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	165264	A. BUILDING _____ B. WING _____	C 09/10/2020

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

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F 000	INITIAL COMMENTS Correction date 10/5/20 The following deficiencies result from the complaint investigation. Complaints # 92691-C, # 92841-C # 92960-C were not substantiated. Complaints # 92788-C, # 92963-C and # 93003-C were substantiated. A COVID-19 Focused Infection Control Survey was also conducted by the Department of Inspection and Appeals in conjunction with the investigation. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		
F 584 SS=E	See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C, Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		

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

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

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F 584	Continued From page 1 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain and provide an adequate supply of linens in good condition that included a complete change of bed linens, available for every bed as required. The facility reported a census of 59 residents. Findings include:	F 584		

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F 584	Continued From page 3 laundry only had two staff. On 9/1/20 at 7:12 a.m., both Staff A, certified nursing assistant (CNA) and Staff C, CNA, stated the facility did not have enough bed linens. On 9/1/20 at 7:32 a.m., Staff E, laundry, stated all soiled laundry in the facility was washed before she left for the day on 8/31/20. 9/2/20 at 11:03 a.m., the assistant director of nursing (ADON) stated the reason there was a shortage of sheets was due to the number of bed changes and lack of available linen. She verified 5 residents had lain on mattresses without linen that morning were on mattresses that required bed linens. She did add that the facility accepted 23 residents from a sister facility that had evacuated due to storm damage and confirmed 21 of the 23 resident evacuees remained at the facility as of that time.	F 584		
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 clinical record review, staff interviews and facility policy review, facility staff failed to follow professional standards of practice that included implementation of physician orders for two of 12 residents reviewed (Residents #6 and #12) that included narcotic medications for Resident #6 and all medications for Resident #12	F 658		

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F 658	Continued From page 4	F 658		

and failed to document medications administered on a medication administration record (MAR) for 1 of 12 records reviewed (Resident #6). The facility identified a census of 59 current residents.

Findings include:

1. The 8/20/20 Minimum Data Set (MDS) Assessment tool recorded Resident #6 admitted to the facility on 8/11/20 with diagnoses that included anemia, malnutrition, anxiety, depression, chronic lung disease and respiratory failure with hypoxia (low oxygen level) or hypercapnea (high carbon dioxide level), scored 14 out of 15 points on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated no cognitive impairment or symptoms of delirium present, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, bathing and toileting, 1 staff assist for dressing, the resident had not received any analgesics administered on a scheduled or as needed basis, the resident denied any pain that had occurred in the 5 days prior to the assessment, and the resident had not required oxygen administration.

Resident #6 was transferred to the facility on 8/11/20 due to a forced evacuation from a facility with structural damage from a weather emergency on 8/10/20.

Physician orders documented in Resident #6's electronic record revealed:

8/16/20 at 7:16 a.m. - Alprazolam (an antianxiety medication) 0.5 milligrams (mg) 2 times daily by mouth for shortness of breath.
8/16/20 at 7:16 a.m. - Alprazolam 0.5 mg by

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F 658	Continued From page 5 mouth every 4 hours as needed for shortness of breath. 8/16/20 at 7:34 a.m. - Alprazolam 0.5 mg by mouth every 4 hours as needed for anxiety. 8/21/20 at 10:56 a.m. - Dilaudid (narcotic analgesic) 2 mg by mouth every 4 hours. 8/21/20 at 11:00 a.m. - Dilaudid 4 mg by mouth every 4 hours as needed. There were no current or discontinued oxygen orders found. Review of the resident's inventory control sheets revealed: a. Three control sheets dated 8/11/20 for prescription #1224346, Alprazolam 0.5 mg by mouth 3 times daily with the quantity received recorded on each sheet as 25, 24 and 20. b. One control sheet dated 8/11/20 for prescription #1347977, Alprazolam 0.5 mg by mouth every 4 hours as needed for shortness of breath or anxiety, quantity received recorded as 16. c. One control sheet dated 8/11/20 for prescription #1336883, Dilaudid 2 mg by mouth every 4 hours, with notation "do not wake if asleep", quantity received had been recorded as 50. The facility could not provide a MAR or documentation of medications administered to the resident prior to 8/16/20, other than what was transcribed on narcotic inventory control sheets. The Alprazolam inventory control sheets revealed 6 doses of Alprazolam administered between 8/11/20 and 8/16/20, when the facility received authorization for the order from the Hospice	F 658		

