanitized his hands with hand sanitizer, then picked up the used gloved, rolled it in a ball between his 2 hands for 10 seconds, then threw the glove in the trash and continued down the hall without re-sanitizing his hands. No hand sanitizer dispensers observed outside of rooms or down the hallways so staff needed to go to the nurses station when they wanted the sanitizer. On [DATE] at 3:35 p.m., the Administrator reported the DON worked at the facility for 3 months as the Infection Preventionist. The Administrator said the former DON did not return to train. The Administrator reported the facility initially set up the 100 hall as an isolation wing as it had its own shower room, linen closet, and they moved symptomatic residents to that hall. The Administrator commented then they found out they had a whole bunch of asymptotic, COVID-19 positive residents throughout the building and they decided they no longer needed to move residents to the isolation wing. The Administrator stated when a resident returned from the hospital, they placed the resident on the 100 hallway. The facility tested the entire building [DATE]. The Administrator stated no new testing occurred since [DATE]. The Administrator responded the facility reported to Local County Public Health Department and State of Iowa Public Health department (IDPH). When asked about the absence of hand sanitizer dispensers on the hallways, the Administrator responded staff had glass bottles of hand sanitizer they could carry on their person. The Administrator reported screenings occurred at the front door and the PPE kept up at the nurses station in the medication room. When asked about the PPE stored in the totes in the soiled utility room next to biohazard waste, the Administrator responded the DON must have set that up for agency personnel to place their N95 facemask and face shield or goggles into them to reuse them. Observation with the Administrator present revealed the soiled utility room door continued to propped open by the trash can and the Administrator acknowledged the door should be kept closed. The Administrator showed the PPE on hand located in the med room in 2 cardboard boxes stored on the floor. The Administrator said they had more gowns in laundry room. Observation of gallon sized bottle sanitizer to refill individual glass bottles. Observation revealed a face shield labeled, DON, laid on the counter with outer surface of shield in contact with the top of the counter; the Administrator acknowledged the used face shield should not be left on the counter. When asked where staff should store PPE they remove but intend to reuse, such as face shields, the Administrator provided no response. Observation throughout the building revealed no areas designated for placement of removed PPE and/or directions for where to disinfect PPE for re-use. The Administrator responded soap and water used to clean PPE and she believed they also had a spray. Observation revealed another face shield on the nurses station counter. The Administrator agreed she did not know whom the face shield assigned to or if it were dirty or clean. In response to where staff should store removed PPE, the Administrator said in the soiled utility room, however, just prior to that observation the Administrator acknowledged in the soiled utility room staff should not store clean PPE there. Another staff member touching face mask talking with Resident #5. The staff member did not wash hands after touching the mask. On [DATE] at 3:46 p.m., the DON identified IDPH as involved in the decision not to make any further room changes. The DON said they were moving and moving when the facility had only 6 or 8 cases then all tested in the facility and ended with huge 24 to 26 cases, something like that. The DON stated they tried to move residents but still had no idea what to do. The DON said the line listing for IDPH updated with dates of symptom onsets. The DON did not know if the facility COVID interventions taken to prepare or react to the outbreak were documented, she did not know how much was fully documented as far as the room changes, and not sure what interventions were developed to contain or minimize the risk of spread of infection related to Resident #6 wandering. On [DATE] at 4:30 p.m., an Infection Control Program interview conducted with the facility Infection Preventionist/DON. The DON acknowledged the facility hired her as the Infection Preventionist approximately a month prior. The DON stated she had only just become aware a few days prior that she was also taking the role of the new DON for the facility. The DON said the previous DON was supposed to train her but she walked out before doing so. The DON reported she did not know where the infection control program policies and procedures were located because she was not shown and she could not voice specifics of the program. The DON identified the ADON as out sick and she herself only knew the basics. The DON said she knew the Administrator had a conference call each week related to COVID -19. The DON did not know who was on the COVID-19 response team. The DON reported she did not think the facility had a real committee and she had no one to turn to other than the corporate nurse consultant at the home office, however, the corporate nurse only helped to answer specific questions, not really give guidance on what to do. The DON stated they met each day and, then when too many residents were infected in one area, they just stopped having the daily meetings which was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165264	A. BUILDING _____ B. WING _____	**05/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QHC MITCHELLVILLE, LLC	**114 CARTER STREET SW MITCHELLVILLE, IA 50169**

