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	165265	A. BUILDING _____ B. WING _____	C 09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC FORT DODGE VILLA , LLC	2721 10TH AVENUE NORTH FORT DODGE, IA 50501

(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 10/22/20 A COVID-19 Focused Infection Control Survey and investigation of Complaints: #93109-C and #93172-C was conducted by the Department of Inspection and Appeals ending on 9/22/20 and resulted in the following deficiencies. Complaint # 93109-C was substantiated. Complaint #93172-C was substantiated. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C).	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 553		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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 553	Continued From page 1	F 553		

of care.

§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-
(i) Facilitate the inclusion of the resident and/or resident representative.
(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff and resident interview the facility failed to included residents in the care planning process for 3 of 3 residents reviewed. (Resident #4 and Resident #5) Facility census was ninety-three (93) residents.

Findings include:

1. Resident #4's most recent Minimum Data Set (MDS) identified the resident with a Brief Interview for Mental Status (BIMS) score of "14" (no cognitive impairment). On 9/14/20 at 1:25 PM, Resident #4 revealed she is not aware of care plan meetings and the facility did not ask her to attend a care plan meeting.

2. Resident #5's most recent Minimum Data Set (MDS) identified the resident with a Brief Interview for Mental Status (BIMS) score of "14" (no cognitive impairment). On 9/14/20 at 1:35 PM, Resident #5 revealed she has never been invited to a care plan meeting.

3. On 9/14/20 at 3:30 PM, the Administrator

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F 553	Continued From page 2 acknowledged staff did not complete quarterly and annual care conferences. The facility initiated a Performance Improvement Plan (PIP) dated 9/14/20 with the objective and goal identified as "care conferences".	F 553		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to notify and document a resident room change for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 93 residents. Findings include: 1. On 9/15/20 at 10:15 AM the Administer revealed the facility did not have a written protocol/policy for resident room and roommate changes. The Administrator further revealed resident room and roommate changes included talking to the resident and if unable to make the	F 559		

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F 559	Continued From page 3 decision for the room change, then the facility would notify the power of attorney (POA)/responsible party. The Administrator identified Resident #3 with a recent room change and a new roommate after coming out of quarantine as the previous roommate no longer wanted to reside with Resident #3. On 9/15/20 at 12:45 PM Staff T, Social Services Designee revealed the protocol for resident room changes is a conversation with the resident, call family if the resident is not able to understand and document in resident's record. Review of Resident #3's clinical record did not reveal notification of the room or roommate change. The facility could not produce a document signed by Resident #3 or responsible party in regards to the room and roommate change.	F 559		
F 584 SS=D	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. (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.	F 584		

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F 584	Continued From page 4	F 584		

(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, resident interview and staff interview, the facility failed to maintain a clean, comfortable and homelike environment. The facility reported a census of 93 residents.

Findings include:

1. Resident #4's most recent Minimum Data Set (MDS) identified the resident with a Brief Interview for Mental Status (BIMS) score of "14" (no cognitive impairment). The resident admitted

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F 584	Continued From page 5 to the facility 9/5/19. On 9/14/20 at 1:25 PM, Resident #4 revealed she would like to look out a clean window and she never observed staff clean her room windows. The resident stated she was hopeful when it rained and it was windy, that it would remove some of the debris from her window. Observation at that time of Resident #4's window revealed cob webs, dead flies, spots on the window and fecal matter from birds. 2. Observation on 9/15/20 at 8:10 AM revealed spider webs and dead flies on the interior window seals in the Villa Dining Room. 3. Observation on 9/15/20 at 1:30 PM of the windows in the main dining room revealed spots on the windows, dead flies and spider webs on the interior window seals and cobwebs throughout the screens. 4. On 9/14/20 at 11:00 AM, the Administrator revealed housekeeping cleaned the facility windows in the early spring, this summer and will clean them again this fall. The Administrator further revealed housekeeping will clean the windows as needed.	F 584		
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	F 602		

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F 602	Continued From page 6	F 602		

by:
Based on record review and staff interview, the facility failed to investigation 2 instances of alleged misappropriation of property for 1 of 6 residents reviewed. (Resident # 3) Facility census was ninety-three (93) residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 7/7/20 for Resident #3 identified a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate impairment. The MDS recorded the resident exhibited no behavioral symptoms during the 7-day assessment period.