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F 658	Continued From page 6 medical director physician. The Dilaudid inventory control sheet revealed 6 doses administered between 8/11/20 and 8/16/20, when the facility received authorization for the order from the Hospice medical director physician. Documentation in the Nurse's Notes (NN) between 8/11/20 and 8/16/20 failed to contain the reasons why the medications were administered without physician orders, or how the resident was affected by the administration. A NN by Staff D, registered nurse (RN) on 8/11/20 at 11:30 p.m. documented the resident stated she was short of breath all the time with oxygen saturation of 89 percent with oxygen administered at 4 liters per minute per nasal cannula (normal value of 95 to 100 percent on room air). Twelve (12) oxygen saturation values documented between 8/11/20 and 9/2/20 revealed the resident wore oxygen per nasal cannula when the assessment was completed, with values that ranged from 89 percent to 99 percent. Observations on the following dates and times revealed: a. 8/31/20 at 12:22 p.m., oxygen administered per nasal cannula via concentrator set at 2 liters per minute. b. 9/2/20 at 7:17 a.m., oxygen administered per nasal cannula via concentrator set at 1 liter per minute. The resident appeared asleep. c. 9/2/20 at 8:58 a.m., resident in bed but awake, respirations 24 to 28 per minute, oxygen administered per nasal cannula at 1 liter per minute per concentrator.	F 658		

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F 658	Continued From page 7 Staff interviews revealed the following information: a. On 9/3/20 at 12:28 p.m., Staff D, RN, stated she was on duty on 8/11/20 when the resident arrived at the facility, had transcribed the generic narcotic inventory control sheets from medications transferred with the resident, and she had worked with the hospice nurse to obtain medication orders for the resident. b. During an interview on 9/2/20 at 11:03 a.m., the Assistant Director of Nursing (ADON) stated the facility did not have policies or procedures for physician orders, medication orders, or medication administration, staff were expected to follow professional standards of practice. c. 9/2/20 at 10:04 a.m., the resident's Hospice agency's Director stated the facility had not contacted them with a request for service until 8/13/20, they assessed the resident 8/14/20, and admitted her into service that day; the facility's medical director would have been responsible for her care and medication list. The hospice medical director (a physician), authorized an order for Alprazolam 0.5 mg by mouth twice a day and every 4 hours as needed on 8/15/20. During a subsequent interview on 9/8/20 at 11:06 a.m., the hospice director stated their medical director authorized the Dilaudid orders on 8/16/20, after the facility faxed the resident's medication list to their agency. d. On 9/2/20 at 9:39 a.m., Staff I, facility pharmacist, stated the pharmacy faxed the facility's medical director physician on 8/21/20 with request for authorization of Resident #6's	F 658		

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Dilaudid orders: 2 mg administered oral every 4 hours, and 4 mg administered oral every 4 hours as needed, and the physician did not approve the order until written authorization was received at the pharmacy on 8/24/20.

2. According the MDS assessment dated 8/21/20, Resident #12 entered the facility on 8/11/20. The assessment documented diagnoses that included non-Alzheimer's dementia, epilepsy, anxiety disorder, recurrent depression, cerebrovascular vasospasm and chronic lung disease. The MDS documented the resident rarely understood others, could rarely make herself understood, and possessed severely impaired cognitive skills for daily decision-making and an altered level of consciousness.

Review of Resident #12's MAR dated 8/11/20 revealed she received no medications at the facility until 8/26/20. Review of an Order Summary Report dated 8/11/20 revealed no physician's orders in place.

On 8/31/20 at 3:30 pm, the Administrator stated Resident #12 arrived from another facility after the sending facility sustained severe storm damage from a derecho. Resident #12 was not on the list of residents transferring, but the list did contain another resident's name. That resident did not arrive, but her records did and subsequently Resident #12 arrived without physician orders. The Administrator stated the ADON spent a lot of time trying to obtain Resident #12's medical records. The Administrator reported supposedly, the records went to a Fort Dodge facility instead of QHC Mitchellville, but at the time they had no computer or facsimile access due to a storm. The facility

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finally accessed the resident's records from the EMR (electronic medical record) and ran the orders.

