STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 7-31-19 On June 17 - 20 2019, the facility's annual health survey and investigation of complaint 83115-C and facility reported incident 82712-M was conducted. Complaint 83115-C was substantiated. Additional findings for 82712-M will be sent to the facility at a later date under separate cover. Amended 7/29/19 by JM, RN	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		

gm

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7.31.19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ___ B. WING ___	06/20/2019

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

(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 578	Continued From page 1	F 578		

entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to ensure advanced directives for health care were clearly documented for 2 of 24 residents reviewed (Residents #13 & #24). The facility reported a census of 50 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool dated March 25, 2019, Resident #13 had diagnoses that
included anemia, hypertension, diabetes mellitus, hyperlipidemia, Alzheimer's disease, anxiety disorder and depression. The resident had no Brief Interview for Mental Status (BIMS) score. The MDS revealed the resident entered the facility on 5/1/2015.

The Care Plan last dated 5/12/19 indicated the resident displayed altered thought processes and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 578	Continued From page 2	F 578		

displayed a self-care deficit related to dementia. The Care Plan documented the resident as at risk for falls/injury/impaired mobility. The Care Plan also documented the resident as at nutritional risk related to depression, dementia, anemia, and diabetes mellitus.

The Iowa Physician Order for Scope of Treatment (IPOST) signed by the physician on 11/14/18 showed the resident desired cardiopulmonary resuscitation (CPR). The IPOST document was kept in a plastic page sleeve, which also included two Supportive Care Plans dated 10/20/15 and 1/21/11. The Supportive Care Plans both directed the resident did not want cardiopulmonary resuscitation (CPR). The resident's Supportive Care Plan contained the signature of their responsible party, social worker, registered nurse, and physician.

Observation on 6/19/19 revealed a red sticker on the outside of Resident #13's chart. Also , the resident's electronic face sheet did not contain any documentation regarding code status. A file tab titled Conditions Alert included a Do Not Resuscitate (DNR-do not perform cardiopulmonary resuscitation) sticker with a notation dated 7/23/10.

During an interview with Director of Nursing (DON) on 6/19/19, she stated the facility was in the process of entering resident code status electronically so staff would know where to go to find it quickly. She reported a red sticker on the outside of the chart meant the resident did not want CPR initiated (DNR status), but added the facility no longer used that system.

2. The MDS dated 4/11/19 revealed Resident #24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 578	Continued From page 3 had diagnoses of asthma, obesity, and mental disorder due to a physiological condition. The MDS documented 7/13/18 as the resident's admission date. The care plan updated 7/24/18 revealed the resident's code status listed on the front of her chart. The Order Summary Report for 6/2019 revealed a physician's order had a start date 4/26/19 for full CPR treatment in the event of a life-threatening emergency when the resident's heart stopped or respirations ceased. The electronic medical record "Order" screen documented the resident had an order for CPR/full code status. The IPOST signed by the resident's representative on 4/19/19, and the physician on 4/24/19 revealed DNR (no CPR) status if the resident had no pulse or respirations. During an interview 6/19/19 at 1:24 PM, the Director of Nursing reported she expected staff looked at the electronic health record to determine a resident's code status.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 582	Continued From page 4	F 582		

for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 582	Continued From page 5 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide 2 of 3 sampled residents the required forms for Medicare Liability Notices and Beneficiary Appeals when skilled services had been exhausted or services no longer covered (Residents #29 and #104). The facility reported a census of 50 residents. Findings Include: 1. Record review for Resident #29 indicated she received skilled services from 1/21/19 to 2/15/19. The facility did not provide the resident with the Notice of Medicare Provider non-coverage (NOMNC) CMS form #10123 or Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNFABN) CMS form #10055. 2. Record review for Resident #104 indicated she received skilled services from 2/23/19 to 5/9/19. The facility initiated discharge from Medicare Part A services and had completed form #10123 but failed to provide form #10055 to the resident or her representative. During an interview 6/18/19 at 3:00 PM, the Facility's Nurse Consultant reported Resident #29 had no ABN notices or forms completed when she had skilled services ending, and Resident #104 had no SNF ABN Form #10055 Form completed when she had skilled services ending.	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING _____ B. WING _____	06/20/2019

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

(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 582	Continued From page 6 The nurse consultant reported a previous staff member assigned to provide ABN notices to the resident or their representative when skilled services ending failed to provide the notices. The nurse consultant reported they had recently designated the MDS Coordinator to provide the ABN notice when a resident discharged from skilled services, and had placed the proper forms (#10055 and #10123) on the MDS Coordinator's computer desktop in order to easily access and print the forms whenever a resident's skilled services ending. During an interview 6/19/19 at 8:43 AM, the MDS Coordinator reported she had became the designee 4/22/19 for provision of the ABN notices for the resident or representative whenever skilled services ending. The MDS Coordinator reported therapy notified her whenever a resident discharging from skilled services. The MDS Coordinator reported the facility mailed ABN forms to those residents who had skilled services in the past prior to 4/2019, in order for their ABN documentation to be current as those residents never received the notices.	F 582		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 602	Continued From page 7	F 602		

Continued From page 7

Based on clinical record review, financial record reviews, personnel file review, facility policy review and interviews, the facility failed to assure residents are free from misappropriation of personal funds for 1 of 1 residents sampled for financial review. Resident #16. The facility identified a census of 50.

Findings include:

1. The Minimum Data Set (MDS) dated 3/27/19 documented diagnoses that included schizophrenia, alcohol dependence and alcohol hepatitis and cirrhosis for Resident #16. The same MDS documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition, required only supervision or set-up assistance for completion of all activities of daily living except bathing.

A care plan problem dated 2/18/19 identified the resident has the diagnosis of bipolar 1 disorder and identified that due to cognitive and physical decline the resident would benefit from a guardian/conservator or power of attorney for healthcare to assist with decision-making, health and safety. Another care plan problem dated 2/7/19 indicated the resident has no plans to discharge from the facility at this time and the set the goal for the resident to be safe and content in his living environment through the next review date.

During interview on 6/1/19 at 3:19 PM the former activity director stated in early March she became frustrated because the resident asked her to buy him cigarettes and he had no money. The resident told her the social services designee (SSD) had his debit/credit card but she was ill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 602	Continued From page 8	F 602		

and not a work. She knew the SSD would purchase things for the resident, but did not know she kept the resident's card in her possession at all times. She reported this to the administrator.

During interview on 6/19/19 at 1:15 PM the administrator stated she started at the first of the year and had not been aware the SSD had possession of the resident's card. She stated she was "shocked" when it was brought to her attention. The next day, 3/11/19, she contacted the SSD, who was out ill, and told her to return his card to the facility. The SSD brought the card back to the facility on 3/19/19. The administrator contacted the SSD by text on 3/19/19 to request she bring in receipts for all transactions she completed with the resident's card. She, the SSD and a facility owner had a meeting on 3/27/19 and again requested she produce receipts. On 4/11/19 she contacted the SSD by text at 12:26 PM to request the receipts be brought to the facility no later than 3:00 PM that day. The SSD never produced receipts and the facility terminated her employment on 4/19/19. The administrator stated the SSD had been ill and out of the facility 3/12-3/22/19 and did not return back to work after she recovered.

Receipts were obtained from all 4 vendors which had transactions listed on the resident's debit card statements for 4/18 through 4/19. Receipts were reviewed with the resident and it was determined the SSD used his card to purchase items for her own use. The items purchased for her own use included beer and cigarettes which were not the brand the resident smoked but identified by the resident as the brand the SSD smoked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 602	Continued From page 9	F 602		

During interview on 6/18/19 at 11:12 AM the resident stated he gave his card to the SSD sometime last spring or summer in order for her to go and purchase cigarettes for him. She never gave him receipts for what she purchased and he did not receive a monthly statement for his card.

Attempts to contact the former business office manager were unsuccessful as phone number is disconnected but the facility's investigation into the incident contained documentation the former business office manager has been aware the SSD had the resident's card in her possession since she started at the facility 5/29/18 but did not know how long she had had it or if there were some kind of formal agreement sent up for this arrangement.

During interview on 6/20/19 at 9:28 AM the administrator stated that if a resident requests the facility hold their credit/debit cards for safekeeping they are to be given to the business office manager to be secured.

The facility's Abuse Prevention, Identification, Investigation and Reporting Policy revised 4/1/17 directed the following:
"Dependent adult abuse" is defined under Iowa Law, pursuant to Iowa Code chapter 235E as:

1c. Exploitation of a dependent adult.
"Exploitation" means a caretaker knowingly obtains, uses, endeavors to obtain or to use or who misappropriates a dependent adult's funds, assets, medications, or property with the intent to temporarily or permanently deprive a dependent adult of the use, benefit, or possession of the funds, assets, medication or property for the benefit for someone other than the dependent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 602	Continued From page 10 adult. The personnel file for the SSD documented she completed dependent adult abuse for Iowa mandatory reporter training on 3/27/17 and had completed Identifying Elder Abuse, Neglect & Exploitation training on 1/6/17, 1/14/17, 6/27/18 and 1/15/19.	F 602		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 622	Continued From page 11	F 622		

resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 622	Continued From page 12 necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide discharge and medical information to the receiving health care institution at the time of discharge for one of two residents reviewed who transferred to the hospital (Resident #24). The facility reported a census of 50 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated 4/25/19 revealed Resident #24 had readmitted to the facility from the hospital on 4/25/19. Review of the MDS dated 4/30/19 revealed Resident #24 had re-entered the facility from the hospital on 4/30/19. Review of the facility's electronic medical record	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 622	Continued From page 13 Census List revealed Resident #24 had transferred to the hospital on 4/23/19, and re-admitted to the facility on 4/25/19, and then transferred to the hospital on 4/26/19 and readmitted to the facility on 4/30/19. Review of the Progress Notes revealed the following: a. On 4/23/2019 at 9:02 AM, resident was out of the facility in the hospital. b. On 4/25/2019 at 6:48 PM, resident returned from the hospital at 5:15 PM via personal vehicle accompanied by family. c. On 4/26/2019 at 7:05 AM, the doctor requested the resident transfer to the hospital for an evaluation and family then transported her to the hospital. d. On 4/30/2019 at 5:45 PM, resident returned to the facility from the hospital. The clinical record lacked documentation of information sent with the resident when she transferred to the hospital on 4/23/19 and 4/26/19. During an interview 6/19/19 at 8:43 AM, the MDS Coordinator reported whenever they transferred a resident to the hospital, she filled out a transfer form, sent a copy of the face sheet, IPOST (advanced directive for code status), the MAR (medication administration record), TAR (treatment administration record), and wrote a quick note of the reason for the transfer. The MDS Coordinator reported no copies made of the forms sent with the resident to the hospital. She made a note in the progress notes whenever a resident transferred to another facility or the hospital.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 622	Continued From page 14 During an interview 6/19/19 at 2:15 PM, Staff D, Registered Nurse, stated she printed the order summary, MAR, face sheet, and sent a copy of the IPOST whenever a resident transferred to the hospital. Staff D reported she called report to the hospital and made a note in the progress notes about the transfer.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 623	Continued From page 15 this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,	F 623		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 623	Continued From page 16 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview the facility failed to notify the Long Term Care Ombudsman of 3 of 3 residents who transferred to the hospital (Residents #3, #15, #24). The facility reported a census of 50 residents. Findings: 1. A quarterly Minimum Data Set (MDS) dated 3/25/19 for resident #15 documented diagnoses of anemia, atrial fibrillation , hypertension, ,	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 623	Continued From page 17	F 623		

Diabetes Mellitus and depression. Brief Interview for Mental Status (BIMS) reflected a score of 15, indicative of intact cognition.

Census List for Resident #15 revealed the resident transferred to the hospital on 12/27/18 and 5/4/19.

2. According to the MDS dated 5/31/19, Resident #3 had diagnoses of hypertension, thyroid disorder, Alzheimer's disease, stroke and anxiety. The resident's BIMS was five, which meant the resident experienced impaired cognition.

The Census List for Resident #3 showed the resident transferred to the hospital 2/10/19 and 5/31/19.

In an interview on 06/19/19 at 09:03 AM, the Administrator confirmed not all residents had been submitted to the ombudsman when they were discharged or transferred to the hospital. She reported that, moving forward, she will document this and submit it to the ombudsman on a monthly basis.
3. Review of the Census List revealed Resident #24 transferred to the hospital 4/23/19 and returned the facility on 4/25/19, and also transferred to the hospital 4/26/19 and returned to the facility on 4/30/19.
Review of the MDS dated 4/25/19 and and the MDS dated 4/30/19 corroborated the information on the Census List.

Email communication from the facility to the LTC Ombudsman dated 6/4/19 failed to contain Resident #24's name on the 4/1/19 to 4/30/19 discharge report list.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 623	Continued From page 18 Upon request, the facility could provide no documentation that showed staff notified the LTC Ombudsman when Resident #24 transferred from the facility on 4/23/19 and 4/26/19.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 625	Continued From page 19	F 625		

interview, the facility failed to provide notice to the resident and/or representative of the facility's bed hold policy prior to or upon transfer to the hospital for 3 of 3 residents reviewed (Resident #3, #15, #24). The facility reported a census of 50 residents at the time of the survey.

Findings:

1. A quarterly Minimum Data Set (MDS) dated 3/25/19 for resident #15 documented diagnoses of anemia, atrial fibrillation , hypertension, , Diabetes Mellitus and depression. Brief Interview for Mental Status (BIMS) reflected a score of 15 which is indicative of intact cognition.

Census List for resident #15 reflected transferred out to the hospital on 12/27/18 and 5/4/19.

2. A MDS dated 5/31/19 for resident #3 documented diagnoses of hypertension, thyroid disorder, Alzheimer's, stroke and anxiety. BIMS reflected a score of 5 which is indicated of impaired cognition.

Census List for resident #3 reflected transferred out to the hospital 2/10/19 and 5/31/19.

An interview on 06/19/19 at 08:05 AM with the Director of Nursing, (DON) acknowledged no documentation in the nurses notes or in the chart of the bed hold policy being explained to resident or their representative. Expectations are for the nurses to be explaining this and documenting this when residents are transferred to the hospital.

An undated facility bed hold policy documented before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 625	Continued From page 20 the facility must provide written information to the resident and a family member or legal representative that specifies: duration of bed hold policy , the facility's policies regarding bed hold, and permitting a resident to return to the facility. 3. The MDS assessment dated 4/11/19 documented Resident #24 had diagnoses of asthma, obesity, and mental disorder due to physiological condition. The MDS assessment dated 4/25/19 recorded Resident #24 had most recently re-entered the facility on 4/25/19 from the hospital. The MDS assessment dated 4/30/19 recorded Resident #24 had re-admitted to the facility on 4/30/19 from the hospital. The care plan revised on 7/13/18 revealed Resident #24 had an intellectual disability and required assistance with cares due to her cognitive status and disease processes. Review of the Census list revealed Resident #24 discharged from the facility to the hospital on 4/23/19 and 4/26/19. The clinical record and progress notes dated 4/23/19 to 4/30/19 lacked documentation of any explanation of the bed hold notification to the resident or the resident's representative when she discharged to the hospital. During an interview 6/19/19 at 8:43 AM, the MDS Coordinator reported the nurse went over the bed hold policy with the resident or representative	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 625	Continued From page 21 whenever a resident transferred to the hospital.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to accurately complete a Minimum Data Set assessment for 1 of 22 residents reviewed in the sample (Residents #16). The facility reported a census of 50 residents. Findings include: The annual Minimum Data Set (MDS) assessment tool dated 12/29/18 revealed Resident #16 had diagnoses of nicotine dependence. The MDS documented the resident had no current tobacco use. The care plan dated 1/17/18 documented the resident smoked cigarettes. On 6/17/19, the facility provided a list of residents who smoked cigarettes and it included Resident #16's name. A smoking assessment dated 4/12/19 revealed Resident #16 smoked 2-5 cigarettes per day and could light his own cigarette. During an interview 6/19/19 at 9:45 AM, Staff C, Certified Nursing Assistant reported Resident #16 obtained smoking materials from the nurse and	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 641	Continued From page 22 signed himself in/out whenever he smoked. During an interview 6/19/19 at 8:43 AM, the MDS Coordinator reported she had worked as the MDS Coordinator since 3/2019. The MDS Coordinator reported she had completed the MDS assessment on admission, quarterly, annually, and whenever a resident had a significant change. During an interview 6/20/19 at 12:56 PM, the MDS Coordinator confirmed Resident #16 smoked cigarettes, but added the previous MDS Coordinator had inaccurately documented the resident had no tobacco use.	F 641		
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).	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 23 (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 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 clinical record review and staff interview, the facility failed to address specific interventions on the comprehensive care plan regarding a resident with COPD and a resident that used oxygen for 2 of 22 active residents reviewed (Resident #17& #25). The facility reported a census of 50 residents at the time of the survey. Findings Include: 1. A Minimum Data Set (MDS) assessment tool dated 3/27/19 documented Resident #17 had diagnosis of heart failure, hypertension, chronic obstructive pulmonary disease (COPD), and atrial fibrillation. A Brief Interview for Mental Status (BIMS) documented a score of 10 which is	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 24 indicative of mildly impaired cognition. The Care Plan failed to contain any staff directives with regard to how to care Resident #17's COPD. In an interview on 6/19/19 at 4:00 PM, the Regional Nurse Consultant confirmed the lack of directives for a resident with COPD. 2. The MDS assessment dated 4/19/19 for Resident # 25 identified the resident usually understood others and usually made self understood. The MDS documented diagnoses that included congestive heart failure (CHF). The MDS coded the use of oxygen therapy. The care plan focus area revised 5/1/19 identified impaired comfort related to difficulty breathing. The care plan lacked documentation pertaining to the use of oxygen. The Order Summary Report dated 6/3/19 contained an active order started 4/24/19 to apply oxygen at 2 liter per nasal cannula (L/NC) for chest pain, changes in LOC (Level of Consciousness), shortness of breath, comfort measures, or saturation less than 90% on room air. Observation on 6/17/19 at 11:23 a.m. revealed Resident # 25 wore oxygen at 2L/NC via concentrator, stated it was hard to breathe, and asked if the oxygen on. Observation on 6/19/19 at 9:21 a.m. revealed Resident # 25 sat in a wheelchair in the commons area with an O2 tank in a pouch on the back, O2	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 25 on at 2 liters per nasal cannula. At 2:33 p.m. Resident # 25 wore O2 at 2L/NC. The Weights and Vitals Summary report printed on 6/20/19 revealed the following O2 sats (pulse ox) revealed the resident utilized oxygen: 4/30/19 - 96% on oxygen per NC 5/2/19 - 95% on oxygen per NC 5/14/19 - 95% oxygen per NC 5/28/19 - 94% oxygen per NC 6/2/19 - 95% on oxygen per NC 6/18/19 - 97% on oxygen per NC On 6/19/19 at 4:42 p.m., the Director of Nursing (DON), said she thought the resident went to the hospital and came back on PRN (as needed) oxygen but staff just started and kept the oxygen in use continuously.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 657	Continued From page 26	F 657		

and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, and staff interview, the facility failed to update the comprehensive care plan for 2 of 22 residents reviewed (Resident #24 and #44). The facility reported a census of 50 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 4/11/19 documented Resident #24 had diagnoses of asthma, obesity, and a mental disorder related to a physiological condition. The MDS revealed the resident had severely impaired cognition and decision making skills. The resident required extensive assist of one staff for dressing, personal hygiene, and bathing.

Review of the MDS dated 4/25/19 revealed Resident #24 re-entered the facility from the hospital on 4/25/19.

The care plan updated on 7/24/18 revealed Resident #24 had an intellectual disability and a potential for impaired skin integrity related to incontinence and impaired mobility. The care plan lacked documentation of a surgical procedure (mastectomy) performed and staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 657	Continued From page 27	F 657		

Continued From page 27
directives for care of the Jackson-Pratt (JP) drains.