Review of Resident #3's record failed to identify the resident missed two watches.

On 9/14/20 at 11:00 AM, the Administrator acknowledged Resident #3 had 2 Apple watches reported missing in the past year; one watch reported missing prior to the Administrator's employment at the facility (Administrator began employment 3/23/20) and one reported missing in April or May of 2020. The Administrator revealed there wasn't any follow-up documentation or investigation in regards to the two missing Apple watches.

Facility form titled QHC Grievance Policy, documented the Facility Administrator is the Grievance Official and is responsible for any necessary investigations and the facility will immediately report all alleged violations including misappropriation of the resident property.

On 9/22/20 at 2:00 PM, the Administrator revealed she did not know she was the Grievance

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F 602	Continued From page 7 Officer for the facility and initiated a Performance Improvement Plan dated 9/22/20 with the objective and goal "grievances and missing items".	F 602		
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 staff interview and record review, the facility failed to provide services that met professional standards of quality for 1 of 7 residents reviewed (Resident #3). The facility reported a census of 93 residents. Findings include: Records for Resident #3 included an appointment at the Veteran's Administration behavioral unit in Des Moines on 8/18/20 at 12:45 PM. Family interview indicated the facility did not supply a medication list and did not send the medication with Resident #3 to the appointment. Review of Medication Administration Record dated 8/1/20-8/31/20 for Resident #3 indicated he did not receive Buspirone 20 milligrams (mg.) for mood at noon on 8/18/20 as ordered as he was out of the facility. In an interview with the Director of Nursing (DON) on 9/14/20 at 11:00 AM she revealed it is an	F 658		

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F 658	Continued From page 8 expectation when a resident is sent to another facility, the facility will supply a face sheet, medication list and Iowa Physician Orders for Scope of Treatment (IPOST) to go with the resident.	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide restorative care for 1 of 6 residents reviewed. The facility reported a census of 93 residents. Findings include: The Minimum Data Set (MDS) assessment tool dated 7/7/20 identified Resident #3 with a Brief Interview for Mental Status (BIMS) of 8 indicating	F 688		

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F 688	Continued From page 9 moderately impaired cognition. The MDS revealed he required extensive assistance of 2 persons with transfers and toilet use and limited assistance of 1 person with bed mobility and personal hygiene. The MDS further indicated he utilized a wheelchair as a mobility device. The MDS included diagnoses of idiopathic peripheral autonomic neuropathy, schizophrenia and post traumatic disorder. On 10/5/20 via email, the Administrator identified the resident's admission date as 10/2/19. Resident #3's Care Plan completed 2/14/20 included a focus area for Impaired Physical Mobility related to the aging process with a goal that he will participate in activities of daily living this quarter. The Nursing Restorative Care Program form dated April 2020 identified Resident #3 with a goal to increase strength with approaches that included Nu-step 2-3 times a week as he tolerated and allowed and exercise class as he tolerated and allowed. Review of the Nursing Restorative Care Program form further indicated the last time staff offered the resident the restorative approaches was 4/3/20. On 9/14/20 at 3:20 PM the Director of Nursing (DON) indicated the facility's Restorative Nursing Aide (RNA) pulled from providing restorative services for the residents in March 2020 due to staffing issues and restorative care for residents was not initiated again until August 2020.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		

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F 692	Continued From page 10	F 692		

(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 record review and staff interview, the facility failed to address a significant weight loss for 1 of 7 residents reviewed (Resident #6). The facility reported a census of 93 residents.

Findings include:

The Minimum Data Set (MDS) assessment initiated 8/19/20 for Resident #6 identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. The MDS revealed the resident required extensive physical assistance of 2 persons for bed mobility and transfers with limited 1 person physical assistance with eating. The MDS documented diagnoses that included cerebrovascular accident (CVA), non-Alzheimer's dementia and arthritis.