The ADON provided a handwritten timeline of her efforts to obtain Resident #12's records and physician's orders. The timeline recorded attempts at contact from the transferring facility beginning 8/12/20 with final access to the resident's EMR and receipt of her orders on 8/25/20.

Review of Resident #12's Physician Orders dated 4/8/20 (the most recent) from the transferring facility revealed her primary care provider ordered that Resident #12 receive:

a. Acetaminophen (Tylenol, a pain reliever) 325 mg (milligrams) twice a day.
b. Aspirin (anti-inflammatory medication) 81 mg every morning.
c. Buspar (anti-anxiety medication) 10 mg twice a day.
d. Celexa (anti-depressant medication) 10 mg every morning.
e. Depakote sprinkle (anti-seizure medication) 125 mg every morning.
f. Lasix (to remove fluid) 20 mg every morning.
g. Ativan (anti-anxiety medication) 0.5 mg three times a day.
h. Magnesium Hydroxide 20 milliliters daily for constipation.
i. Remeron (anti-depressant medication) 15 mg every evening.
j. A multivitamin every morning.
k. Roxicodone (pain medication) 5 mg three times a day.
m. Risperdal (anti-psychotic medication) 0.5 mg twice a day.

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F 658	Continued From page 10 n. Senokot 8.6 mg two tablets twice a day for constipation. The Order Summary Report dated 9/2/20 recorded the facility received orders for and began administering the resident's medications listed above on 8/25/20. On 9/8/20 at 1:30 pm, the Administrator provided a New Admit Checklist and stated the facility used the checklist prior to the residents' recent admissions. The checklist instructed, in part, to review orders if correct in the EMR and to fax orders to a resident's physician, which would included skilled orders, standing orders and clarification forms as needed.	F 658		
F 677 SS=E	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 observation, clinical record review, and resident and staff interviews, the facility failed to provide activities of daily living (ADL) assistance for 5 of 10 residents reviewed for oral care and hygiene assistance (Residents #1, #2, #7, #10 and #12). The facility also failed to provide eating assistance for one of six residents reviewed (Resident #8). The facility identified a census of 59 current residents. Findings include: 1. The 7/2/20 Minimum Data Set (MDS)	F 677		

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F 677	Continued From page 11 Assessment tool revealed Resident #1 admitted to the facility on 10/9/18, with diagnoses that included quadriplegia, anxiety, depression and neurogenic bladder. The MDS showed the resident scored 15 out of 15 points on the Brief Interview for Mental Status (BIMS) cognitive assessment, which indicated the resident show cognitive impairment or symptoms of delirium. The MDS revealed Resident #1 required extensive assistance of at least 2 staff to transfer from surface to surface, and extensive assist of 1 staff for repositioning in bed, dressing, and personal hygiene. During an interview on 8/31/20 at 2:23 p.m., the resident stated the only way has oral hygiene or care completed is if she asks staff for assistance with it, otherwise, she added, staff never offer to provide the care. 2. The 8/19/20 MDS revealed Resident #7 admitted on 8/11/20, with diagnoses that included cerebrovascular accident (a stroke), dementia and repeated falls. The MDS documented the resident 3 out of 15 points possible on the BIMS cognitive assessment, which indicated the resident displayed severe cognitive impairment. The MDS also documented the resident required extensive assistance of at least 1 staff to reposition in bed and transfer form surface to surface, and assistance by 1 staff for dressing, personal hygiene and toilet use. The initial nursing care plan recorded on a Resident Status Sheet indicated the resident required assistance to comb/brush hair and shave and also required assistance for nail care and oral care assistance. The resident had teeth and did not have dentures.	F 677		