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 11) a week or two prior. The DON said she did not know why, just the Administrator's choice saying no more meetings. The DON stated there still were monthly meetings scheduled for all staff although they had not had one. The Administrator sends out a general email. The DON responded communication with staff not formal and not sure where it came from. In response to the question how many COVID-19 cases the facility had to date, the DON reported 2 residents passed away that week; 1 early and thought 1 the day before. The DON stated she was off a day, worked a lot of nights the previous week as the charge nurse, and therefore she was not fully aware of what was going on with the infection control program. The DON commented she believed they had 24 residents who tested positive for COVID-19. The DON stated IDPH just stated to keep up with the line listing for daily reporting of cases. The DON responded to questions about audits of staff for competency testing. The DON stated since she had been hired she did not know of any audits for hand hygiene or for donning/doffing PPE. The DON stated they used to have binder with the directions on skills testing and staff read and signed it but never completed competency tests. In response to what education the facility provided to staff on PPE, the DON stated first the girls pull from the sleeve of gown to take it off. The DON reported they had a conversation about dedicating consistent staff to care for the COVID-19 positive residents but staff got sick and with staffing an issue its too hard to set up. The DON stated the staff have had outbreaks of infections. The DON again confirmed she had not taken any audits and she did not know specific dates. In response to where PPE stored, the DON stated the green cloth homemade gowns worn at all times during the day then laundered every day. The DON responded there was nowhere for staff to hang the homemade gowns and no direct room to store used, extended-use PPE. The DON stated since it was a new thing, it was left in a blur and they go day by day. The DON did not have a response on where staff should put dirty PPE but said the new PPE kept in the med room. The DON stated IDPH letter guided the reuse of face masks, face shields or eyewear, and gowns, if not visibly soiled due to PPE shortages; gloves to be thrown away after use. The DON responded she did not know where staff placed their used PPE; some staff took it with them to their cars, some kept N95 facemasks in baggies. The DON commented that would be an each person question. The DON voiced did not receive training and they were falling apart. The DON responded she did not think the facility had any staff education documented for training on disinfecting/cleaning and she did not think anyone verified if the cleaner used in the facility was on an approved EPA List N listing for effectiveness against COVID-19. The DON responded she was not familiar with the CDC preparedness checklist for long-term care facilities. The DON stated only the Administrator attended the two weekly conference calls. The DON voiced the Administrator did not have any experience in infection control from a nursing perspective and the DON herself was the highest knowledgeable person in the facility, but she had been working long hours on-call so she couldn't get anything done. The DON stated the ADON did the staffing/scheduling and she had been gone; so as new Infection Preventionist with no ADON, no DON, and no training, she tried to provide the most care she could and focused on essential needs as a nurse. The DON commented they had bed-ridden, weakened residents with no one to help them. The DON responded she called a lot of the families and a girl did updates with the positive results and logged them in. The DON responded they had enough soap and paper towels for hand washing. The DON said staff were not allowed in the kitchen. The DON reported she had to send 2 dayshift staff home that day due to having temperatures. The DON responded the respiratory surveillance should be documented in the Medication Administration Record [REDACTED]. The DON stated their goal was to keep the current healthy residents healthy. The DON commented the basic nursing needs were all followed and kept up on. The DON commented observation of overflowing trash not a typical thing. The DON responded she expected staff to wash their hands after handling trash. The DON commented she observed staff wash their hands when they went in and out of rooms. The DON felt the Administrator should be the one to complete the Infection Preventionist interview about the facilities infection control program. On [DATE] at 5:10 p.m., the Infection Preventionist interview conducted with the Administrator. The questions for the interview derived from the Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and Other Long-term Care Settings (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html). The Administrator reported 22 residents tested positive for COVID-19 and no tests pending. The Administrator stated they had not put a team together specifically for COVID-19 response, but had a QAPI team (Quality Assurance and Performance Improvement). The Administrator said the management had morning meetings but to keep social distancing she canceled the meetings. Every Wednesday the Administrator had a meeting with the corporate home office and she did not necessarily directly educate staff about the meetings. The Administrator stated the home office got with her and she listened to webinars if she could. The Administrator thought the home office brought to the Wednesday meeting information from calls on Tuesday with public health. In response to how the facility implemented a surveillance plan for identifying, tracking, monitoring, and reporting infections, the Administrator said they completed the daily public health line listing. The Administrator reported she could not get refills for the automatic ABHS (alcohol-based hand sanitizer) dispensers so local public health provided her gallon jugs to refill individual, small glass bottles with ABHS. The Administrator responded they did have enough soap and paper towels for hand washing. In response to signage posted to indicate Transmission-Based Precautions (TBP), the Administrator explained the exclamation point sign on the resident doors indicated staff should wear full PPE before entering that room. The Administrator stated the rooms with gowns hanging on doors indicated residents who were on Transmission-Based Precautions. When asked if she verified the facility had access to EPA-registered hospital grade disinfectants, the Administrator responded she believed the housekeeping contract staff verified they used an EPA-registered hospital grade disinfectant. The Administrator stated the contract staff had a large binder of COVID-19 information and they were responsible for ensuring the use of the correct product. In response to how they identified and managed residents with symptoms specifically of respiratory infection upon admission and daily, the Administrator responded the COVID screen sent from the hospital, they took temperatures, quarantined, listened to lung s