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The care plan focus area initiated 8/18/20 identified a potential for altered nutrition related to aging process. The care plan revealed the facility would identify the resident's significant loss/gain with proper interventions. The care plan revealed the dietician is to consult on admission, quarterly and as needed and directed staff to notify doctor/family of any significant weight loss/gain.

On 8/30/20 at 1:36 PM, Staff S, Registered Dietician (RD), documented Resident #6 had a current body weight of 167.6 pounds.

On 9/6/20 at 2:57 PM, Staff L, Licensed Practical Nurse (LPN), documented Resident #6 had a weight of 156.9 pounds.

Nutritional assessment data completed 8/13/20, indicated Resident #6 did not receive supplements and had an appetite pattern of 50-75%.

Review of facility form titled Nutrition/Hydration Process, upon significant change in condition the RD will complete nutrition/hydration assessment of resident and make recommendations to the physician and interdisciplinary team (IDT).

Clinical record review indicated the doctor/family was not notified and the RD (registered dietician) not consulted in regards to the significant weight loss of 10.7 pounds in 7 days. The clinical record further revealed no additional or revised interventions put in place related to the weight loss.

On 9/15/20 at 3:10 p.m. the Director of Nursing stated the facility was aware of the weight loss on

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F 692	Continued From page 12 9/6/20 and the RD should assess the resident this week.	F 692		
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. 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 staff received yearly performance reviews for 4 of 4 sampled staff employed greater than 1 year (Staff I, K, L and M). The facility identified a census of 93 residents. Findings include: 1. The personnel file for Staff I, Certified Medication Assistant (CMA) documented a hire date of 7/12/18. The personnel file did not contain a yearly performance evaluation. 2. The personnel file for Staff K, Certified Nursing Assistant (CNA) documented a hire date of 8/21/18. The personnel file did not contain a yearly performance evaluation. 3. The personnel file for Staff L, Licensed Practical Nurse (LPN) documented a hire date of 12/21/10. The personnel file did not contain a yearly performance evaluation	F 730		

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F 730	Continued From page 13 4. The personnel file for Staff M, Cook documented a hire date of 8/12/19. The personnel file did not contain a yearly performance evaluation. On 9/8/20 at 11:20 AM, the Administrator revealed continuous turnover in leadership at the facility resulted in the facility not completing annual evaluations.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		

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reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to ensure they secured and locked medication carts and a treatment cart while unattended in resident care areas. The facility reported a census of 93 residents.

Findings include:

Observation on 9/1/20 at 10:35 AM revealed a medication cart and treatment cart unlocked between the 100 and 200 hallway on the outside of the nurse's station near the main entrance without staff present. At 10:40 AM Staff H, Nurse Manager, notified of unlocked medication and treatment cart and proceeded to lock both carts.

Observation on 9/2/20 at 11:00 AM revealed Staff I, Certified Medication Aide (CMA) walked away from an unlocked medication cart located in the 500 resident hallway, enter a resident's room with her back to the resident's doorway and perform a blood glucose monitoring procedure.

Observation on 9/2/20 at 11:15 AM revealed a medication cart unlocked on the outside of the nurse's station near the 300 hallway without staff present. Director of Nursing locked cart after notification of observance of unlocked cart.

In an interview with the Director of Nursing on 9/2/20 at 11:15 AM, she revealed she expects staff to lock medication and treatment carts

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F 755	Continued From page 15 unless the carts are within the peripheral vision of the staff person responsible.	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		

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law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview the facility failed to document in a resident's clinical record for 1 of 6 resident's reviewed (Resident #3). The facility reported a census of 93 residents.

