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 03/28/2018

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	F 000		
✓KK 4/16/18	Correction date 3/29/18			
	The following deficiencies relate to the investigation of facility reported incidents #74634, #74684 & #74688.			
	(See Federal Code of Regulations (42-CFR) Part 483, Subpart B-C).			
F 635 SS=J	Admission Physician Orders for Immediate Care CFR(s): 483.20(a)	F 635		
	§483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on record review, Physician office interview and staff interviews the facility failed to ensure residents had physician orders to address the residents' immediate care needs for 1 of 4 residents reviewed (Resident #1). Record review revealed Resident #1 had been admitted from the hospital to the nursing home with a diagnosis of diabetes. The resident's record lacked physician admission orders, including diabetic monitoring of blood sugars or medications to address his diabetic needs. The findings resulted in an immediate jeopardy to resident's health and safety due to the resident being hospitalized with a blood glucose of 607. The facility reported a census of 39 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 3/14/18, Resident #1 had			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/12/2018

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 03/28/2018

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 635	Continued From page 1 diagnoses a pertinent diagnosis of diabetes mellitus. The MDS also indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 indicating a moderately impaired cognitive status. Upon admission to the facility on 3/7/18, the hospital report dated 2/28/18 revealed Resident #1 was seeking nursing home placement. The Progress Note revealed the resident presented to the hospital with hypoglycemia and hyponatremia. The report documented the resident was hypoglycemia and diabetic. The list of at home medication included the following: a. Methylphenidate 2.5 milligram (mg) BID (two time a day) with the comment hold for now. b. Glipizide 5 BID (Stop indefinitely) (diabetic medication) c. Metformin 1000 BID- (Stop indefinitely) (diabetic medication) d. Lisinopril 20 daily (blood Pressure) e. Loratidine 10 mg daily (allergy) f. Mucinex BID prn g. Mag OX 400 mg. (vitamin) h. Melatonin 3 mg daily (sleep aid) The same hospital report dated 2/28/18 listed the following active medications: Acetaminophen, Albuterol, Amlodipine Besylate, Aspirin, Dorzolamide, Famotidine, Finasteride, Latanoprost, Lisinopril, Paroxetine HCl, Quetiapine Fumarate, Senna, Sodium Chloride Deep Sea, and Tamsulosin HCl. (This list did not include resident's diabetic medications.) The 2/28/18, hospital report also documented resident hypoglycemic and diabetic. Accuchecks (blood glucose monitoring) stable and will decrease monitoring to twice a day. (This was not	F 635		

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 03/28/2018

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 635	Continued From page 2 clarified with the residents physician.) The facility's Order Summary Report dated 3/7/18 identified Resident #1 had a diagnosis of Type 1 Diabetes Mellitus without complications. Staff C documented the following medications for Resident #1: Acetaminophen, Albuterol, Amlodipine Besylate, Aspirin, Dorzolamide, Famotidine, Finasteride, Latanoprost, Lisinopril, Paroxetine HCl, Quetiapine Fumarate, Senna, Sodium Chloride Deep Sea, and Tamsulosin HCl. The Facilities Order Summary Report indicated orders for medication regimen which was sent to pharmacy by Staff C. The orders were not signed by the physician. There was no clarification for use of the resident's diabetic medication or glucose monitoring. Resident #1's Medication Administration Record from admission date of March 7, 2018 to the time of hospital transfer March 16, 2018 showed no monitoring of blood sugars by facility staff. The MAR did not show any medication administered to treat Resident #1's known history of Type 1 Diabetes Mellitus without complications. The record also lacked clarification on all the medications the resident had taken to determine if the physician wanted them continued or stopped. The one page facsimile dated 3/7/18 written by Staff C identified the following: Admit under the care of the physician. Order for Physical Therapy; Occupational Therapy/Speech Therapy to evaluation and treatment. The facsimile did not address any routine labs or any drug monitoring. The ARNP (nurse practitioner) approved the orders as stated above. The resident's record failed to contain admission	F 635		