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F 677	Continued From page 12 Resident observations on 8/31/20 at 3:40 p.m. revealed the resident had facial hair at least 1 inch long, appeared groomed. On 9/1/20 at 1:11 p.m., the facial hair remained unchanged in appearance as the resident sat in a wheel chair at the nurse's station as he spoke on the telephone. Observation in the resident's room that he shared with a room mate revealed: 9/1/20 at 1:42 p.m., one dry tooth brush and tube of tooth paste without a name on it positioned on the left side of the sink (toward the room mate's side of the room). No other oral care items were found throughout the sink area, drawers by the sink, or resident's night stand. 9/2/20 at 7:26 a.m., one dry tooth brush and tube of tooth paste appeared un-moved on the left side of the sink, no other oral care items visible. 9/2/20 at 2:02 p.m., no other visible oral care supplies in the resident's room, dry tooth brush and tube of tooth paste remained on the left side of the sink. 9/3/20 at 7:50 a.m., no oral care supplies in the resident's room other than the unlabeled dry tooth brush and tube of tooth paste. 9/3/20 at 8:53 a.m., observation with the Assistant Director of Nursing (ADON) revealed the one tube of tooth paste and one dry tooth brush, which the ADON believed belonged to the room mate. She then went through all the resident's drawers and drawers by the sink but could not locate any other oral care supplies. She said she would have to check with staff to see how they	F 677		

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F 677	Continued From page 13 provided his oral care. 3. The 6/13/20 MDS revealed Resident #10 admitted to the facility on 6/7/18 with diagnoses that included diabetes, Alzheimer's disease, anxiety, and depression. The resident scored 7 out of 15 points possible on the BIMS cognitive assessment that indicated severe cognitive impairment with symptoms of delirium present. The MDS documented the resident required assistance of 1 staff to reposition in bed and dressing, and extensive assistance of at least 1 staff for surface to surface transfers, toilet use, personal hygiene and bathing. A dental care problem manifested by refusal to wear dentures initiated on the nursing care plan on 6/7/18 directed staff to examine the resident's mouth for lesions, inflammation, and bleeding or swelling daily and as needed. Observations revealed: 9/1/20 at 6:58 a.m., the resident positioned in bed in a room he shared with a room mate. There were 2 emesis basins with tooth paste and tooth brushes in wrappers, located at the sink in the room that failed to contain a name or label. Staff A, certified nursing assistant (CNA) and Staff C, CNA, initiated care to dress the resident dressed and assist him up for breakfast. Continuous observation that concluded at 7:09 a.m. revealed the resident transferred to a wheel chair, staff applied a cloth face mask, and pushed the resident out of the room en route to the dining room for the breakfast meal. Staff did not provide oral care, or offer the care to the resident. 9/1/20 at 10:10 a.m., the resident had been	F 677		

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F 677	Continued From page 14	F 677		

transferred to the room next door, now without a room mate. One of the emesis basins with tooth brushes had been transferred with the resident, and closer inspection revealed a zip-lock baggie that contained a dry tooth brush contained in an individual cellophane wrapper marked "1/2/20," with no visible moisture in the bag.

9/1/20 at 1:41 p.m., no change of oral care supplies, the tooth brush remained dry.

9/2/20 at 8:38 a.m. revealed no change in the condition or position of oral care supplies. A denture cup that contained dentures and labeled with the name of the resident that was transferred out of the room the day before, was positioned near the emesis basin with oral care supplies.

9/2/20 at 2:08 p.m. revealed no change in condition or position of oral care supplies; the tooth brush remained inside the wrapper inside the zip-lock baggie.

9/3/20 at 6:57 a.m. revealed no change of position or condition or oral care supplies and no signs oral care had been provided. The other resident's denture cup with dentures remained at the sink and near the emesis basin with oral the care supplies.

4. According to the MDS dated 7/22/20, Resident #2 had diagnoses that included coronary artery disease, and quadriplegia. The assessment documented she had intact memory and cognition, as evidenced by a BIMS score of 14. The assessment documented Resident #2 required the assist of one staff member to meet her hygienic needs.