Findings include:

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F 842	Continued From page 17 A Minimum Data Set (MDS) assessment dated 7/7/20 assessed Resident #3 with a Brief Interview for Mental Status (BIMS) of 8 indicating moderate cognitive impairment. The MDS included diagnoses of: idiopathic peripheral autonomic neuropathy, schizophrenia and post traumatic disorder. Resident #3's progress notes did not reveal that he was out of the facility on 8/18/20 for an appointment including the time he left the facility and the time he returned to the facility. In an interview on 9/15/20 at 3:20 PM, after reviewing the schedule of appointments for 8/18/20, the Director of Nursing (DON) indicated Resident #3 left the facility for an appointment scheduled for 12:45 PM at the Veteran's Administration in Des Moines on 8/18/20 and returned from the appointment on the same day prior to receiving his scheduled 7 PM medication. She further indicated she expected staff to document when a resident leaves for an appointment outside the facility and the time the resident returns to the facility.	F 842		
F 880 SS=K	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 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

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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 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

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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 observation, record review and staff interview, the facility failed to implement proper infection control practices/procedures when providing care and when screening staff prior to commencing work with residents. The facility failed to ensure resident safety related to infection control by allowing staff to take their own temperatures and complete their own screenings related to COVID-19 at the beginning of their shift and take their own temperature at the end of the shift. The facility allowed staff to work with symptoms consistent with COVID-19. The facility was notified of the 1st COVID-19 positive resident on 8/21/20. On 8/30/20, 19 more residents tested positive for COVID-19. 1 resident passed away from COVID-19. 8 staff tested positive for COVID-19 from 8/21/20-8/28/20. This resulted in an immediate jeopardy situation for the facility. The facility reported a census of 93 residents.

Finding include:

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1. Review of facility form titled, Start of Shift to Prevent COVID-19 Employee Screening Log, Staff N, Licensed Practical Nurse (LPN) intermittently documented she had symptoms of cough, vomiting and/or diarrhea, muscle pain, headache and new loss of taste or smell at the beginning of her shift from 7/27/20-8/17/20 and was not asked to go home. On 8/23/20, Staff N documented at the beginning of her shift that she had a cough, sore throat, muscle pain, headache and new loss of taste of smell and was not asked to go home. Staff N documented a temperature of 100.0 at the end of her shift. On 8/24/20, Staff N was tested for COVID-19 with positive results. Review of time card punch detail for Staff N revealed she worked from 8/23/20 at 7:16 PM until 8/24/20 at 7:42 AM.

2. On 9/2/20 at 3:05 p.m. the Administrator stated staff screen themselves and take their own temperature. She stated if staff have symptoms they come to the Administrator in regards as what to do and the Administrator calls a nurse on the phone for further assessment of the staff member.

3. Review of facility form titled, Start of Shift to Prevent COVID-19 Employee Screening Log, Staff O, Certified Nursing Assistant (CNA) revealed she did not take her temperature at the beginning or end of her shift on 6/30/20 as no thermometer available. Records reveal Staff O was tested for COVID-19 on 8/21/20 with positive results on 8/24/20. Review of time card punch detail for Staff N revealed Staff O worked 8/24/20 6:04 AM-3:18 PM.

4. Review of facility form titled, Start of Shift to

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Prevent COVID-19 Employee Screening Log, Staff P, CNA revealed she had a sore throat and muscle pain at the beginning of the shifts 7/19/20 and 7/20/20 and was not asked to go home. On 8/24/20, Staff P documented she had a cough at the beginning of her shift. Time card punch detail revealed she worked from 1:43 PM 8/24/20 until 2:30 AM 8/25/20. Staff P was tested for COVID-19 8/27/20 with positive results 8/27/20.

5. Review of facility form titled, Start of Shift to Prevent COVID-19 Employee Screening Log, Staff Q, CNA revealed she had new shortness of breath, vomiting and/or diarrhea, chills and headache intermittently from 7/26/20-8/23/20 and was not asked to go home. On 8/24/20, Staff Q documented symptoms that included new shortness of breath or difficulty breathing and headache. At the end of the shift on 8/24/20, Staff Q documented a temperature of 99.3. Time card punch detail revealed Staff Q worked 5:31 PM 8/24/20 until 6:46 AM 8/25/20. Staff Q was tested for COVID-19 on 8/28/20 and the results were positive.