The Order Summary Report directed JP drain output documented every two hours and as needed (PRN).

The progress notes revealed the following:

a. On 4/25/2019 at 6:48 PM, resident returned from the hospital. The resident had a Jackson-Pratt drain visible on the right side, and a large bruise on her upper right arm.
b. On 4/25/2019 at 9:30 PM, the resident pulled out the JP drain. Physician and family contacted.
c. On 4/26/2019 at 7:05 AM, physician requested resident return to the hospital.
d. On 4/30/2019 at 5:45 PM, resident returned from the hospital with an incision to her right chest and a JP drain to the right axilla. The JP drain had a moderate amount of serosanguinous drainage in the bulb.

In an interview 6/19/19 at 8:43 AM, the MDS Coordinator reported she and the Director of Nursing and (DON) updated the care plans. The MDS Coordinator reported she updated the care plans whenever they completed the MDS assessment quarterly and annually, and whenever they had pertinent information to add. The MDS Coordinator reported resident care plans not updated routinely prior to her taking over the role 3/2019.

During an interview 6/19/19 at 2:15 PM, Staff D, RN, reported the facility sent Resident #24 to the hospital when she had pulled out the JP drain to have a new drain inserted. Staff D commented the resident had removed her JP drain "a couple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 657	Continued From page 28	F 657		

of times." Staff D reported Resident #24 displayed poor cognition and lacked the ability for understanding her condition or what had happened.

2. The MDS assessment dated 5/16/19 documented Resident #44 had diagnoses of seizure disorder, psychotic disorder, and a traumatic brain hemorrhage. The MDS documented the resident as fully dependent on two staff for bed mobility and transfers.

The care plan updated on 3/8/19 revealed Resident #44 had a risk for falls related to decline in physical mobility and weakness. The care plan directed staff to use a Hoyer lift and two staff assistance for all transfers.

During observation 6/18/19 at 11:07 AM, Staff B, Certified Nursing Assistant (CNA) and Staff C, CNA, used an EZ Stand lift and transferred Resident #44 from the bed to the wheelchair.

During an interview 6/20/19 at 12:56 PM, the MDS Coordinator reported Resident #44 required a Hoyer lift for transfers for awhile, but thought the resident currently used an EZ Stand lift. The MDS Coordinator reported she needed to update the resident's care plan to reflect her current transfer status.

In an interview 6/19/19 at 8:43 AM, the MDS Coordinator reported she and the Director of Nursing and (DON) updated the care plans. The MDS Coordinator reported she updated the care plans whenever they completed the MDS assessment quarterly and annually, and whenever they had pertinent information to add. The MDS Coordinator confirmed care plans had

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 657	Continued From page 29 not been updated routinely before she took over the position this in March.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident and staff interviews, the facility failed to ensure professional standards of medication administration for 1 of 1 residents reviewed (Resident #17). The facility reported a census of 50 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated 3/27/19 documented Resident #17 had diagnosis of heart failure, hypertension, depression and atrial fibrillation. A Brief Interview for Mental Status (BIMS) documented a score of 10 which is indicative of mild impaired cognition. An observation on 6/18/19 at 7:27 AM with resident #17 was given a Bevespi Inhaler and took 2 puffs. No direction was given to the resident from the nurse to rinse after inhalation. Label on the inhaler instructed resident/staff to rinse mouth after inhalation. A Physician Order Summary for the month of June documented an order for Bevespi Inhaler 9-4.8mcg/act 2 puffs inhale orally two times a day	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 658	Continued From page 30 for Chronic Obstructive Pulmonary Disease. An interview on 6/18/19 at 9:20 AM with Staff A, Licensed Practical Nurse (LPN) acknowledged that she failed to have the resident rinse after the 2nd inhalation. I know better as I have inhalers at home. An interview on 6/19/19 at 4:00 PM with the Regional Nurse Consultant her expectations are for all nurses to follow the labeling directions on an inhaler and have the resident rinse and spit after the 2nd inhalation. Nurse Consultant will review with all staff.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to assist dependent residents with repositioning when the residents demonstrated a need to reposition for 2 of 2 residents reviewed for positioning (Resident #11, #25). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/27/19 for Resident #11 identified a Brief Interview for Mental Status (BIMS) score of 04 with the continuous behavior of inattention and disorganized thinking. A score of 04 indicated	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 677	Continued From page 31 severe cognitive impairment. The MDS revealed the resident required the extensive physical assistance of 1 person for transfers and impairments in functional range of motion present on both sides of the lower body. The MDS documented diagnoses that included non-Alzheimer's dementia and Parkinson's disease. The care plan focus area revised 12/22/17 identified a self-care deficit related to weakness, poor mobility, cognitive status, and disease processes. The care plan informed the resident used a wheelchair for mobility, the resident had a walker but did not seem to comprehend safe use, cues needed for transfers, and the resident did not assist by pushing off the bed or wheelchair much of the time. On 6/14/18 the care plan directed staff to provide the assistance of 1 person for ADLs (Activities of Daily Living). Observation on 6/17/19 at 4:00 p.m. revealed Resident # 11 sat in a wheelchair, buttocks forward in the seat of the chair, and leaned back with neck resting on the top of the seat back. Resident # 11 did not appear to be able to make major position changes. Observation on 6/18/19 at 4:10 p.m. revealed Resident # 11 sat in a wheelchair in room, buttocks scooted forward towards the edge of the seat, neck rested on the back of the wheelchair seat, and resident's eyes closed. Observation on 6/19/19 at 2:06 p.m. revealed Resident # 11 sat in a wheelchair in room, with buttocks moved forward toward the edge of the seat, neck rested on the back of the wheelchair seat, and resident's eyes closed. At 2:09 a.m. Staff H, Certified Nurse Aide (CNA), entered the	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 677	Continued From page 32	F 677		

room to ask the resident how she was doing and Resident # 11 aroused easily. Staff H passed linens and then the resident responded, just taking a nap for the rest of the day. Staff H made no offer to assist Resident # 11 to transfer to a bed, reposition in the chair, or inquire about the resident's comfort in that position. At 2:12 p.m., Resident # 11 aroused easily when asked if she could sit up on own or needed help. Resident # 11 reported she would need help.

On 6/19/19 at 3:08 p.m., the Director of Nursing (DON), stated she had addressed repositioning in the wheelchair when the resident scooted down before. The DON stated she educated the aides to tell the nurse if they found the resident sitting like that. The DON acknowledged she would have expected staff to encourage repositioning or at least ask if the resident wanted to be repositioned.

2. The MDS assessment dated 4/19/19 for Resident # 25 identified the resident had diagnoses that included generalized muscle weakness and chronic pain, and usually understood others and made themselves understood. The MDS revealed the resident required extensive physical assistance of 1 person for transfers and impairments in functional range of motion present on both sides of the upper and lower body.

The care plan revised 11/24/17 identified a self-care deficit related to weakness, chronic arthritic type discomfort, depression, and a history of confusion at times. The revision dated 6/15/18 informed staff the resident transferred with assist of 1 staff to and from the bed, recliner, wheelchair, and toilet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 677	Continued From page 33	F 677		

The Restorative Nursing Care Program Weekly Progress Notes included the following documentation:
a. 3/1/19 to 3/15/19 - When resting in the recliner the resident leaned to the left and ankles turned outward causing discomfort when she attempted to rotate them in. Also, since the resident leaned forward, she needed staff to reposition her when she leaned he leans she needs repositioning and experienced discomfort when she turning her neck to the right or sitting up straight. The resident participated less with ADLs and propelling the wheelchair.
b. 3/18/19 to 3/29/19 - No improvement with neck frequent repositioning, leans to the left when in recliner and wheelchair, and attempts with positioning devices at times refuses those.
c. 4/1/19 to 4/12/19 - Continues to lean to the left, reposition as much as she will allow. She is able to reposition herself and neck to straight position holding 1.5 minutes before starting to lean again.
d. 4/15/19 to 4/26/19 - Continues to lean to the left, staff offer her positioning device and at times refuses. Resident is able to hold herself straight for less than a minute before she starts leaning again.
e. 4/29/19 TO 5/10/19 - Able to hold head and neck in straight position for 30 seconds, experiences discomfort on the left side of neck, and almost always leaning to the left.
f. 5/13/19 to 5/31/19 - Reposition as she will allow so she isn't leaning to the left.
g. 6/3/19 to 6/14/19 - Leans to the left, reposition as she will allow.

Observation on 6/17/19 revealed Resident # 25 asleep in her recliner in her room after breakfast leaning to the left with head tilted to the side.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING _____ B. WING _____	06/20/2019