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 03/28/2018

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 635	Continued From page 3 orders from the physician relevant to the resident's clinical condition. The record lacked information alerting the physician of medications that were on hold and failed to ask whether or not the facility staff should monitor the resident's blood sugars. Progress Notes dated 3/16/18 at 12:30 p.m. indicated Resident #1 was found lethargic and not responding per usual. Skin color grayish, responds to painful stimuli, respirations 28, blood pressure 90/60, pulse 60 and unable to obtain an oxygen saturation level. Blood sugar checked and read high in two attempts. Order received for 20 units of Novolog (insulin). Resident #1 transferred to hospital emergency department at 1:35 p.m. Hospital Discharge Summary dated 3/16/18 indicated Resident #1 with diagnosis which included septic shock, pneumonia, lactic acidosis, profound hypotension, hyperglycemia, hypernatremia and acute kidney injury. Resident #1 presented to the ED (Emergency Department) with low blood BP (blood pressure) 52/32, and high blood sugar on arrival. The general chemistry report revealed the resident's blood sugar at 607 (critical). Resident #1 placed on comfort measures and transferred to a hospice facility. In an interview on 3/21/18 at 12:34 p.m. Staff C, Registered Nurse, stated Resident #1 was scheduled to be admitted on 3/6/18, but due to a family issue arrived on 3/7/18. Staff C stated the family brought Resident #1 in with no accompanying paper work from the hospital. Staff C stated she faxed an order to admit under the care of the primary care physician (PCP) and	F 635		

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 03/28/2018

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 635	Continued From page 4 for physical, occupational and speech therapies to evaluate and treat to the PCP. That order was signed and returned. Staff C stated the Director of Nursing gave her a progress note from a hospital physician (not from the PCP) dated 2/28/18 in which she extracted a listing of Resident #1's medications. From that list, Staff C created a medication list in their system and faxed it to pharmacy. Staff C stated she completed an admit assessment. Staff C stated she never followed up with the physician to verify and obtain medication and treatment orders for Resident #1. The physician was contacted for an interview and his nurse responded on 3/21/18 at 2:50 p.m. The nurse reported the physician expected to receive information regarding new admissions. The nurse reported they sometimes have little or no medical history for a resident and rely on the information provided in the resident's medical records to determine medications and care. An interview with the Director of Nursing (DON) on 3/21/18 at 1:40 p.m., revealed she was not aware of the admission process and had only worked as the DON for a month. The DON stated after the incident involving Resident #1, she developed a checklist to ensure nurses address all potential resident issues. During the interview, the surveyor reviewed the checklist which failed to show any direction for nurses to notify the physician when verifying [admission] orders. The DON stated she would amend the checklist to include physician verification. On 3/21/18, the surveyor received the amended checklist. The facility abated the IJ on 3/21/18, when they	F 635		

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 03/28/2018

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 635	Continued From page 5 updated the New Admission check list to include a provision that the nurse completing the admission would review all orders with the physician. The facility created a system for the nurse and oncoming nurse to double check the admission orders; which would also be reviewed by the DON. The IJ was lowered from "J" severity level to "D" with the need for continued monitoring of residents medications.	F 635		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

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 03/28/2018

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 656	Continued From page 6	F 656		

rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review and staff interviews, the facility failed to ensure care plan interventions were followed as planned for three of six residents reviewed. (Resident #2, #4 & #6) The facility census was 39 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 12/22/17, documented Resident #4 had diagnoses that included Schizophrenia, bipolar disorder and diabetes mellitus, had a brief interview for mental status (BIMS) score of 13, indicating an intact cognition and was independently mobile and required supervision with transfers, dressing, toilet use and personal hygiene needs.

The care plan noted under self care deficit interventions resident goes out to the patio to smoke. Instructed to leave all smoking materials at nurse's station. Make sure resident does not

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 03/28/2018

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 656	Continued From page 7 smoke with male residents date initiated was 10/24/17. Under focus of smoking an intervention was added on 3/20/18, staff reminded resident was not allowed to smoke with other males outside. During interview on 3/26/18 at 5:50 p.m., the Administrator stated on the afternoon of 3/20/18 at around 1:00 p.m. Resident #4 entered her office and reported she was outside smoking and a resident (male) pinched her boobs. The Administrator stated the resident had a history of making sexual allegations involving males. The Administrator stated the male resident denied the allegation, but affirmed he was outside smoking with Resident #4. The Administrator stated an intervention was implemented which prohibited Resident #4 from smoking with males without supervision. The Administrator stated all staff were re-educated of the intervention and smoking times posted. During interview on 3/27/18 at 1:50 p.m., the Director of Nursing (DON) stated on 3/20/18, she was informed by the Administrator that Resident #4 was alleging a male resident touched her breast while out smoking on the patio. The DON talked to both residents, and Resident #4 insisted the male resident touched her boobs and the male resident denied doing so. The DON stated Resident #4 had made a similar allegation regarding another male resident some time ago and stated she instructed her nurses not to allow Resident #4 to smoke with male residents and updated the care plan. 2. The Significant Change MDS assessment dated 2/2/18, documented Resident #6 required extensive assistance with transfers, dressing,	F 656		