Resident #2's care plan, dated 7/14/20, did not

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F 677	Continued From page 15 include instructions on when and how to complete the resident's oral care. During interview and observation on 9/2/20 at 12:30 pm, Resident #2 stated she received oral care only on the days she received a shower. Observation revealed a tray containing a dry toothbrush on the counter in her room. Review of the Task screen in the resident's EMR (electronic medical record) did not reveal a section to document the provision of oral care. 5. According to the MDS assessment dated 8/20/20, Resident #8 had diagnoses that included dementia, chronic lung disease, and chronic atrial fibrillation (an irregular heart rhythm). Resident #8 possessed severe cognitive and memory impairment, as evidenced by a BIMS score of 6. The assessment documented she required the assistance of one staff to eat. The resident's care plan, dated 6/26/20, identified Resident #8 had a nutritional risk related to confusion and physical signs of mild malnutrition and muscle wasting. The care plan instructed staff to serve the resident's diet as ordered, but contained no instruction related to eating assistance. Observation on 9/1/20 from 8:25 am to 9:30 am revealed Resident #8 eating slowly in her room without staff present to assist or cue the resident. She consumed an estimated 10% of her meal when staff removed her tray at 9:30 am. At 12:30 pm, Resident #8 sat in her room recliner with a full plate of food on a table in front of her and her eyes closed; no staff were present to cue or assist her. Continued observation through 12:45	F 677		

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F 677	Continued From page 16	F 677		

pm revealed the resident ate only bites of her food with no staff present to cue or assist her. At 12:45 pm, Staff L CNA took the resident's tray and stated she had been declining for a while now, but was worse today. She ate a bit of her pudding.

Observation on 9/2/20 beginning at 8:50 am revealed the resident seated in bed with her head elevated to 45 degrees, a filled breakfast tray over her lap and her eyes closed. The food sat untouched and no staff cued or assisted the resident. At 9:10 am, she consumed fluids only and staff removed the resident's tray.

Resident #8's Intake Recording Form for 9/1/20 documented she ate 50% of her breakfast and 75% of her lunch and on 9/2/20, she ate 75% of her breakfast (which differed from observations).

The resident's Weight Records dated 5/25 - 8/25/20 documented she had stable weight measurements.

6. According the MDS dated 8/21/20, Resident #12 entered the facility on 8/11/20. The assessment documented diagnoses that included non-Alzheimer's dementia, epilepsy, anxiety disorder, recurrent depression, cerebrovascular vasospasm and chronic lung disease. The MDS documented she possessed severely impaired cognitive skills for daily decision-making and an altered level of consciousness. Resident #12 required the assistance of one staff

Resident #12's Status Sheet dated 8/11/20 instructed staff she required total assistance with mouth care.

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F 677	Continued From page 17 Observation on 9/1/20 at 10:30 am revealed the resident in bed on her left side in bed. Her lips appeared dry. Observation of the resident's bedside drawer and sink surfaces revealed two dry electric toothbrushes, neither marked with a name. Observation on 9/2/20 at 7:40 am revealed Resident #12 lay on her back in bed and her lips were dry. During observation and staff interview at 12:20 pm, Staff B CNA stated the facility assigned her to help with Resident #12's care and Staff B had not completed the resident's oral care yet. Staff B then looked through the resident's drawers, on her sink and table and stated she could find no oral care supplies for the resident. Review of the Task screen in the resident's EMR (electronic medical record) did not reveal a section to document the provision of oral care.	F 677		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and medical provider interviews, and profession reference review, the facility failed to ensure one of 12 sampled residents (#12) did not receive a significant medication error. Resident #12 entered the facility on 8/11/20 and staff failed to obtain medication orders until 8/25/20. That situation constituted Immediate Jeopardy to resident health and safety. The facility identified a census of 59 current residents.	F 760		

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F 760	Continued From page 18 Findings include: 1. According the Minimum Data Set (MDS) assessment dated 8/21/20, Resident #12 entered the facility on 8/11/20. The assessment documented diagnoses that included non-Alzheimer's dementia, epilepsy, anxiety disorder, recurrent depression, cerebrovascular vasospasm, and chronic lung disease. The MDS documented the resident rarely understood others, could rarely make herself understood, and had severely impaired cognitive skills for daily decision-making and an altered level of consciousness. Review of Resident #12's Medication Administration Record dated 8/11/20 revealed she received no medications at the facility until 8/26/20. Review of an Order Summary Report dated 8/11/20 revealed no physician's orders in place. On 8/31/20 at 3:30 pm, the Administrator stated Resident #12 arrived from another facility after the sending facility received severe storm damage from a derecho. Resident #12 was not on the list of residents transferring, but the list contained another resident's name. That resident did not arrive, but her records did and thus Resident #12 arrived without physician orders. The Administrator stated the Assistant Director of Nursing (ADON) spent a lot of time trying to get Resident #12's medical records, but supposedly, the records went to a Fort Dodge facility instead of QHC Mitchellville, which at the time they had no computer or facsimile access due to a storm. The facility finally accessed the resident's records from the EMR (electronic medical record) and ran	F 760		