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

(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 677	Continued From page 34 Observation on 6/18/19 revealed Resident # 25 out the dining room for breakfast, fed self, but leaned slightly to the left. Observation on 6/19/19 at 9:17 a.m. revealed Resident # 25 sat in a wheelchair and leaned to the left side with the arm rest in the resident's left armpit, and no positioning device or arm bolster on the chair. Resident # 25's left cheek rested on her left upper bicep. No staff encouraged the resident to reposition. At 2:28 p.m. Resident # 25 sat in recliner in room leaned over to the left side. Resident # 25 able to obtain a round pillow from her right side off the floor and stated she used that pillow for a head rest when sleeping. Resident # 25 commented she had a positioned for her wheelchair on the left side that staff would put in but not while she ate as it was difficult to eat with it. Resident # 25 responded the positioner would be beneficial in the recliner and staff do not always put the positioner in the wheelchair. Resident # 25 stated she would have accepted and wanted the positioner in her wheelchair earlier in the day when she was sleeping and leaning. The positioning device could not be located in the room and Resident # 25 stated they must have taken it out. On 6/20/19 at 12:10 p.m., Staff I, Licensed Practical Nurse (LPN), responded she thought Resident # 25 did have an arm bolster positioning device for the left arm of the wheelchair. Staff I reported the CNAs (Certified Nurse Aides) placed the positioning devices. In an interview on 6/20/19 at 12:55 p.m., the MDS Coordinator reported since she had been the the position only since March 2019 and therefore did not know why the resident's positioning device had been canceled on the care plan in January.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 677	Continued From page 35 She speculated the resident might have refused it. On 6/20/19 at 1:00 p..m., Staff D, Registered Nurse (RN), responded she had only worked for the facility since February 2019 and did not recall Resident # 25 having a positioning device for her left side. The clinical record lacked documentation that showed the resident refused a positioning device or refused assistance to reposition in her recliner or wheelchair on 6/17/19, 6/18/19, or 6/19/19.	F 677		
F 689 SS=D	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, observation, staff interview, and policy review, the facility failed to ensure staff appropriately and safely transferred a resident for 1 of 3 residents observed during transfers (Resident #44). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated 5/16/19 identified Resident # 44 had diagnoses of seizure disorder, psychotic disorder, and a	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 36 traumatic brain hemorrhage. The MDS revealed the resident had a Brief Interview for Mental Status Score (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented Resident #44 as fully dependent on two staff for bed mobility and transfers and revealed the resident displayed inattention and disorganized thinking. The care plan updated on 2/8/19 revealed Resident #44 had a risk for falls related to decline in physical mobility and weakness and directed staff to use an EZ stand lift and assistance of two staff for all transfers. During observation on 6/18/19 at 11:07 AM, Staff B, Certified Nursing Assistant (CNA) and Staff C, CNA assisted Resident #44 to sit upright up on the edge of the bed then let go of the resident as she sat on the edge of bed. Resident #44 leaned toward her right side and her body fell backward toward the bed. Staff B reached under the resident's left side and pulled the resident toward the edge of the bed. Staff C pushed the EZ stand lift in front of the resident and placed the resident's feet on the platform. Staff B and Staff C placed the EZ stand sling behind the resident's back and connected the sling to the EZ stand lift. Staff C raised the resident with the EZ lift. Staff B positioned a wheelchair behind the resident, lifted the back wheels of the wheelchair off the floor, and tilted the wheelchair forward so the smaller front wheels touched the floor. Staff B lowered the back wheels of the wheelchair onto the floor as Staff C lowered the EZ lift and resident into the wheelchair. Staff B and Staff C removed the sling behind the resident. The DON stood in the room and observed during cares and the transfer.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 37 During an interview 6/18/19 at 11:16 AM, Staff B, CNA, reported she lifted the wheelchair wheels up when Resident #44 transferred in the EZ Stand because she thought this technique helped position the resident back further into her wheelchair. During an interview 6/19/19 at 1:43 PM, the DON reported she expected staff use the straps on the back of the sling to pull a resident back toward the wheelchair when they transferred a resident with an EZ lift. The DON reported staff should not lift the wheelchair wheels off the floor when transferred a resident for safety reasons. The EZ Stand policy dated 10/9/15 revealed staff to use the device for safe resident transfers to and from the bed, chair, and toilet. The policy directed a minimum of two staff needed anytime they used a mechanical lift. The procedural stapes included: a. EZ lift placed by one staff, as another staff stayed by the resident at the bedside b. Place resident's feet on the platform c. Ensure EZ lift brakes locked d. Place sling around the resident and attach the sling to the appropriate hook. e. Secure the belt around the resident's waist f. Have resident hold onto the bars and lift the resident g. Remove brakes and pivot the resident in the EZ lift to the chair/wheelchair h. Lower resident into the chair/wheelchair i. Remove sling and move the EZ lift away from the resident	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 690	Continued From page 38 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to complete pericare	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 690	Continued From page 39 on 1 of 2 residents reviewed, (#3). The facility reported a census of 50 residents at the time of the survey. Findings include: A Minimum Data Set (MDS) dated 5/31/19 for resident #3 documented diagnoses of hypertension, thyroid disorder, Alzheimer's, stroke and anxiety. BIMS reflected a score of five which is indicated of impaired cognition. Toilet use and personal hygiene both coded for resident to require limited assistance and 1 person physical assist. Bowel and bladder coded occasionally incontinent of urine and always continent of bowel. Observation on 6/18/19 at 11:49 a.m. revealed Staff E, Certified Nurse Aide (CNA), entered Resident # 3's room to assist the resident with toileting. Staff E assisted the resident to lower slacks and pull-up underwear. The indicator strip on the outside of the pull-up blue to indicate the brief wet and the inside of the brief contained streaks of bowel movement. Staff E removed gloves, washed her hands, and donned a new pull-up. At 12:03 p.m., Staff E turned on the call light stating she did so because only 1 washcloth available. Staff E asked the surveyor if she could leave the resident alone on the toilet to get supplies and informed the surveyor could not answer that question as there to observe only. Resident # 3 remained seated on the toilet with Staff E in the room. At 12:07 p.m., Staff E adjusted the gait belt, placed soap and water on the 1 washcloth, and wiped each groin front to back using separate areas of the cloth. Staff E continued to wipe down the perineum front to back with separate area of the washcloth then	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 690	Continued From page 40	F 690		

wiped the rectal area 1 time with the same cloth. The washcloth soiled with some feces present on the cloth. Staff E did not dry the resident's skin. Staff E removed gloves and pulled up the pull-up and slacks.

Care plan with an initiation date of 11/7/17 and revision date of 2/11/19 documented resident has an activity of daily living self care performance deficit related to aging and will maintain current level of function through the review date. The resident is able to offer assistance at times, if I have a urinary tract infection will offer more assistance.

Interview on 6/18/19 at 1:17 PM with Staff E, CMA, CNA. resident does some times get up by herself to go to the bathroom. I assisted her today to the bathroom before lunch. I had just cleaned her up from breakfast a couple of hours before and I didn't think she would be dirty this time. I only had 1 washcloth available to use and we don't have walkie talkies to ask for assistance. Usually we have wash clothes on us to wipe their face, etc. It was my fault for not checking. Wipes are also available for staff to use, but they're not kept in the resident room, they keep them in the 400 hall supply room.

Interview on 6/20/19 at 10:00 AM with the Director of Nursing regarding peri care. Expectations are that staff would gather all supplies prior to doing care and have enough washcloths to complete cares. I will be reviewing with all staff.

Review of undated facility policy directed staff to :

Equipment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 690	Continued From page 41 Waterproof protector Bedpan Washcloths Towels Gloves Bath Blanket Incontinent products as appropriate PROCEDURE: Knock and identify yourself Explain procedure Gather equipment Set up basin of warm water not to exceed 105 degrees Raise the bed Remove bedspread and blanket Turn resident to their back and cover with bath blanket. Instruct resident to raise hips while bed protector is placed underneath resident Offer bedpan Position bath blanket so only the area between legs is exposed Female perineal care: Ask resident to separate her legs and flex knees. If she is unable to the perineal area can be washed with the resident on the side with legs flexed Put on disposable gloves Wet washcloth make mitt and apply soap or perineal washing solution lightly Use one gloved hand to stabilize and separate the labia, with the other hand wash from front to back Rinse and pat dry with towel.	F 690		
F 692	Nutrition/Hydration Status Maintenance	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 692 SS=D	Continued From page 42 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to ensure fluids readily accessible to residents when in bed for 2 of 3 residents reviewed for sufficient hydration (Resident #11, #37). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/27/19 for Resident #11 identified a Brief Interview for Mental Status (BIMS) score of 04 indicating severe cognitive impairment. The MDS revealed the resident required the extensive	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 692	Continued From page 43 physical assistance of 1 person for bed mobility and supervision with set up help only with eating. The MDS documented diagnoses that included non-Alzheimer's dementia and Parkinson's disease. The care plan focus area revised 12/22/17 identified a self-care deficit related to weakness, poor mobility, cognitive status, and disease processes. The care plan informed the resident used a wheelchair for mobility, the resident had a walker but did not seem to comprehend safe use, cues needed for transfers, and the resident did not assist by pushing off the bed or wheelchair much of the time The care plan revision dated 11/1/18 informed staff the resident had a planned weight loss related to a recent hospital stay and fluid loss. On 6/14/18 the care plan directed staff to provide the assistance of 1 person for ADLs (Activities of Daily Living). Observation on 6/18/19 at 8:10 a.m. revealed Resident # 11's water mug with straw placed out of reach on the counter by the sink approximately 5 feet from where the resident laid in bed. Observation on 6/19/19 at 9:27 a.m. revealed Resident # 11 sat out in the commons area in a wheelchair, eyes closed, and no access to any water. Resident # 11 opened eyes easily when spoken to and smiled. Observation on 6/19/19 at 2:12 p.m. revealed a water mug on the counter by the sink; Resident # 11 responded she could get a drink of water by herself if she needed to. The water mug approximately 2 feet away from the resident as she sat in the wheelchair. Resident # 11 not seen to attempt to self propel her wheelchair at any	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 692	Continued From page 44 time during the survey process. On 6/19/19 at 3:06 p.m. the Director of Nursing (DON) responded she was not sure if the resident could move herself to self propel her wheelchair but stated the resident could take drinks of water on her own. The DON stated she would expect staff to keep water within reach of the resident when in her bed or wheelchair. 2. The MDS assessment dated 5/9/19 for Resident #37 identified a BIMS score of 03 indicating severe cognitive impairment. The MDS revealed the resident totally dependent upon 2 persons for bed mobility and required supervision with set up help only for eating. The MDS documented diagnoses that included traumatic brain injury. The care plan focus area revised 6/14/18 identified a potential for self-care deficit related to disease process, impaired mobility, impaired cognition, and weakness as evidenced by a need for assistance with all ADL's. Observation on 6/17/19 at 2:25 p.m. revealed Resident # 37's water mug with straw on the counter by the sink approximately 5 feet from the bed where the resident laid with eyes closed. Observation on 6/18/19 at 8:41 a.m. revealed Resident # 37 out in the dining room for breakfast and able to take drinks on own. Observation on 6/19/19 at 9:23 a.m. revealed Resident # 37 sat out at a table in the commons area, no drinks in front of the resident. At 2:35 p.m. Resident # 37 laid in bed with water mug on the counter by the sink approximately 5 feet from the bed out of the resident's reach.	F 692		