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 03/28/2018

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 656	Continued From page 8 toilet use and personal hygiene needs. The care plan documented the resident had impaired physical mobility and had an intervention that included encourage the resident to bear weight during transfers, provide wheelchair for locomotion, provide merry walker while restorative staff present and the resident preferred to sleep in the recliner. Focus on potential for falls with injury with interventions which include chair alarms, foot buddy on wheelchair, reclining wheelchair. During observation on 3/27/18 at 4:15 p.m., the resident was transferred from the bed to the Broda chair using a hoyer lift with the assistance of two staff. During interview on 3/27/18 at 5:00 p.m., Staff D, licensed practical nurse, stated the resident was declining in January 2018 and was placed on hospice in February 2018. The resident was no longer able to safely bear weight and transfer and was made a hoyer lift and her bed was returned to her room. Staff D stated the change in interventions was addressed in the communication log. During interview on 3/27/18 at 4:30 p.m., the Director of Nursing (DON) stated the resident had a significant change in February 2018 and was placed on hospice. The DON admitted the care plan was not updated to reflect the residents current status. 3. The MDS assessment dated 1/5/18, documented Resident #2 had a diagnosis of multiple sclerosis, had a BIMS score of 15,	F 656		

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 03/28/2018

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 656	Continued From page 9 indicating intact cognition and required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. During interview on 3/27/18 at 7:40 a.m., Staff A, certified nurse aide, stated just after lunch on 3/14/18 she had given the resident a shower and had propelled her back to her room in the shower chair. Staff A got the assistance of Staff B to help with the mechanical lift (hoyer) transfer into bed. Staff B was running the lift and Staff A was positioned on the resident's right side between the chair and bed as the resident was lifted her feet made contact with the lift. Staff A pushed the residents foot down and out of the way from the lift. Staff B pushed the residents left leg down and in to rotate the resident. Staff B had to use more force downward to get the leg to bypass the center bar of the lift. Staff A stated the resident did not bend at her knees which made it more difficult to rotate her in the lift. During interview on 3/26/18 at 4:05 a.m., the Director of Nursing (DON), stated she was involved with interviewing Staff A and Staff B following the transfer of the resident on 3/14/18. The DON stated her understanding was that the resident was in the shower chair and was lifted by the hoyer. Staff B was running the lift and Staff A was touching the resident. As the resident was lifted, Staff A went to rotate the resident sideways. Because the resident does not flex at her knees, her legs are straight out requiring additional force downward to guide her legs past the center bar of the lift. During the process the residents right leg fractured. The DON stated the lift and rotation was proper in most instances, however with a resident that does not flex at the knees, the aides should have positioned the resident with both legs	F 656		

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 03/28/2018

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 656	Continued From page 10 on one side of the center bar, so that it was not necessary to rotate the legs past the center bar. The DON stated she educated both aides of the safer way to do the lift and was not sure if the proper way to lift the resident with the mechanical lift was addressed on the care plan. Review of plan of care found no guidance provided either prior to the incident or following it. On 3/27/18, the plan of care was updated to include direction for staff to transfer the resident via a hoyer lift device with both legs on one side of the hoyer lift due to stiff/non-bendable knees.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews, the facility failed to provide adequate supervision to protect 1 of 6 residents from hazards (Resident #2). The facility staff failed to safety transferred Resident #2 via a Hoyer lift device which resulted in the resident sustaining a femur fracture. The facility reported a census of 39 residents. Findings include:	F 689		