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F 760	Continued From page 19 the orders. The ADON provided a handwritten timeline of her efforts to obtain Resident #12's records and physician's orders. The timeline recorded: 8/12/20 - No meds. Attempted to call (sending) facility and no answer. The ADON learned the resident's medications went to a Fort Dodge facility as Resident #12 was a last minute swap. 8/13/20 - Attempted to call Fort Dodge related to the resident's medications; no answer. 8/14/20 - The ADON called the Fort Dodge facility and nursing management would return her call. 8/17/20 - No update on meds at this time. 8/18/20 - Fort Dodge staff stated they would ask their DON what was going on. The speaker saw some of Resident #12's medications but was unaware of the situation. 8/19/20 - The nurse at Fort Dodge stated she had Resident #12's medication cards but no chart or access to orders. The ADON requested a handwritten copy of the resident's medications if possible. 8/20/20 - The ADON attempted to call the sending facility but they were unreachable. 8/21/20 - Unable to reach Fort Dodge. 8/22/20 - Fort Dodge nurse stated Resident #12's medication cards were sent to QHC Mitchellville but that had not seemed to happen. The medication cards remained in Fort Dodge, but no chart. 8/23/20 - The ADON called the Fort Dodge facility and the DON was aware of the multiple attempts made. The ADON utilized standing orders. 8/24/20 - No update on the resident's medications; standing orders utilized today. 8/25/20 - A staff member from home office was contacted due to the communication between the	F 760		

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F 760	Continued From page 20	F 760		

facilities going unanswered. The orders were then transferred via the EMR.

Review of Resident #12's Physician Orders dated 4/8/20 (the most recent) from the transferring facility revealed her primary care provider ordered that Resident #12 receive:

a. Acetaminophen (Tylenol, a pain reliever) 325 mg (milligrams) twice a day.
b. Aspirin (anti-inflammatory medication) 81 mg every morning.
c. Buspar (anti-anxiety medication) 10 mg twice a day.
d. Celexa (anti-depressant medication) 10 mg every morning.
e. Depakote sprinkle (anti-seizure medication) 125 mg every morning.
f. Lasix (to remove fluid) 20 mg every morning.
g. Ativan (anti-anxiety medication) 0.5 mg three times a day.
h. Magnesium Hydroxide 20 milliliters daily for constipation.
i. Remeron (anti-depressant medication) 15 mg every evening.
j. A multivitamin every morning.
k. Roxicodone (pain medication) 5 mg three times a day.
m. Risperdal (anti-psychotic medication) 0.5 mg twice a day.
n. Senokot 8.6 mg two tablets twice a day for constipation.

The Order Summary Report dated 9/2/20 recorded the facility received orders for and began administering the resident's medications listed above on 8/25/20.

During review of the handwritten timeline and

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interview with the ADON on 9/1/20 at 11:55, the ADON agreed she spoke to a nurse at the Fort Dodge facility on 8/19/20 and that nurse had the resident's medication records. When asked if she inquired the name of the resident's physician during that call in order to contact them for medication orders, she stated she did not but that would have been a good idea.

During interview on 9/2/20 at 11:00 am with the resident's Primary Care Provider (PCP) during her stay at the sending facility. The PCP stated Resident #12 received anti-seizure and anti-depressant medications and there could be problems if the anti-depressant medications were discontinued abruptly. The PCP thought Resident #12's Depakote level should be checked, and concluded that going two weeks without ordered medications would constitute a significant medication error.

According to website www.accessdata.fda.gov, abrupt discontinuation of Celexa may result in a dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia and hypomania.

According to the website www.nami.org, stopping mirtazapine (Remeron) abruptly may result in one or more of the following withdrawal symptoms: irritability, nausea, dizziness, vomiting, nightmares, headache and/or paresthesias (prickling, tingling sensation on the skin).

Review of Nursing Progress Notes dated 8/11 - 9/3/20 showed no documentation of seizure activity or edema for Resident #12.

