STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165264	A. BUILDING _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 2/24/17 The following deficiencies relate to the investigation of compliant #64743. (See Code of Federal Regulation (42 CFR) Part 483, Subpart B-C).	F 000	F 100 The response or providers plan of correction contained herein shall not be considered to be or construed as an admission of the validity of the citation or alleged deficiency to which is it addressed.	2/17/17 CO
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia Coates, LNHA — TITLE: Administrator — (X6) DATE: 02/16/2017

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

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F 323	Continued From page 1 interviews, the facility failed to provide adequate nursing supervision and failed to keep the resident's environment safe from hazards in order to mitigate falls (Resident #7). The sample consisted of 7 residents and the facility reported a census of 49 residents. Findings include: 1. Resident #7 had a MDS (Minimum Data Set) assessment, with the reference date of 11/26/16. The MDS indicated the resident had short and long term memory deficits and severely impaired cognition. The MDS identified the resident required limited assistance of one staff person for transfers and ambulation and used a walker for ambulation (walking). The MDS identified the resident as not steady, could only stabilize with staff assistance and demonstrated functional limitations on both sides of the body. The Care Plan identified a concern with the resident being at high risk for injury related to impaired mobility and cognition. The interventions included and directed the staff to ensure the resident wore non-skid, well-fitting footwear when up, assure call light within easy reach in room at all times; did not always use assistive devices, and will use Merry walker with restorative aide as needed. The care plan did not identify any new fall interventions for fall precautions after 3 falls between 11/30/16 and 12/14/16. An Incident Report dated 11/30/16 at 3:45 p.m. documented the staff found the resident lying on the floor in the hallway. The incident report noted an unlocked wheelchair near the resident and the resident may have tried to sit down on it. The staff	F 323	**F 323** Resident #7 has been provided adequate Supervision and safe environment to Mitigate falls. All residents will have adequate Supervision and be provided a safe Environment to mitigate falls.	2/17/17 CW CW

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F 323	Continued From page 2 documented no injuries or redness noted. The Progress Notes dated 11/30/16 at 5:42 p.m. indicated the staff found the resident on the floor, wheelchair about two feet back from the resident with unlocked brakes. The resident may have tried to sit on it and the wheelchair rolled back. The family member and the physician notified. The resident had no injuries noted at the time. At 7:53 the staff documented the resident denied pain when asked, up walking around in a pleasant mood, smiling and laughing. An Incident report dated 12/05/16 at 1:01 a.m. with a revision date of 12/23/16 at 10:31 a.m. documented the resident had attempted to get up from a recliner, fell forward and hit head on the floor. The incident report identified a staff member was across the room and unable to get to the resident soon enough to prevent the fall. The incident report identified the facility assessment noted a 4 centimeter diameter hematoma (collection of blood under the skin) on the left forehead and the resident complained of head hurting. The neuro [neurological] checks were within normal limits, blood pressure slightly elevated and the nurse could not obtain a third set of pupil checks due to the resident squinting eyes closed. The resident guarded the left arm/wrist area. The nurse contacted the physician and the physician requested the resident be sent to the hospital emergency room for an evaluation. The Progress Notes dated 12/05/16 at 1:00 a.m. indicated the resident attempted to get up from a recliner, fell forward and hit head on the floor. The Progress Notes indicated the staff were across the room and unable to reach the resident in time	F 323	All staff in serviced by 01/27/17 For proper supervision and providing A safe environment. DON and/or designee will complete Routine audits regarding supervision and Safe environment to mitigate falls and Communicate the audit results on a monthly basis to the QA committee.	2/17/17 CW

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F 323	Continued From page 3 to prevent the fall. The staff noted a four centimeter diameter hematoma to the left forehead, range of motion to all extremities without complaint. The resident voiced her/his head hurt. At 4:45 a.m. the staff documented the resident returned from the hospital, no new orders, CT (computerized tomography) scan and laboratory reports, vital signs and neuro checks within normal limits A report notification dated 12/14/16 at 03:25 a.m. documented the staff found the resident in the hall in front of the resident's room with head against doorway. The resident voiced pain. The resident wore non- skid socks and cause of the fall unknown. The resident yelled in pain and grabbed hip with right hand when attempted to get up. The resident obtained a skin tear to the top of the left hand and retracted hand when touched. The Progress Notes dated 12/14/16 at 03:35 a.m. indicated the nurse notified the physician and received orders to send to the emergency room to be evaluated. The resident went to the hospital at 4:20 a.m. At 1:57 p.m. the nurse documented she called the hospital. The hospital indicated the physician admitted the resident with a diagnoses of a "subdural hematoma (collection of blood under the Dura-the Dura covers brain) to the face". A radiology report dated 12/14/16 at 4:47 a.m. indicated findings of a scalp hematoma to the left, subacute extra-axial subdural blood products noted along both cerebral hemispheres with the right greater than the left with a maximal AP diameter of 13 millimeters.	F 323		2/17/17 CP