6. A Minimum Data Set (MDS) completed for Resident #2 dated 6/9/20 revealed a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. The resident required extensive assist with transfers, dressing and personal hygiene. Diagnoses included Diabetes Mellitus (DM), Parkinson's Disease and Fracture. A care plan intervention dated 4/27/20 revealed potential risk for COVID-19 infection related to recent outbreak with interventions in place to reduce the risk of exposure and infection including all staff, providers, vendors to enter the front door to have temperature taken and screen performed prior to

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entering the facility.

Form titled Analytical Report from the State Hygienic Laboratory revealed Resident #2 had lab drawn for COVID-19 detection on 8/27/20, analyzed on 8/29/20, released on 8/30/20 with positive results. Review of progress notes indicated resident passed away on 9/1/20 at 4:30 AM.

7. In an interview with the Director of Nursing on 9/1/20 at 2:30 PM, she revealed on 8/21/20 the facility had their first resident test positive for COVID-19. On 8/21/20, Webster County Public Health Department sent COVID-19 testing kits to the facility for staff and residents that had close contact with Resident #1 to be tested. On 8/25/20 received results that 3 staff members tested positive. On 8/27/20, the owner requested the Director of Nursing to test all of the residents that hadn't recently been tested. On 8/30/20 received results that 19 additional residents had tested positive.

Observations:
8. During initial tour of the facility on 9/1/20 at 10:40 AM, observation revealed Staff A, Certified Nursing Assistant (CNA), cleaning off a resident's face without goggles or a face shield in place.

9. Observation on 9/1/20 at 3:20 PM, revealed Staff B, Laundry and Staff C, Housekeeping, conversing while standing less than 6 feet apart in front of the time clock located in the hallway. Staff B wore a mask below her nose and goggles on top of her head. After observation, Staff B pulled up her mask while goggles remained on top of her head. Staff C wore her goggles on top of her head. After observation, Staff C removed

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her goggles from on top of her head and placed them over eyes.

10. Observation on 9/2/20 at 9:50 AM, revealed Staff D, Registered Nurse (RN) sitting behind the nurse's station between the 100 and 200 hallway working on the computer. Staff D had her face mask hanging from her right ear and goggles on top of her head. Two staff stood at the medication cart less than 6 feet from Staff D.

11. Observation on 9/2/20 at 11:00 AM, revealed Staff E, Certified Medical Assistant (CMA) stood at the medication cart in the hallway with resident's rooms with goggles on top of her head.

12. Observation on 9/2/20 at 4:20 PM, revealed Staff F, CNA stood at the nurse's station near the main entrance without goggles or a face shield in place. Staff G, RN sat at the nurse's station working on the computer without goggles or a face shield.

13. Observation on 9/14/20 at 1:20 PM, revealed Staff C, Housekeeping, cleaning in room 310 with her goggles on her forehead above her eyes and her face mask on her chin. Two residents were present in the room at the time without facemasks. After observation, Staff C pulled her goggles down over her eyes and pulled her face mask over her mouth.

14. Observation on 9/15/20 at 12:00 PM, revealed Staff Q, CNA in the dining hall pushing a resident in a wheelchair to the dining room table with her face mask below her nose and her face shield pushed up above her nose. After observation Staff Q pulled her face shield down however her face mask remained below her nose.

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15. In an interview with the Director of Nursing on 9/2/20 at 10:10 AM, she revealed she expected staff to wear a face mask, goggles/face shield at all times unless outside the facility or on break and no else is around them.

16. Observation on 9/2/20 at 10:45 AM, Staff J, Certified Medication Aide (CMA), took an Accucheck blood glucose meter into a resident's room and placed the meter on the resident's side table without a barrier. Following the blood glucose monitoring procedure, Staff J returned the meter to the medication cart and placed it on the cart without a barrier. After placing the meter on the cart, Staff J used a Wipe Out antibacterial wipe to wipe down the meter and then immediately placed the meter on a barrier on top of the medication cart to air dry.

On the facility form titled, Blood Sugar Monitoring, under procedure it stated to follow manufacturer's directions for the equipment used in the facility.