(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 692	Continued From page 45 On 6/19/19 at 3:10 p.m. the DON stated the resident is capable of taking her own drinks and she would expect staff to ensure water kept within reach of the resident when in bed.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, resident interview, and staff interview, the facility failed to assess a resident's blood oxygen saturation levels, failed to ensure humidification water bottle for oxygen use contained water, and failed to label and date oxygen equipment to ensure clean, for 1 of 1 residents reviewed for respiratory care (Resident #25). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated 4/19/19 for Resident # 25 identified the resident usually understood others and made themselves understood. The MDS documented a pertinent diagnoses of congestive heart failure (CHF) also documented the resident used oxygen therapy.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 695	Continued From page 46 The care plan focus area revised 5/1/19 identified impaired comfort related to difficulty breathing. The care plan lacked documentation pertaining to the use of oxygen. The Order Summary Report dated 6/3/19 contained an active order started 4/24/19 to apply oxygen at 2 liter per nasal cannula (L/NC) for chest pain, changes in LOC (Level of Consciousness), shortness of breath, comfort measures, or saturation less than 90% on room air. The order directed if using oxygen, check pulse ox (blood oxygen level) 2 times per shift and notify the physician immediately by fax, or phone if more urgent. The order summary contained no orders for changing the oxygen tubing or humidification water bottle. Observation on 6/17/19 at 11:23 a.m. revealed Resident # 25 wore oxygen at 2L/NC via concentrator, stated it was hard to breathe, and asked if the oxygen was on. The humidification water bottle observed to be empty. Observation on 6/19/19 at 9:21 a.m. revealed Resident # 25 sat in a wheelchair in the commons area with an O2 tank in a pouch on the back, O2 tubing in a plastic bag, and O2 on at 2 liters per nasal cannula. At 9:39 a.m., the concentrator in the resident's room contained a humidifier bottle 1/2 half full of water, the tubing in a plastic bag. Observation also revealed none of the equipment contained a label to record when someone cleaned or filled the bottle or changed the tubing. At 2:33 p.m., Resident # 25 wore O2 at 2L/NC with the tubing off the floor, and a half full humidifier bottle with no dates or labels. The clinical record revealed weekly	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 695	Continued From page 47	F 695		

Continued From page 47

measurements of the oxygen in the blood via pulse oximeter (pulse ox), although the record contained an order that directed staff to measure it two times per shift with oxygen in use.

The Weights and Vitals Summary report printed on 6/20/19 revealed the following O2 saturations (sats) recorded (pulse oximeter) only:

4/30/19 - 96% on oxygen per NC
5/2/19 - 95% on oxygen per NC
5/7/19 - 96% on room air
5/14/19 - 95% oxygen per NC
5/21/19 - 96% on room air
5/28/19 - 94% oxygen per NC
6/2/19 - 95% on oxygen per NC
6/4/19 - 96% on room air
6/11/19 - 93% on room air
6/18/19 - 97% on oxygen per NC

Review of the June 2019 Treatment Administration Record (TAR) revealed the TAR lacked documentation that showed staff changed oxygen tubing or the humidification bottle weekly.

On 6/19/19 at 4:42 p.m., the Director of Nursing (DON), reported the nurses should assessing the pulse ox sats if the resident on oxygen. The DON commented she thought the resident went to the hospital and came back on PRN (as needed) oxygen and then staff just started and kept the oxygen in use continuously. The DON stated the nurses should obtain orders that dictate when to change the tubing and the humidification bottle and then document the changes on the TAR when completed. The DON confirmed oxygen tubing and the humidification bottle should be labeled and dated, the oxygen tubing and humidification changed at least weekly, and the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 695	Continued From page 48 nebulizer machine cleaned weekly.	F 695		
F 700 SS=K	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on the United States Food & Drug Administration's Guide, observations, clinical record review, and staff interviews, the facility failed to assess bed rails for risk of entrapment and obtain consent for the use of side rails for 5 out of 50 beds reviewed for side rail safety. (Resident #21, #20, #51, #103, #1). This failure constituted immediate jeopardy to resident health and safety. The facility reported a census of 50 residents.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 700	Continued From page 49 Findings include: The website article updated 8/30/18 titled Hospital Beds (https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/hospital-beds), published by the United States Food & Drug Administration (FDA), included the following factual information: Between January 1, 1985 and January 1, 2013, FDA received 901 incidents of patients caught, trapped, entangled, or strangled in hospital beds. The reports included 531 deaths, 151 nonfatal injuries, and 220 cases where staff needed to intervene to prevent injuries. Most patients were frail, elderly or confused. The efforts of the FDA and the Hospital Bed Safety Workgroup (HBSW) have culminated in FDA's release of Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. This guidance provides recommendations for manufacturers of new hospital beds and for facilities with existing beds (including hospitals, nursing homes, and private residences). Healthcare facilities developing comprehensive bed safety programs should consider - a. following the Clinical Guidance for the Assessment and Implementation of Bed Rails to assess an individual patient's needs when using a side rail; and b. consulting with the hospital bed manufacturer and their facilities' risk managers. The Guidance for Industry and FDA Staff Hospital	F 700		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 700	Continued From page 50 Bed System Dimensional and Assessment Guidance to Reduce Entrapment issued on 3/10/06 included the following documentation: Introduction This guidance provides recommendations relating to hospital beds (the terms "medical bed" and "hospital bed" are used interchangeably throughout this document and include adult medical beds with siderails) and hospital bed accessories. The guidance provides recommendations intended to reduce life-threatening entrapments associated with hospital bed systems (as used in this guidance, "hospital bed system" encompasses the bed frame and its components, including the mattress, bed side rails, head and foot board, and any accessories added to the bed). It characterizes the body parts at risk for entrapment, identifies the locations of hospital bed openings that are potential entrapment areas, and recommends dimensional criteria for these devices. Background For 20 years, FDA has received reports in which vulnerable patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities. The term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. Key Body Parts at Risk Three key body parts at risk for life-threatening entrapment in the seven zones of a hospital bed system discussed in this guidance are the	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 700	Continued From page 51	F 700		

head, neck, and chest. International anthropometric data references have been used to determine the relative sizes of these body parts for the population at greatest risk for entrapment and to provide a guide for the dimensional limits that would reduce their risk of entrapment.

a. Head - To reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head (head breadth measured across the face from ear to ear) to be trapped. Country-specific anthropometric data show that a 1st percentile female head breadth may be as small as 95 mm (3 ¾ inches). A dimension of 120 mm (4 ¾ inches) encompasses the 5th percentile female head breadth in all data sources used to develop these recommendations, and includes 1st percentile female head breadth as reported in some data sources. FDA is therefore using a head breadth dimension of 120 mm (4 ¾ inches) as the basis for its dimensional limit recommendations. This dimension is consistent with the dimensions recommended by the HBSW and the IEC (International Electrotechnical Commission).

Potential Zones of Entrapment
This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions.

a. Zone 1 - Within the Rail - Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. The HBSW and IEC recommend that the space be less than 120

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 700	Continued From page 52 mm (4 ¾ inches), representing head breadth. 2. An observation completed on 6/20/19 at 9:12 a.m. of all the bed side rails in the facility revealed the following rooms contained quarter side rails on both sides of the bed with measurements greater than 4 and 3/4 inches (") within the perimeter of the side rails: a. Room 106B - Resident #51 sat in a wheelchair beside the bed during measurement, both bed rails in the up position. b. Room 204A - Resident #21 not present in room at time of measurement, right side rail against wall in up position left one down. c. Room 310A - Resident #20 not present in room at time of measurement, both side rails in down position, only 1 bed in room. d. Room 311B - Resident #103 lay in the first bed by the door during measurement, right side rail against the wall in the up position left one down. e. Room 507A - Resident #1 lay in bed during the measurement, both bed rails in the up position, and stated she used the rail for positioning. Each side rail contained the same style of side rails with 3 rungs within the side rail. The spaces within the rails measured: a. space towards head of bed - 5 and 3/4" width, 7 and 3/4" length, 9" diagonal b. center space - 7 and 1/4" width, 7 and 3/4" length, 10" diagonal c. space towards end of bed - 7" width, 7 and 3/4" length, 9 and 3/4" diagonal The Zone recommendations for Zone 1 within the rail: Any open space between the perimeters of	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 700	Continued From page 53	F 700		

the rail can present a risk of head entrapment. FDA recommended space less than 4 and 3/4"

1. Observation on 6/20/19 at 9:34 a.m. revealed a surveyor with her head thru the middle section of the side rail. This finding reported to the Administrator at 9:40 a.m. The Administrator stated the facility would remove and replace the side rails immediately.

On 6/20/19 at 12:38 p.m. the Administrator and the Nurse Consultant reported 5 beds with that type of side rail removed from the building and placed outside by the dumpster after they became aware of the concern for potential for entrapment with the side rail measurements. The Administrator stated discussed a plan moving forward to ensure proper side rail/equipment use. The Nurse Consultant reported facility to complete side rail assessments for residents to determine if need or type of side rail.

2. According to the Minimum Date Set Assessment too dated 6/6/19, Resident #21 had diagnoses of Alzheimer's disease and glaucoma and experienced severe memory impairment and displayed fluctuating inattention and disorganized thinking. The MDS revealed the resident required limited physical assistance of 1 staff for bed mobility and transfers and did not identify that the resident used bed rails.

a. On 4/1/19, the care plan focus area documented the resident displayed altered thought processes.
b. On 4/2/19, the care plan identified a risk for falls related to antidepressant medication use, glaucoma, and c. Alzheimer's disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 700	Continued From page 54	F 700		

d. On 4/26/19, the facility revised the care plan to identify a moderate risk for falls and directed staff to round hourly and anticipate the resident's needs (offer drinks, water, offer to take to restroom).
e. On 5/8/19, the care plan identified the resident had impaired visual function.

Observation on 6/17/19 at 11:33 a.m., revealed: Resident # 21 sat next to the nurses station in a regular chair and made multiple attempts to stand by herself with a wheeled walker. At 2:19 p.m., Resident #21 lay in bed with a quarter side rail in the up position. Resident # 21 yelled for help, sat up in bed, and tried to scoot to the end of the bed. After a couple of unsuccessful attempts, Resident # 21 lay back down.