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F 760	Continued From page 22 During interviews on 9/3/20 at 8:30 am, the ADON and Staff J, CNA (certified nursing assistant) stated that neither had received reports of seizure activity or edema for Resident #12. At 11:30 am, the ADON stated she did not contact the facility's Medical Director to help resolve the order and medication concern and contacted corporate staff first on 8/25/20. The situation detailed above resulted in Immediate Jeopardy for the facility. The facility was notified of the Immediate Jeopardy on 9/3/20. The facility abated the Immediate Jeopardy situation on 9/4/20 by developing, implementing and educating staff on revised admission policies, including an Irregular Admission Medication Process which showed nurses how to proceed when residents admitted to the facility in an unusual or emergent manner.	F 760		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide necessary adaptive feeding equipment that had been ordered for one of six residents reviewed (Resident #5). The facility reported a census of 59 residents.	F 810		

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F 810	Continued From page 23 Findings include: The 6/29/20 Minimum Data Set (MDS) Assessment recorded Resident #5 admitted to the facility 9/14/19 with diagnoses that included anxiety, depression, and muscle weakness. The MDS documented the resident displayed intact cognition and required limited assist 1 staff for repositioning in bed, transfers from surface to surface, ambulate (walk) within their room, dressing, personal hygiene, and toilet use. The MDS also documented the resident required set-up assistance by staff for eating. A physician order dated 7/28/20 authorized therapy staff to assess the resident for need of adaptive silverware related to increased tremors. A purchase order dated 8/28/20 described the resident's adaptive silverware, weighted utensils that included 2 serrated knives, 2 forks and 2 spoons that totaled $54.58, with a 9/2/20 delivery date. Observation on 8/31/20 at 12:47 p.m. revealed Resident #5 sat in the dining room at a table as she ate her noon meal with regular silverware. The resident stated she should have feeding assistance by staff due to her tremors, and demonstrated the use of a spoon as she attempted to raise it from the plate to her mouth. She displayed constant tremors that shook her arms and hands, with movements of at least 1/2 inch to 1 inch; any liquid that would have been on the spoon was lost. Observation on 9/1/20 at 8:38 a.m. revealed the resident sat in the dining room for the breakfast meal, and used regular silverware.	F 810		

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F 810	Continued From page 24 On 9/1/20 at 9:55 a.m., therapy staff confirmed they completed the evaluation and recommended weighted silverware for the resident on 7/30/20, with the recommendation given to the administrator who should have authorized the purchase and submitted the order per usual. During an interview on 9/2/20 at 10:05 a.m., the Administrator stated the reason the 7/30/20 order for weighted silverware was not placed until 8/28/20 was because of the weather derecho on 8/10/20, she thought a sister facility that transferred 23 residents to their facility on 8/11/20 were supposed to transfer equipment that would include weighted silverware, and as of the bus that arrived on 9/1/20 with those resident's belongings, they hadn't received any such equipment.	F 810		

This Plan of correction and the individual responses to each F tag are written solely to maintain certification with Medicare and Medicaid programs and as required are submitted as credible allegation of compliance. These written responses do not constitute an admission of noncompliance with any requirement. Mitchell Village Care Center wishes to preserve our right to dispute these findings in their entirety should any remedies be imposed and in any legal or administrative proceedings.

- F 584 – Mitchell Village Care Center reasonably ensures a safe/clean/comfortable/homelike environment including maintaining and providing an adequate supply of linens in good condition available for every bed as required.

1.

- R #10 – Resident has new clean fitted sheet on bed
- R #6 – Resident no longer resides in the facility

2.

- All residents in the facility could be affected
- A linen order was placed on 9/1/2020 and arrived 9/10/2020 for 36 fitted sheets, 24 pillow cases, 240 white washcloths, 180 burgundy washcloths, and 24 gowns.
- On 9/5/2020 a linen audit was conducted to ensure a satisfactory number of linens were in the building.
- On 9/29/2020 an additional linen audit was conducted to include the most recent linen order

3.

- An education was conducted on 10/2/2020 and ongoing explaining that linen pars need to be submitted monthly so that new linen can be ordered appropriately.
- An education was conducted on 10/2/2020 and ongoing explaining to staff what linens are necessary to correctly make a bed.

4.

- Administrator or designee will complete weekly audits for 12 weeks to ensure there is an adequate supply of linens in good condition for resident beds.

5.