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 03/28/2018

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 689	Continued From page 11 According the Minimum Data Set (MDS) dated 1/5/18, documented Resident #2 had a diagnosis of multiple sclerosis, had a BIMS score of 15, indicating intact cognition and required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. During interview on 3/27/18 at 7:40 a.m., Staff A, certified nurse aide, stated just after lunch on 3/14/18 she had given the resident a shower and had propelled her back to her room in the shower chair. Staff A got the assistance of Staff B to help with the mechanical lift (hoyer) transfer into bed. Staff B was running the lift and Staff A was positioned on the resident's right side between the chair and bed as the resident was lifted her feet made contact with the lift. Staff A pushed the resident's foot down and out of the way from the lift. Staff B pushed the residents left leg down and in to rotate the resident. Staff B had to use more force downward to get the leg to bypass the center bar of the lift. Staff A stated the resident did not bend at her knees which made it more difficult to rotate her in the lift. During interview on 3/21/18 at 3:25 p.m., Staff B, CNA stated on 3/14/18 Staff A asked her to help with transferring the resident from the shower chair into bed. Staff B stated they attached the sling to the lift and lifted slowly, as the resident was lifted, Staff A rotated the residents legs past the center bar and in doing so, the resident began screaming and claimed her leg was broken. Staff B stated Staff A did not use excessive force when rotating the resident and did not understand how the resident was injured. Staff A stated in her experience with doing mechanical lifts, everything was done properly. Staff B denies the resident's feet got caught up in the lift.	F 689		

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 03/28/2018

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 689	Continued From page 12 During interview on 3/26/18 at 3:45 p.m., the resident stated staff broke her leg when they were transferring her from the shower chair to the bed. The resident said staff was not rough or forceful when moving her legs around the lift, but was just not paying attention. During interview on 3/26/18 at 4:05 a.m., the Director of Nursing (DON), stated she was involved with interviewing Staff A and Staff B following the transfer of the resident on 3/14/18. The DON stated her understanding was that the resident was in the shower chair and was lifted by the hoyer. Staff B was running the lift and Staff A was touching the resident. As the resident was lifted, Staff A went to rotate the resident sideways. Because the resident does not flex at her knees, her legs are straight out requiring additional force downward to guide her legs past the center bar of the lift. During the process the residents right leg fractured. The DON stated the lift and rotation was proper in most instances, however with a resident that does not flex at the knees, the aides should have positioned the resident with both legs on one side of the center bar, so that it was not necessary to rotate the legs past the center bar. The DON stated she educated both aides of the safer way to do the lift and was not sure if the proper way to lift the resident with the mechanical lift was addressed on the care plan. Review of plan of care found no guidance provided either prior to the incident or following it. On 3/27/18 the plan of care was updated to show how to properly transfer the resident to ensure further injury does not occur. The radiology report dated 3/14/18, documented	F 689		

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 03/28/2018

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 689	Continued From page 13 the right x-ray femur view indicated a distal femur fracture. Findings: bones diffusely demineralized ; Impression: contour irregularity along weight bearing surface of the lateral femoral condyle, concerning for an impaction fracture.	F 689		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure physician visits occur at least every 30 days for the first 90 days after admission and every 60 days thereafter for two of four resident records reviewed. (Resident #3 & #5) The facility census was 39 residents.	F 712		

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 03/28/2018

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 712	Continued From page 14 Findings include: 1. Review of Resident #3's record noted an admission date of 7/21/17. Progress notes indicated the resident was visited by the physician on 7/28/17 and was again until 10/27/17, by a nurse practitioner. During interview on 3/28/18, the Administrator stated she was unable to provide documentation of any visit completed in August and September. 2. Review of Resident #5's record noted the resident was seen on 8/23/17 and was again until 11/9/17. During interview on 3/28/18, the Administrator stated she was unable to provide documentation of a visit for October.	F 712		
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as	F 947		

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 03/28/2018

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 947	Continued From page 15 determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on personnel record review, the facility failed to ensure three of four nurse aides reviewed received no less than 12 hours of inservices per year to ensure competence. The facility census was 39 residents. Findings include: 1. Staff E, certified nurse aide was hired 10/5/01. Review of Staff E's training records for 2017 found only one hour of inservice training. 2. Staff F, certified nurse aide was hired 3/19/08. Review of Staff F's training records for 2017 found only ten hours of inservice training. 3. Staff G, certified nurse aide was hired 1/17/17. Review of Staff G's training records for 2017 found only ten hours of inservice training.	F 947		