On 6/20/19 at 10:00 a.m., clinical record review revealed Resident #21's hard chart contained a form titled Use of Side Rails Education Sheet/Consent Form. The form documented the resident requested side rails be used per preference for mobility and/or safety but the form failed to contain a date or signature of the resident or resident representative. The record also contained a Side rails Risk Assessment for the use of Side Rails that contained the resident's name and room number on it but was otherwise left blank.

3. According to the MDS assessment dated 4/4/19, Resident # 20 had a diagnoses of non-Alzheimer's dementia and a Brief Interview for Mental Status (BIMS) score of 03 (severe cognitive impairment). The MDS documented the resident displayed with fluctuating behaviors of inattention and disorganized thinking and was fully dependent of staff . A score of 03 indicated .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 700	Continued From page 55 The MDS revealed the resident totally dependent upon 1 person for bed mobility and 2 persons for transfers. The MDS recorded bed rails not used. The care plan focus area revised 1/24/19 identified a risk for injury related to non-compliance with transfers. On 2/8/19 the care plan identified a high risk for falls related to gait, balance problems, generalized weakness, incontinence, and psychoactive drug use. On 2/11/19 the care plan documented the resident attempted self-transfers, required assistance of 2 persons, and to help minimize potential for falling from bed, staff directed to use a bolstered mattress. On 6/20/19 at 10:00 a.m. record review revealed Resident #20's clinical record lacked a bed side rail assessment or consent for the use of side rails. 5. The MDS assessment dated 5/30/19 for Resident #51 identified a BIMS score of 14 indicating intact cognition. The MDS revealed the resident independent with bed mobility and transfers. The MDS documented diagnoses that included recurrent major depressive disorder and chronic pain syndrome. The care plan focus area revised 12/15/17 identified mobility deficits and at times needed assist with ADLs related to chronic arthritis, ankylosing spondylosis (causes inflammation of the spinal joints), RA (rheumatoid arthritis) in hands, and flexion contractures in knees. The care plan informed staff the resident no longer able to ambulate and wheelchair dependent.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 700	Continued From page 56 On 6/5/19 the care plan revised for a risk for falls related to mobility deficits, arthritis, contractures, chronic pain, and use of antidepressant, hypnotic, opioid, antianxiety, and anticonvulsant medications. On 6/20/19 at 10:00 a.m. record review revealed Resident #51's clinical record lacked a bed side rail assessment or consent for the use of side rails. 6. The electronic record for Resident # 103 revealed the resident newly admitted to the facility on 6/14/19. The care plan focus area dated 6/15/19 identified a risk for falls related to history of falls, use of walker, decreased strength, natural aging process, and diagnoses of muscle weakness, TIA (Transient Ischemic Attack), COPD (Chronic Obstructive Pulmonary Disease), Alzheimer's disease, and dementia with behaviors. The care plan direct staff to provide frequent checks of the resident. On 6/20/19 at 10:00 a.m. record review revealed Resident #103's clinical record lacked a bed side rail assessment or consent for the use of side rails. 7. The MDS assessment dated 6/5/19 for Resident #1 documented a new admit to the facility. The care plan focus area dated 6/7/19 identified a risk for falls related to a history of falling, hip displacement, and afib (atrial fibrillation).	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 700	Continued From page 57 On 6/20/19 at 10:00 a.m. record review revealed Resident #1's clinical record lacked a side rail assessment or consent for the use of side rails. The facility abated the Immediate Jeopardy situation on 6/20/19 by implementing the following actions: 1. The five offending beds were removed from the facility and replaced with different beds that complied with regulations. 2. All 51 current residents have had a bed rail assessment, and consent form completed. All care plans have been updated to reflect use of bed rails. 3. All residents have a potential to be affected. A 100% audit was completed for residents to include completion of the bed rail assessment, consent and update to the care plan to reflect side rail usage. 4. The maintenance and housekeeping/laundry services department heads were educated regarding the measurements of the opening on bed rails need to be less than 4 ¾ inches. 5. A bed rail assessment for each resident will be conducted quarterly and upon admission. 6. Bed rail assessment audits will completed by the Administrator or designee to ensure all residents have a bed rail assessment and consent weekly for 6 weeks, bi-monthly times 1 month with results reviewed by the facility's QA committee for further determination.	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education.	F 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING _____ B. WING _____	06/20/2019

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

(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 730	Continued From page 58	F 730		

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
Based on personnel file reviews and staff interview, the facility failed to assure all certified nursing assistants (CNA's) received 12 hours of inservice education yearly and to complete annual performance evaluations for 2 of 3 sampled CNA's employed greater than 1 year (Staff O and P). The facility identified a census of 50 residents.

Findings include:

1. The personnel file for Staff O, CNA, documented a hire date of 2/1/17. Review of the facility's inservice records revealed from 5/1/18-5/1/19 Staff O only did 5 hours of online inservices during this time.

Staff O's personnel file contained 1 undated performance evaluation signed by the former director of nursing who left employment in March, 2018 .

2. The personnel file for Staff P, CNA, documented a hire date of 3/6/15. Review of the facility's inservice records from 5/1/18-5/1/19 revealed Staff P failed to attend any scheduled inservices or complete online training.

Staff P's personnel file contained 2 undated and unsigned performance evaluations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING _______ B. WING _______	06/20/2019

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

(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 730	Continued From page 59 During interview on 6/21/19 at 2:10 PM the Administrator stated she is unable to say why personnel files were not complete because she did not start as Administrator until early January of this year. She had noted they were not being done and is working to get them caught up but has no formal plan on how to accomplish this task.	F 730		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility record review, the facility failed to properly prepare and test sanitizer, store clean serving utensils in a manner to avoid contamination, and handle ready-to-eat food items in a manner to reduce the risk of contamination and food-borne	F 812		

(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 812	Continued From page 60 illness. The facility reported a census of 50 residents. Findings include: Observation on 6/17/19 at 8:55 a.m. with Staff K, Dietary Cook, and Staff L, Dietary Aide, present in the kitchen revealed the following: a. Four (4) pairs of serving tongs stored as clean hung from a wall rack in front of the window air conditioner; air conditioner with some dust buildup present b. A small oscillating fan on the counter by the double sink pointed at the food prep counter with moderate amount of dust build up present on the fan blades in need of cleaning c. The cabinet that stored the clean serving scoops contained several manuals with visible stains and grime present on the outside of the books in need of cleaning with 1 of the books resting on top of the clean serving utensils e. A red sanitization bucket identified by Staff K as Quatinary Sanitizer contained 1 washcloth. Staff K could not test the bucket because he could not find any test strips. Staff K commented he needed to change the water after his morning cleanup, he normally changed the water ever 2 hours. Staff K then changed the water in the bucket pouring 1 thin capful from the bottle labeled Quatinary Sanitizer. The label on the bottle directed proper preparation to dilute the product for sanitization; for 150 PPM (parts per million) required a set ounce level 0.25 oz (ounces)/gallon. Then Staff K filled the small bucket approximately 1/2 full of water. Staff K still unable to test the water to ensure proper sanitization level due to unable to locate test strips.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 812	Continued From page 61	F 812		

Observation on 6/18/19 at 8:42 a.m. revealed Staff L removed toast from toaster with bare hands, placed toast on a plate, grasped the outside crust as he buttered the slice of toast with a knife, then held the bottom of one slice of toast with his bare hands as he buttered the top part of the bread. Staff M, Dietary Cook, used tongs and placed the toast on plate.

On 6/19/19 at 9:51 a.m. a follow-up tour of the kitchen revealed 7 pairs of serving tongs hung directly in front of the window air conditioner with 1 pair actually touching the vent. Fan on the counter pointed at the food prep area where Staff M placed food from the oven.

In an interview on 6/20/19 at 12:05 p.m., The Nurse Consultant confirmed the staff should test the sanitization level of the red bucket sanitizer each time it was filled to ensure proper sanitization levels. The Nurse Consultant acknowledged staff should not store clean serving utensils in front of air conditioner, fans should point toward the food prep area, and staff should not touch ready-to-eat food with bare hands.

The undated sign posted in the dining room titled Be Aware of Gloves included the following documentation:

It is best to remember when handling food items to use tongs, utensils, paper tissues, etc.
Or use a glove on only 1 hand and the utensil in the other hand when touching the food item.
Also think, "Is my hand clean before touching food?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 868	Continued From page 62	F 868		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to ensure effective quality assurance program in place to provide quality care to residents. The facility identified a census of 50 residents. Findings include: 1. Review of the survey activity reports posted in the facility revealed the following repeated deficient practices were identified in during a total of 4 previous survey activities from during the period of 3/21/18 (the date of the last annual s survey) to present: a. Failure to assure nursing staff followed professional standards cited at a D level (isolated	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 868	Continued From page 63 occurrence with no actual harm with potential for more that minimal harm) during the survey revisit 5/24/18, complaint survey 1/16/19, and during this current survey. b. Failure to provide adequate nursing supervision to residents as directed by individualized care plan at a D Level during the annual survey 3/21/18, at a J level (isolated immediate jeopardy to resident health or safety) 5/24/18, cited at a G level (isolated actual harm with potential for more than minimal harm) on 1/16/19, and at a D level during this current survey. c. Failure to develop individualized resident-centered care plans cited at an E level (patterned occurrence with no actual harm with potential for more that minimal harm) on 3/21/18 and cited at a D level during this current survey. d. Failure to maintain adequate nutrition and hydration status for residents cited at a D level on 5/25/18 and during this current survey. During discussion on 6/21/19 at 2:00 PM until exit on the same day at 4:45 PM, the administrator, corporate nursing consultant, and the director of nursing, could provide no documentation that showed the facility monitored or focused on these repeat citations.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 880	Continued From page 64	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(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:

§483.80(a)(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;

§483.80(a)(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ____ B. WING ____	06/20/2019

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

(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 880	Continued From page 65	F 880		