Per the Accucheck manufacturer's disinfecting procedures, the meter is to be kept wet with disinfection solution contained in the wipe for a minimum of 2 minutes.

17. In an interview with the Director of Nursing on 9/2/20 at 11:00 AM she revealed the Accucheck machines are shared between residents. She expected barriers used at all times in resident rooms and on medication carts with the Accucheck machines and they are to be wrapped in antibacterial wipes for 2 to 5 minutes following use.

Abatement:

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F 880	Continued From page 25 The facility abated the immediate jeopardy to a F level on 9/8/20 by beginning to actively check staff temperatures, implementing new forms that would identify the staff member actively checking temperatures and education to staff on the new screening policies and forms. The State agency notified the facility of the immediate jeopardy on 9/3/20.	F 880		

Fort Dodge Villa Care Center
Plan of Correction
COMPLAINT SURVEY
Sept 22, 2020
Revised Dates 11/16/2020

This plan of correction constitutes my written credible allegation of compliance.

The response or providers plan of correction contained herein shall not be considered to be or construed as an admission of the validity of the citation or alleged deficiency to which it is addressed.

F553

QHC Fort Dodge Villa Care Center will reasonably ensure each resident is provided the opportunity to participate in his or her Care Planning by inviting the resident and/or his or her resident representative to each resident's quarterly and annual care planning, per QHC Policies and Processes.

1. Care Plan for residents # 4 and #5 have been scheduled on 10/21/2020. Each resident and Resident Representative were invited to participate.
2. All residents have the potential to be affected. A process has been developed to include each resident and resident representative in Care Planning. The process includes written and verbal invitations to attend the Care Conference.
   IDT will document in resident's chart when any resident or resident representative who chooses to not participate in the quarterly and/or annual Care Plan or Care Conference.
   DON will be notified of any resident or resident representative who chooses to not participate in the quarterly and/or annual Care Plan or Care Conference, as scheduled.
3. Training and re-education with IDT regarding resident and resident representative right to be included in the Care Plan and Care Conference processes will be completed with IDT by 10/22/2020 and ongoing.
4. DON or Designee will audit weekly x12 weeks.
5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F559

QHC Fort Dodge Villa Care Center will reasonably ensure each resident or resident representative is provided notice of room or roommate change, including reason for change, prior to the change being made. This change and reason for change, will be documented in the resident's medical record, as outlined in QHC Clinical Policies and Processes.

1. Contact information has been reviewed and updated on Resident #3 to ensure contact can be made when needed.
2. All residents have the potential to be affected. A written protocol/process has been developed to ensure resident or resident representative is notified prior to a room or roommate change with documentation in resident record. This includes any resident moving or receiving a roommate to be notified.
3. Training and re-education with IDT and Department Managers will be completed by 10/22/2020 and ongoing.
4. DON or Designee will audit for compliance weekly x12 weeks.
5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F 584

QHC Fort Dodge Villa Care Center will maintain a safe, clean and homelike environment per QHC Environmental Policies and Processes.

1. Resident #4's window was cleaned and washed inside and outside on 9/21/2020, removing cob webs and other debris.
2. All residents have the potential to be affected. All resident room and facility windows were cleaned and washed inside and outside on 9/21 and 9/22/2020, removing cob webs and other debris. The facility's window cleaning process reviewed and updated to include routine cleaning and dusting, as needed.
3. Environmental Services staff has been re-educated to clean windows and window sills routinely to remove cob webs and other matter that might impede a resident's view. This was completed immediately, repeated prior to 10/22/2020 and will be ongoing training.
   Training and re-education for all staff will be completed by 10/22/2020 and ongoing.
4. NHA or Designee will audit resident rooms and common areas to ensure windows are clean and free of debris weekly x12 weeks.
5. Results will be reviewed by Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F 602

QHC Fort Dodge Villa Care Center will investigate all allegations of misappropriated property by residents or resident representatives per QHC Grievance Policies and Processes.