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F 323	Continued From page 4 A Progress note dated 12/16/16 at 3:00 p.m. indicated the resident returned from the hospital, escorted by ambulance. Upon arrival the resident appeared very sleepy and vital signs stable. On 01/18/16 at 11:09 a.m. Staff A, CNA/CMA was interviewed and stated she had been working on the medication cart when Resident #7 fell. She stated the resident had fallen several times. Staff A stated the resident had been independent one time the resident had been in the living room and tripped over own feet, the second time the resident the resident had been in the hallway and fell over own feet and the third time had sat down like had been trying to sit in a chair that had not been there. On 01/18/17 at 12:38 p.m. Staff B, LPN was interviewed and stated she worked when Resident #7 fell. Staff B stated it appeared as if the resident had fallen in the doorway. Staff B stated the resident bled from the head, and thought the resident complained of right wrist pain. Staff B stated when getting the resident, the resident complained of left hip hurting. Staff B stated she called the emergency system, doctor and family. On 01/19/17 at 9:55 p.m. Staff D, LPN was interviewed and stated she did not work the day of the fall. Staff D stated the resident fell frequently. Staff D stated the resident is in a wheelchair but because of a diagnoses of Alzheimer's Disease, she/he will forget not to walk on own and would get out of the chair. Staff D stated the staff would walk with the resident or attempt to redirect back to the wheelchair.	F 323		2/17/17 CW
F 353	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING	F 353		CW

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F 353 SS=E	Continued From page 5 STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed	F 353	**F 353** F 353 did not identify specific residents. Residents call lights will be answered in A timely manner in order to meet the Resident's needs.	2/24/17 CO 2/24/17 CO

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F 353	Continued From page 6 nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to ensure sufficient staff was available to answer resident call lights in a timely manner in order to meet the needs of four residents interviewed. The facility census was 49 residents. Findings include; 1. During group interview on 1/19/17 at 1:10 p.m., four residents indicated at times it took 45 minutes to get the call light answered. One resident that required two staff assistance stated he/she would often have to wait for staff to get assistance before they could be placed on the toilet and put to bed. All four residents stated if someone asked to use the bathroom during a meal, they would be told they could not because staff were assisting residents with the meal service. All residents stated there was just not enough staff in order to meet resident needs. During interview on 1/18/17 at 11:09 a.m., Staff A, certified medication aide, CMA indicated most are agency staff and the facility only has four full time facility staff presently on the day shift with the rest of the staff being agency. Staff A stated staffing has been one certified nurse aide, CNA for each	F 353	All staff in serviced by 02/24/2017 on Answering resident call lights in a timely Manner to meet the resident's needs. DON and/or designee will conduct Routine audits on answering call Lights in a timely manner. Results of the audits will be reported to the QA committee on a monthly basis.	CW 2/24/17

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F 353	Continued From page 7 hallway with a float, with a bath aide and restorative aide unless they are pulled to work the floor. Staff A stated the restorative aide was an agency aide. During interview on 1/18/17 at 12:38 p.m., Staff B, licensed practical nurse, LPN indicated from 6:00 pm-10:00 pm, the CNAs assignments were one CNA for Hall I, one CNA for Hall 2, and 1 CNA for Hall 3. Staff B indicated two nurses split the three hallways to provide nursing care and medication pass. Staff B stated the 10:00 pm-6:00 am shift has one nurse and 3 CNA's but feels the staff work well together. During interview on 1/19/17 at 9:34 a.m., Staff C, CNA indicated staffing has been one CNA for each of the three hallways with one float CNA and two nurses, and occasionally there was a bath aide and rehab aide on the day shift. During interview on 1/19/17 at 11:10 a.m., Staff F, CNA stated the facility was staffed with one CNA for each of the three hallways with one float CNA and two nurses, and occasionally there was a bath aide and restorative aide on the day shift. The 2-10 pm shift was staffed with one CNA for each hallway with occasionally a CNA float and 2 nurses. On the 10p-6a shift staff included one CNA for each hall and one nurse. Staff F stated felt residents do not get the attention needed because staff are hurrying to get tasks completed. Staff F stated if they ask the nurses for assistance they will help but they will not volunteer even knowing the aides are short staffed. Staff F stated the assisted residents are to be toileted every two hours but it does not happen like that.	F 353		CW 2/24/17