- Date of Compliance: 10/5/2020

- F 658 – Mitchell Village Care Center reasonably ensures services provided meet professional standards, including timely implementation of physician orders and documentation of medications administered on the Medication Administration Record.

1.

- R #12 – All physician orders have been implemented and medications signed out appropriately
- R #6 – Resident no longer resides in the facility

2.

- All residents who require medication administration could be affected.
- On 9/30/2020 a large red stop sign was placed on the narcotic books on each medication cart indicating that all PRN Medications that are given must be placed into PCC.
- On 9/3/2020 an admission checklist with additional irregular admission process was developed to ensure timely implementation of physician orders.

3.

- An education was conducted on 10/2/2020 and ongoing that all medications that are given must be sign out of the eMAR or Paper MAR.
- An education was conducted on 9/3/2020 and ongoing prior to the licensed nursing staff of the new QHC Facility Admission Checklist that includes an irregular admission sheet as well as corporate contact information for any additional questions of unforeseen obstacles.

4.

- Director of Nursing or designee will complete weekly audits for 12 weeks to ensure that all physician orders are implemented in a timely manner.
- Director of Nursing or designee will complete weekly audits for 12 weeks to ensure that all medications administered are documented on the Medication Administration Record.

5.

- Date of Compliance: 10/5/2020

- F 677 – Mitchell Village Care Center reasonably ensures ADL care for dependent residents including oral care/hygiene and eating assistance.

1.

- R #1 – Resident has received consistent oral care
- R #2 – Resident has received consistent oral care
- R #7 – Resident has received consistent oral care
- R #10 – Resident has received consistent oral care
- R #12 – Resident has received consistent oral care
- R #8 – Resident has been moved to the dining room for meals to ensure proper cueing

2.

- All residents in the facility could be affected.
- On 9/28/2020 additional quality measures were added to the tasks on Point of Care for CNAs including oral care twice per day.

3.

- An education was conducted on 10/02/2020 and ongoing regarding the importance of oral care and the new QA measures placed into POC.
- An education was conducted on 10/02/2020 and ongoing regarding the importance of eating assistance for residents who need it.

4.

- Director of Nursing or designee will complete weekly audits for 12 weeks to ensure that oral care is being completed on POC.
- Director of Nursing or designee will complete weekly audits for 12 weeks to ensure that those needing eating assistance are receiving it.

5.

- Date of Compliance: 10/5/2020

- F 760 – Mitchell Village Care Center reasonably ensures that residents are free of significant medication errors including obtaining medication orders.

1.

- R #12 – Resident has had no additional medication errors

2.

- All residents who take medication could be affected.
- On 9/3/2020 an action plan was created to ensure that all residents entering the facility are admitted with orders.
- On 9/3/2020 an admission checklist with additional irregular admission process was developed to ensure timely implementation of medication orders.

3.

- An education was conducted on 9/3/2020 and ongoing prior to the licensed nursing staffs next scheduled shift on the new admission checklist as well as additional people to call if a resident does not have medication when entering the facility.
- An education was conducted on 9/3/2020 and ongoing prior to the licensed nursing staffs next scheduled shift on the irregular admission process.
- An additional education was completed for all employees on the new admission checklist and irregular admission process on 10/2/2020.

4.

- Director of Nursing or designee will complete weekly audits for 12 weeks to ensure that all residents have been free of medication errors.
- Director of Nursing or designee will complete weekly audits for 12 weeks to ensure that all residents have medication orders.

5.

- Date of Compliance: 10/5/2020

- F 810 – Mitchell Village Care Center reasonably ensures assistive devices such as adaptive eating equipment be provided for residents who require them.

1.
   - R #5 – Resident utilizes weighted silverware at every meal and has not had a significant weight loss

2.
   - All residents who require eating assistance could be affected
   - All residents who require adaptive eating equipment could be affected

3.
   - An education conducted on 10/2/2020 and ongoing was completed for all staff to understand the importance of adaptive equipment.
   - An education conducted on 10/2/2020 and ongoing was completed for therapy staff to email all purchasing requests to the administrator.

4.
   - Administrator or designee will complete weekly audits for 12 weeks to ensure that all residents requiring adaptive equipment have it available to them.

5.
   - Date of Compliance: 10/5/2020