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.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(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 clinical record review, observation and interview, facility failed to provide a safe, sanitary and comfortable environment and to help prevent the transmission of pathogens for 2 of 24 residents (#8, #44). The facility reported a census of 50 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool dated 3/7/19, Resident #8 had the following pertinent diagnoses: amnesia, chronic venous hypertension with inflammation of left lower extremity, lymphedema, not elsewhere classified, psoriasis, unspecified, and unspecified fracture of right lower leg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 880	Continued From page 66 An MDS dated 6/6/19 (updated after fall) documented the resident as fully dependent on two staff for transfers and bed mobility. The nursing note from 5/29/19 8:18 a.m. revealed a CMA found the Resident #8 lying on her left side on the bathroom floor. After medical attention, it was discovered the resident had sustained a fractured right lower leg and required a stabilizer boot and assist of two staff. The Care Plan documented the resident displayed a self-care deficit and impaired cognition and mobility and required assistance with activities of daily living, including bathing. The Care Plan also documented the resident experienced incontinence related to confusion, dementia, and history of urinary tract infections. Observation on 6/17/19 9:30 am revealed Resident #8 sat on the side of the bed in pajamas with a protective boot on her right leg. The room smelled of urine and feces and the bedding was heavily soiled. Staff F approached the door with a Medcare lift and reported she was waiting for help to transfer the resident to a wheel chair and take her to the shower room. Staff F then removed the resident's soiled gown and incontinence brief and put them on the bed as Staff G entered the room and positioned the lift. The resident's skin was soiled with BM when staff applied the lift sling and raised the resident approximately two feet above the bed utilizing the Medcare lift. Staff F used a wash cloth in an attempt to remove the feces, however the resident's skin was still soiled as they moved her in the lift and lowered her into the wheelchair that contained no barrier or pad between the resident's buttocks and the seat.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 880	Continued From page 67 Staff then covered the resident with a sheet, wheeled her through the hallway to the shower room, and transferred her to the shower chair using the lift. Staff F briefly wiped the seat of the wheel chair with a wash cloth, removed the sling and protective boot and individually placed them on the seat of the wheel chair. In an interview on 6/19/19, Staff F recalled the morning of 6/17 and care for resident and stated, "I saw her pulling the lift away from the bed" so she continued to clean the resident of feces. She sated that she would have preferred to have assisted the resident lay back in the bed to make the resident more comfortable to clean the feces from her skin and apply a clean incontinence brief before taking her to the shower room. Staff acknowledged she should have put a protective pad in the wheel chair and was aware that the resident had not been completely cleaned before they transferred her into the wheel chair. She acknowledged that, although she quickly wiped the seat of the wheel chair after she transferred the resident into the shower chair, "it was probably still soiled". She also confirmed she put the lift sling and the resident's stabilizing boot on the soiled wheel chair seat. 2. The MDS assessment dated 5/16/19, identified Resident # 44 used an indwelling catheter for elimination and experienced moisture associated skin damage (MASD). The care plan revised on 2/8/19 documented the resident had an indwelling catheter due to skin breakdown. During observation on 6/18/19 at 11:02 AM, Staff	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 880	Continued From page 68 B, CNA, washed her hands, donned a pair of gloves, and obtained a graduate container from the bathroom. Staff B placed the graduate container onto the tile floor and then opened an alcohol swab package. The alcohol swab fell into the graduate container. Staff B removed the alcohol swab and placed the contaminated swab onto the tile floor. Staff B opened another alcohol swab package, took the alcohol swab and cleansed the catheter port, then placed the alcohol swab onto the floor. Staff B unclamped the port, drained the urine from the catheter the graduate container, re-clamped the port, and opened another alcohol swab and cleansed the port. Staff B picked up the soiled alcohol swabs and graduate with urine off the tile floor, then emptied the graduate into the toilet and placed the graduate container into a plastic bag in the bathroom. Staff B removed her gloves and washed her hands. Staff B failed to use a barrier between the graduate and bare floor and did not disinfect the tile floor where soiled objects had been. During an interview 6/19/19 at 1:43 PM, the Director of Nursing (DON) reported she expected staff use a plastic bag or non-permeable barrier and place items on when they emptied the catheter for infection control reasons. In an undated procedure for Emptying Catheter Bag, revealed the following procedural steps: a. Assemble equipment including paper towel, graduate container, and alcohol wipes. b. Wash hands and don gloves c. Place paper towel under graduate d. Open drain and empty urine into graduate e. Wipe end of spout with alcohol swabs and close spout	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	06/20/2019

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

(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 880	Continued From page 69 f. Measure urine, empty into toilet, rinse container g. Remove gloves and wash hands.	F 880		

This plan of correction constitutes our credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws.

F 578

The facility reasonably ensures advanced directives for the facility are clearly documented in the resident's clinical record.

- R #13 and R #24 clinical record were reviewed and updated to ensure the current IPOST were in place and easily assessable in the front of the resident's medical record. The previous supportive care plans, stickers, order screens were removed from the R # 13 and R # 24 medical record.

- All facility residents have the potential to be affected.

- On 6/24/19 an audit was completed of all resident's medical record to ensure a current IPOST was in place and easily assessable in the front of the resident's medical record. All conflicting information (supportive care plans, stickers, order screens) was removed from the resident's medical record.

- Quarterly during Care Conferences, the residents' IPOST and medical record will be reviewed by the IDT to ensure the advanced directives are clearly documented, easily accessible, and any conflicting information is removed.

- On 6/28/19 All nursing staff was educated on the IPOST, and IPOST/advance directives process

- The Director of Nursing or designee will complete an audit which will include IPOST and ensuring conflicting information has been removed weekly for 12 weeks. The audits will be reviewed quarterly by the QA Committee

- Compliance Date: July 31, 2019

F 582

The facility reasonably ensures it provides the required forms for Liability Notices and Beneficiary Appeals when skilled services have been exhausted or services are no longer covered.

- R #29 had no negative impact from the form # 1005 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) and form # 10123 Notice of Medicare Provider Non- Coverage (NOMNC) not being provided to the resident or her representative. R #104 had no negative impact from the form # 1005 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) not being provided to the resident or her representative.

- All residents receiving skilled nursing services (Medicare Beneficiary's) have the potential to be affected.

- The Facility updated the process of providing the required forms for Liability Notices and Beneficiary Appeals when skilled services have been exhausted or services are no longer covered. Which includes printed forms #'s 1005 and # 10123 being provided, the MDS Nurse being responsible for providing the forms to the resident and resident representative and the DON assigned as the back up in the absence of the MDS Nurse.

- On 06/25/19 the MDS Coordinator received education on the process of providing the required forms for Liability Notices and Beneficiary Appeals.

- The Director of Nursing or designee will complete an audit weekly for 12 weeks of the residents receiving skilled services to ensure the resident or their representative were provided form's 1005 and #10123. The audits will be reviewed quarterly by the QA Committee

- Compliance Date: July 31, 2019

F 602

QHC Winterset North, LLC believes each resident has the right to be free from misappropriation of property and exploitation.

- A self-report was initiated by the Administrator on 4/11/19 for resident #16, an investigation was completed and findings were uploaded. The missing funds were replenished by the facility on 4/16/19.
- There is a potential for other residents with credit or debit cards to be affected.
- A policy regarding Handling of Resident Credit and Debit Cards was implemented.
- Staff were in-serviced regarding the policy on 6/28/19. All newly hired staff will be educated about the Handling of Resident Credit and Debit Cards policy during orientation.
- Audits will be conducted by the Administrator or designee to determine if the facility is in possession of resident credit or debit cards weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.
- Correction Date July 31, 2019

F 622

QHC Winterset North, LLC must ensure a resident transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

- Resident #24 was affected. Resident #24 did not have a negative outcome due to the facility not recording documentation of information sent to the hospital at transfer.

- All residents have the potential to be affected in the event of transfer to the hospital.

- A discharge process was developed which includes the information / documents required to be sent with a resident, which includes (A) contact information of the practitioner responsible for the care of the resident, (B) resident representative information including contact information, (C) Advance Directive information, (D) All special instructions or precautions for ongoing care, as appropriate, (E) comprehensive care plan goals .

- Licensed nurses were in-serviced on 6/28/19 and 7/30/19 regarding the hospital discharge process.

- The Director of Nursing and / or her / his designee will audit the hospital discharges weekly for one month, then twice per month for one month and monthly thereafter to assure that the discharge process is being followed correctly. The audit results will be reviewed quarterly by the QAPI/QA/QI Committee for two quarters.

- Correction Date July 31, 2019.

F 623

QHC Winterset North, LLC will notify the State Long-Term Care Ombudsman of all resident discharges and transfers.

- The State Long-Term Care Ombudsman was notified of the discharge of Residents # 3, 15, and 24.
- All residents have the potential of being affected who transfer or discharge from the facility.
- Administrator obtained from IHCA a "Notice of Transfer Form to Long Term Care Ombudsman."
- On July 26, 2019, the Administrator was instructed on how to retrieve discharge and transfer information from PCC.
- The administrator will submit to the Ombudsman's Office a completed "Notice of Transfer Form to Long Term Care Ombudsman" on a monthly basis.
- The Administrator and / or her / his designee will audit the completion and submission of "Notice of Transfer Form to Long Term Care Ombudsman," monthly for one quarter and then every other month for two months. The audit results will be reviewed quarterly by the QAPI/QA/QI Committee for two quarters.
- Correction Date July 31, 2019

F 625

QHC Winterset North, LCC provides written information upon transfer for hospitalization or therapeutic leave to the resident or resident representative that specifies duration, reserve bed payment policy, and the facility's policies regarding bed hold periods.

- Residents #3, 15 and 24, or their representatives did not receive bed hold information prior discharge from the facility, with no negative outcomes for not receiving proper documentation prior to discharge.

- All residents have the potential to be affected. Bed hold agreement forms were distributed to nursing staff and business office staff for completion with all transfers to the hospital and therapeutic leaves.

- Facility staff were in-serviced on 6/28/19 and ongoing re: bed hold requirements and bed hold agreement forms.

- Bed hold agreement audits will be completed by the Administrator or designee weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.