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 03/28/2018

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) COMPLETE DATE
L 190	58.10(3)a General policies 481-58.10(135C) General policies. 58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements: a. Employees shall have a physical examination and tuberculin test before employment; (I, II,III) This Statute is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to ensure employees had a physical examination and tuberculin test completed as required for four of four staff reviewed. (Staff H, I, J & K) The facility census was 39 residents. Findings include: 1. The personnel file for Staff H, certified nurse aide, CNA documented a hire date of 5/15/17. The Tuberculin (TB)Skin test was given on 5/6/17 and read on 5/8/17. However, there was no repeat TB test given and no physical examination completed. 2. The personnel file for Staff I, CNA noted a hire date of 6/23/17. The Tuberculin Skin test was given on 6/23/17 and read on 6/25/17. However, no repeat TB test was given. 3. The personnel file for Staff J, CNA noted a hire date of 9/1/17. No physical examination was completed as required. 4. The personnel file for Staff K, CNA noted a hire date of 3/5/18. The Tuberculin Skin test was given on 3/5/18 and read on 3/7/18. However, no repeat TB test was given and no physical examination was completed.	L 190		

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 03/28/2018

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) COMPLETE DATE
L 190	Continued From page 1 During interview on 3/28/18 at 2:35 p.m. the Operations/nurse specialist stated the process involving new hires included a drug screen, physical and TB screen forty eight hours prior to hire. If drug and TB screens are negative the employee can be scheduled to work and the repeat TB screen completed within two weeks.	L 190		

Plan of Correction for Mitchell Village Care Center

This Plan of Correction (POC) constitutes QHC Mitchellville, LLC requirement to submit a credible allegation of compliance. This POC does not constitute an admission or agreement of any kind by the facility of the truth of the facts alleged or the correctness set forth by the agency. The submission of the POC should in no way be considered or construed as agreement with the allegations or noncompliance or admission by the facility. We are providing this POC to comply with Federal participation requirements.

F635

All new admissions will have physician's orders for the resident's immediate care. An admission checklist has been created to ensure orders are clarified with the doctor, charted in the nurses' progress note that Dr. Connor was called and orders verified. All orders are rechecked by the nurse coming on duty next, verified all orders and that it has been charted in the progress notes. All nurses were re-educated 3/16/18 on the admission process and need to have physician orders confirmed. The DON or designee will conduct routine audits on admission paperwork and orders. The findings will be reported at the monthly QA meeting. 03/29/2018

F656

Residents 2, 4, and 6 care plans and interventions are being followed as planned. All resident care plans will be followed as planned. All nursing staff have been re-educated 3/16/18 on the importance of following care plans and care plan being specific to each individual. DON or designee will audit care plan and staff to ensure they are being followed. The findings will be discussed at the monthly QA meeting. 03/29/2018

F689

Resident 2 will receive adequate supervision to prevent from hazards. All residents will have adequate supervision to prevent hazards. All nurses' staff were educated 3/17/18 on the importance/requirement for proper manual/electric portable patient lifts. The DON or designee will conduct routine audits regarding supervision to prevent hazards. The findings will be reported at the monthly QA meeting. 03/29/2018

F712

Residents 3 & 5 will be seen by a physician in a timely manner. All residents will be seen by the physician in a timely manner. DON or designee will perform audits to monitor and ensure timely visits from the physician. The findings will be reported at the monthly QA meeting. 03/29/2018

F947

All staff will receive no less than 12 hours of in-services per year to ensure competence. The staff were educated 3/29/18 on use of computer software to use as well as attending monthly in-services. The business office manager or designee will conduct monthly audits to verify in-services are being completed. The findings will be reported at the monthly QA meeting. 03/29/2018

Kristen Canham 4-16-18

This Plan of Correction (POC) constitutes QHC Mitchellville, LLC requirement to submit a credible allegation of compliance. This POC does not constitute an admission or agreement of any kind by the facility of the truth of the facts alleged or the correctness set forth by the agency. The submission of the POC should in no way be considered or construed as agreement with the allegations or noncompliance or admission by the facility. We are providing this POC to comply with Federal participation requirements.

L190

Staff H, I, J & K have had initial TB, repeat TB and physicals.

The process involving new hires require the initial TB, physical and drug test to be performed before the new hire is scheduled to do paperwork. After 48 hours, if the TB screen is negative the employee may work and the repeat TB will be completed within two weeks.

The DON or designee will complete the physical and TB on the first day of hire. The business office manager and administrator or designee will place a reminder of the 2nd TB due date on their outlook calendars.

This will be monitored monthly by the administrator and reported on at the monthly QA meeting.
03/29/2018

Kristen Canham
4-16-18