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F 353	Continued From page 8 During interview on 1/19/17 at 12:30 p.m., Staff G, CNA stated she did not feel the residents were getting the quality of care they should be getting when they are staffed with just one CNA per hallway. Staff G stated the nurses are very good about helping if asked. Staff G stated it was very stressful trying to get everyone ready for bed and get them in bed. Staff G stated the assisted resident's are not getting checked and changed every two hours as they are supposed to be. On 1/24/17 at 11:20 a.m., the Director Of Nursing, DON stated the expectation was to toilet dependent residents every two hours or to check and change every two hours as needed. The DON acknowledged they were having problems with getting permanent staff and were using agency staff to fill in the gaps.	F 353		2/24/17 CW
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441	**F 441** Resident #4 no longer resides in the Facility. Residents will receive care per proper Infection control techniques to Prevent the spread of infection.	CW

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F 441	Continued From page 9 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective	F 441	All staff in serviced by 01/27/17 on Proper infection control practices.	2/24/17 CW

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F 441	Continued From page 10 actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and clinical record review, the facility failed to follow proper infection control techniques in order to prevent the spread of infection for one of seven residents observed. (Resident #4) The facility census was 49 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/16/16, documented Resident #4 required extensive assistance for all activities of daily living and was incontinent. Observation on 1/18/17 at 10:35 a.m., revealed Staff C, certified nurse aide, CNA and Staff J, CNA entered the resident's room to provide cares. Staff C removed the sheet from the residents bed that revealed a visibly soaked air mattress. Staff C stated they would need a clean sheet and recovered the resident with the wet sheet. Staff performed cares for the resident and took a wet periwipe and swiped it over the soiled air mattress. Staff C placed a clean sheet and incontinency pads under the resident. Staff failed to properly sanitize the air mattress that had urine residue present.	F 441	DON and/or designee will perform Routine audits on infection control Practices and report the results to the Monthly QA committee.	2/24/17 CC

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Department of Inspections and Appeals of an accident causing	N 101	**N 101** Resident #7 has not had any incidents of injury that has required any hospitalization or required reporting since last incident of 12/14/16.	2/17/17 CO

SION OF HEALTH FACILITIES - STATE OF IOWA
ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/16/17

DEPARTMENT OF INSPECTIONS AND APPEALS

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QHC MITCHELLVILLE, LLC	114 CARTER STREET SW MITCHELLVILLE, IA 50169

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N 101	Continued From page 1 major injury which required hospitalization for Resident #7. The sample consisted of 7 residents and the facility reported a census of 49 residents. Findings include: 1. Resident #7 had a MDS with a reference date of 11/26/16. The MDS identified the resident required limited assistance of one staff for transfers and ambulation and used a walker. The MDS indicated the resident not steady and could only stabilize with staff assistance and demonstrated functional limitations on both sides of the body. A report notification dated 12/14/16 at 03:25 a.m. documented the staff found the resident in the hall in front of his/her room with head against the doorway. The resident yelled in pain and grabbed hip with right hand when attempted to get up. The resident obtained a skin tear to the top of the left hand and retracted hand when touched. Progress notes dated 12/14/16 at 03:35 indicated the physician ordered the resident be sent to the emergency room for evaluation. The resident was transferred at 4:20 a.m. A radiology report dated 12/14/16 at 4:47 a.m. indicated findings of a scalp hematoma to the left, subacute extra-axial subdural blood products noted along both cerebral hemispheres with the right greater than the left with a maximal AP diameter of 13 millimeters. A Progress note dated 12/16/16 at 3:00 p.m. indicated the resident returned from the hospital, escorted by ambulance.	N 101	Facility will follow DIA requirements of reporting Major injury. 2/17/17 CO All staff were in-serviced by 01/27/17 to report To the DON and/or Administrator any resident Fall and/or injury within the appropriate Reporting time frames. The Administrator and/or the DON will monitor resident falls and/or injuries and follow DIA requirements of reporting Major injury.	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0615	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

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N 101	Continued From page 2 On 12/24/16, during the exit conference, the interim Director of Nursing acknowledged the fall with injury had not been reported to the Department of Inspections and Appeals. Review of the department's records identified the facility had not reported the resident's major injury.	N 101		2/17/17 CW