- Correction Date July 31, 2019

F 641

QHC Winterset North, LLC will assure each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.

- Resident #16's MDS was modified to accurately indicate he is a tobacco smoker.
- All smoking residents have the potential to be affected. A 100% audit was completed of the smoking residents on 6/24/19.
- The MDS Coordinator participated in a Staff Education on 7/26/19 wherein she was instructed on the importance of the MDS accurately reflecting the residents' status at the time of assessment.
- The Director of Nursing and / or her / his designee will audit the MDSs weekly for one month, then twice per month for one month and monthly thereafter, to assure the MDSs are accurate. The audit results will be reviewed quarterly for two quarters by the QAPI/QA/QI Committee.
- Correction Date July 31, 2019

F 656

QHC Winterset North, LLC develops and implements a comprehensive person-centered care plan for each resident that address specific interventions regarding COPD and oxygen use.

- Residents #17 and #25 were affected. The care plans for both residents were modified to include the COPD diagnosis and oxygen use, respectively.

- All residents who have COPD or use oxygen have the potential of being affected. On 6/28/19 a 100% review of care plans was completed to ensure all care plans reflect accurate respiratory assessments.

- Facility nurses were in-serviced on 6/28/19 and ongoing re: oxygen assessments on the MAR.

- Audits will be conducted by the DON or designee to determine if COPD and oxygen use are being addressed on the care plan 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for two quarters.

- Correction Date July 31, 2019

F 657

QHC Winterset North, LLC reviews and revises the comprehensive care plans quarterly, with comprehensive assessments and as needed based on the resident's condition.

- Residents #24 and 44 were affected. Resident #24's care plan was updated to include placement and care of her Jackson Pratt drain and interventions to ensure all care needs are met. Resident #44's care plan was updated to include proper and accurate transfer information. Conflicting transfer information was removed.

- All residents have the potential of being affected. On 6/28/19 a 100% review of care plans was completed to ensure all care plans reflect accurate conditions and transfers for the residents' care needs.

- MDS Coordinator was educated regarding development, implementation and updating of a comprehensive care plan.

- Care plan audits will be completed by the DON or designee weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.

- Correction Date July 31, 2019

F 658

QHC Winterset North, LLC provides services that meet professional standards of quality that includes ensuring steroidal inhalers are administered to residents with appropriate follow-up.

- Resident #17was affected. Resident #17 will be offered water to swish and spit after receiving a steroidal inhaler.
- Minimal residents have the potential to be affected.
- Staff A was educated on 6/28/19 as to professional standards and proper medication administration with regard to steroidal inhalers.
- Nurses were educated on 6/28/19 as to professional standards and proper medication administration with regard to steroidal inhalers.
- Steroidal inhaler administration audits will be completed by the DON or designee weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.
- Correction Date July 31, 2019

F 677

QHC Winterset North, LLC ensures residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

- Residents # 11 and 25 were affected. Residents #11 and 25's pocket care plans were updated to include assistance with repositioning to be offered.

- All residents who require assistance with repositioning have a potential of being affected. Pocket care plans will be updated with care plans and / or changes as they occur.

- A 100% audit of pocket care plans was completed on 7/17/19.

- Nursing staff was in-serviced on 6/28/19 regarding the need to offer and assist residents with repositioning.

- Nursing staff will be in-serviced monthly for three months as to the need offer repositioning to residents who require repositioning.

- Repositioning audits will be completed by the DON or designee weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.

- Correction Date July 31, 2019

F 689

QHC Winterset North, LLC ensures the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.

- Resident #44 was affected. Resident #44 will be transferred appropriately and safely.
- All residents using a wheelchair have the potential to be affected.
- Nursing staff were in-serviced on June 28, 2019, as to proper transferring of residents.
- All CNAs were provided education and competencies were completed by 6/29/19.
- Nursing staff will be in-serviced monthly for three months as to properly transferring residents.
- Transferring audits will be completed by the DON or designee weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.
- Correction Date July 31, 2019

F 690

QHC Winterset North, LLC ensures a resident with fecal incontinence, receives appropriate pericare.

- Resident #3 was affected. Resident # 3 will receive appropriate pericare.

- All residents who require pericare have the potential to be affected. Facility nursing staff was in-serviced on 6/28/19 as to proper pericare.

- All CNA staff were provided education and competencies were completed by 6/29/19.

- Nursing staff will be in-serviced monthly for three months as to proper pericare.

- Pericare audits will be completed by the DON or designee weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.

- Correction Date July 31, 2019

F 692

QHC Winterset North, LLC reasonably ensures the residents are offered sufficient fluid intake to maintain proper hydration and health.

- Residents #11 and 37 were affected. Residents #11 and 37 had their water pitchers moved within reach of their preferred seating location in their rooms.
- All residents have a potential to be affected.
- Every resident MAR has been revised to include to offer fluids except where contraindicated.
- Nursing staff was in-serviced on June 28, 2019, a water pitcher is to be put within the residents' reach when in their beds or chairs in their rooms.
- Facility revised the water pass protocol.
- Facility nurses and CNAs were in serviced on 6/28/19 and ongoing re: offering fluids to residents.
- Nursing staff will be in-serviced monthly for three months as to water pass protocol.
- Water pass audits will be completed by the DON or designee weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.
- Correction Date July 31, 2019

F 695

QHC Winterset North, LLC reasonably ensures that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences.

- Resident #25 was affected. Resident #25's care plan was reviewed and revised as necessary to include oxygen assessment. Resident #25's concentrator water was replenished. Resident #25's oxygen equipment was labeled with a dated.

- All residents who require oxygen have a potential to be affected. A 100% audit was completed on all current residents regarding their oxygen assessment. An oxygen assessment was added to the MAR for each shift and PRN.

- Facility nurses were in serviced on 6/28/19 and ongoing re: completion of oxygen assessments.

- Oxygen assessment, humidification and dated equipment audits will be conducted by the DON or designee weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.

- Correction Date July 31, 2019

F 700

QHC Winterset North, LLC completes bed rail assessments including risk for entrapment prior to the installation of bed side rails for all residents, as well as reviewing the risks and benefits of bed side rails with the resident and/or resident representative and obtains informed consent prior to installation.

- Residents #21, 20, 51, 103 and 1 were affected.

- All residents with bed side rails have a potential to be affected.

- The five offending beds were removed from the facility and replaced with different beds on 6/20/19.

- All 51 current residents have had a bed rail assessment, and consent form completed. All care plans have been updated to reflect use of bed side rails.
- A 100% audit was completed for residents to include completion of the bed side rail assessment, consent and update to the care plan to reflect bed side rail usage on 6/20/19.

- The maintenance and housekeeping/laundry services department heads were educated regarding the measurements of the opening on bed side rails need to be less than 4 ¾ inches.

- A bed side rail assessment for each resident will be conducted quarterly and upon admission.

- Bed side rail assessment audits will be completed by the Administrator or designee to ensure all residents have a bed rail assessment and consent weekly for 6 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.

Correction date June 20, 2019

F 730

QHC Winterset North, LLC provides 12 hours of in-service education for all certified nurse aides every 12 months and annual performance reviews.

- All residents have a potential to be affected.
- A 100% audit of staff in-services was completed on 6/24/19 to ensure staff have completed the annual in-service requirements.
- A 100% audit of staff performance reviews was completed on 6/24/19 to ensure staff have received their annual performance reviews.
- All CNAs and all staff, respectively, have a potential to be out of compliance
- Facility staff were re-in serviced on 6/28/19 and ongoing re: in-service requirements.
- Facility staff were given performance reviews to those who were in need of reviews.
- CE Solution audits and performance reviews will be completed by the Administrator or designee to ensure all staff are current with in-service requirements weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.
- Correction Date July 31, 2019

F 812

QHC Winterset North, LLC reasonably ensures it stores prepares, distributes and serves food in accordance to professional standards.

- All residents have a potential to be affected.
- All dietary staff received education on wearing gloves when serving food.
- Dietary staff received education on proper preparation of sanitizing solution and locations of ph test strips.
- A new window air conditioner was installed in the kitchen.
- The tongs in question were moved to a different location in which the air conditioner would not blow on them.
- The fan was cleaned and then removed from the kitchen.
- The CDM or designee to ensure the fan is no longer in the kitchen, items are not in front of the air conditioner, staff do not touch food with bare hands and staff are aware of the location of the ph test strips and proper use weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.
- Correction Date July 31, 2019

F 868

QHC Winterset North, LLC will maintain a Quality Assessment and Assurance Committee to provide quality of care to residents.

- All residents have a potential to be affected.

- The internal QAA team will meet monthly with external entities meeting quarterly (QAPI).

- The team is consisting of Administrator, DON, ADON, MDS Coordinator, CDM, Housekeeping / Laundry Supervisor, Maintenance Supervisor, Social Services Designee, Activities Coordinator.

- The QAPI team will include the above mentioned along with Medical Director and Pharmacy Consultant.

- Nursing staff will be in-serviced monthly for three months as catheter care and infection control.

- An agenda including failure to assure nursing staff followed professional standards, failure to provide adequate nursing supervision to residents as directed by individualized care plans, failure to develop individualized resident centered care plans, and failure to maintain adequate nutrition and hydration status for residents.

- Correction Date July 31, 2019

F 880

QHC Winterset North, LLC has established and maintained an infection prevention and control program that provides a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

- Resident #44 was affected. Staff were educated as to proper catheter drainage and barriers.
- All residents with catheters have potential to be affected.
- Urine bag drainage competencies were completed.
- Resident #8 was affected by having an un-sanitized boot placed in her wheelchair.
- All incontinent residents have potential to be affected.
- Nursing staff were re-in serviced about proper infection control practices regarding not placing soiled items in a wheelchair.
- Nursing staff were re-in serviced on 6/28/19 and ongoing re: infection control and catheter care.
- Nursing staff will be in-serviced monthly for three months as catheter care and infection control. The DON or designee will audit correct catheter bag drainage and wheelchair sanitation weekly for 4 weeks, twice per month times 1 month with results reviewed by the facility's QA committee for further determination.
- Correction Date July 31, 2019