1. Resident #3 – investigation of two missing watches completed. No reimbursement of first watch wanted/needed, per POA. Investigation of second missing watch found watch in resident belongings. This watch is secured in the facility safe in the business office until retrieved by POA.
2. All residents have the potential to be affected.
   Abuse, Neglect and Misappropriation process has been implemented
3. NHA is designated Facility Abuse, Neglect and Misappropriation Officer and has received training per QHC policies and processes.
   Staff re-education with Department Managers regarding Abuse, Neglect and Misappropriation process will be completed by 10/22/2020 and ongoing.
4. NHA or Designee will audit grievance logs weekly x12 weeks.
5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F 658

QHC Fort Dodge Villa Care Center will meet professional standards of quality and Plan of Care per QHC Clinical Policies and Processes.

1. Resident #3 has not experienced any negative outcomes from missed medication dose while OOF for appointment at VA Hospital and Clinic.
2. All residents who leave the facility for medical care have the potential to be affected. The facility's process for managing residents who leave the facility for medical care has been reviewed and re-implemented.
   All residents who leave facility for an appointment or ED visit, will be sent with appointment information, clinic information, Face Sheet, Medication List (and IPOST, if going to hospital/ED).
3. Nursing Staff re-education regarding medications and information to be sent as able with residents while OOF for appointments completed before 10/22/2020 and ongoing.
4. DON or Designee will audit process weekly x12 weeks.
5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F688

QHC Fort Dodge Villa Care Center will provide Nursing Restorative Care for residents as prescribed by their physician.

1. Resident #3 is receiving Nursing Restorative Care as prescribed by physician and per therapy recommendations.
2. All residents with Nursing Restorative Care orders from his or her physician have the potential to be affected.
   A facility-wide audit was completed of residents requiring restorative nursing services, which included assessment and revision of Care Plan as needed.
   Facility designated a Restorative CNA to complete restorative nursing care plans.
3. Restorative CNA re-education for Nursing Restorative Care completed before 10/22/2020 and ongoing.
4. DON or Designee will audit process weekly x12 weeks.
5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F692

QHC Fort Dodge Villa Care Center will monitor and address residents with significant weight loss per QHC Clinical Policies and Processes.

1. Resident #6 has been reweighed and monitored to ensure correct weight is captured and maintained, and any significant weight loss or gain is addressed immediately.
2. All residents have the potential to be affected. The facility's updated process includes weekly review and monitoring of all residents at risk of weight loss or gain during IDT/Risk Management Meeting to ensure correct weight is captured and maintained, and significant weight loss or gain is addressed immediately.
3. Nursing Staff education regarding revised process for Nutrition and Hydration, which includes weight loss, completed before 10/22/2020 and ongoing.
4. DON or Designee will audit resident weights weekly x12 weeks.
5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F 730

QHC Fort Dodge Villa Care Center will complete annual performance reviews for all staff per QHC Administrative and HR Policies and Processes.

1. All Villa Care personnel have had yearly performance review completed on 10/08/2020.
2. All personnel have the potential to be affected. A written process for completing yearly performance reviews has been developed and reviewed with all department managers. The process includes written evaluation and verbal review of the performance evaluation with each employee.
3. Department Manager re-education of performance review process completed on 9/23/2020 and ongoing.
4. NHA or Designee will audit personnel records monthly x3 months to ensure annual performance reviews are completed timely for each Villa Care employee.
5. Results will be reviewed by Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F 755

QHC Fort Dodge Villa Care Center will follow medication and treatment cart security precautions per QHC Clinical Policies and Processes.

1. Counseling and re-education provided to two employees who failed to secure medication and/or treatment carts in resident care areas.
2. All clinical employees who use medication and/or treatment carts have the potential to be affected by a breach of security precautions.
   A written process for medication and treatment cart security has been developed which includes cart security while the cart is attended as well as unattended.
3. Licensed Nurses and CMAs received re-education regarding secured medication and treatments carts completed on 9/01 and 9/02/2020, and ongoing.
4. DON or Designee will audit medication and treatment cart security weekly x12 weeks.

5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F 842

QHC Fort Dodge Villa Care Center will keep complete and accurate medical records for all residents per QHC Clinical Policies and Processes.

1. Resident 3 attended VA Hospital and Clinic appointment and returned safely to facility.
2. All residents who leave the facility for any type of appointment or outing have the potential to be affected. Out of Facility (OOF) process has been developed which includes documenting when a resident leaves and returns, and with whom.
3. Nursing staff re-education regarding resident medical appointment OOF process completed by 10/22/2020 and ongoing
4. DON or Designee will audit resident records for appointments out of facility weekly x12 weeks.
5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/22/2020

F880

QHC Fort Dodge Villa will ensure resident safety related to Infection Prevention and Control by having another staff member take employee temperature & complete covid-19 screening questions at the beginning and end of their shift. The screener will be required to initial the screening tool, as will the employee being screened.

QHC Fort Dodge Villa will follow CMS Guidelines for covid-19 testing for all staff and all residents and report to appropriate local (Public Health) and state agencies (IDPH) per guidelines.

QHC Fort Dodge Villa will secure all entrances to ensure staff, visitors and vendors enter through one designated entrance where each person will be screened before entering the facility for any reason. NHA, DON or Designee will review the logs daily to ensure compliance.

1. Staff N no longer works at this facility.
   Staff O has been re-educated regarding Next Steps if screening tools are missing and/or not working.
   Staff P is a smoker and was re-educated about new symptoms vs chronic symptoms and how to complete the screening tool.
   Staff Q no longer works at this facility.
2. All residents have the potential to be affected. A written process has been developed so that any staff member who has an elevated temperature and/or answers **YES** to any of the Covid-19 screening questions will wait in the Entrance until a nurse comes to that area to further evaluate and screen them.
   NHA, DON or Designee will be notified of any employee, visitor or vendor who presents with an elevated temperature and/or answers **YES** to any of the Covid-19 screening questions.
   A new Covid-19 Screening Form has been created to include the initials of the individual completing the screening.
3. All Staff re-education regarding new screening protocols completed on 9/08/2020 and ongoing.
4. NHA or Designee will monitor screening form to ensure compliance
5. Results will be reviewed by Quality Assurance Team monthly
   Compliance Date: 10/05/2020

F 880 (continued – PPE)

1. Staff A has been re-educated regarding the proper way to wear PPE for greatest efficacy for both employee and resident protection.
   Staff B and Staff C have been re-educated regarding social distancing practices and proper way to wear PPE for greatest efficacy.
   Staff C has been re-educated regarding airborne virus, transmission and the role properly worn PPE has in preventing the spread of disease.
   All staff re-educated regarding PPE usage during outbreak– face shield or goggles, face mask, gown, gloves, shoe covers, hair bonnet – donning/doffing, storage, requirements.

2. All staff has potential to be affected. A written process has been developed which includes donning and doffing PPE.
   Proper PPE equipment during protective quarantine – face shield or goggles, face mask, gown, gloves, shoe covers, hair bonnet – donning/doffing, storage, requirements education completed on 9/01/2020, 9/02/2020 and ongoing.
3. All staff re-educated regarding new covid screening log, questions and process by 09/08/2020 and ongoing.
4. DON or Designee will monitor and audit usage weekly x12 weeks.
5. Results will be reviewed by IDT and Quality Assurance Team monthly.
   Compliance Date: 10/05/2020.

F 880 (continued – Accu-check, blood glucose monitoring)

1. Staff J has been re-educated on using a barrier for nursing equipment when in a resident room.
   Staff J has been re-educated on the proper cleaning method of Accu-check machine per manufacturer recommendations.
   Education given regarding barrier being placed while performing blood sugar monitoring, blood glucose meter and any surface and cleaning blood glucose meter 2-5 minutes with microbial wipe, per manufacturer's instructions.
2. Every resident whose blood sugar is monitored via blood glucose meter has his/her own meter with case.
3. DON or Designee will monitor weekly x12 weeks
4. Results will be reviewed by IDT and Quality Assurance Team monthly.
5. Education completed on 9/01 and 9/02/2020 and ongoing
   Compliance Date: 10/05/2020