STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165263	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mechanicsville Specialty Care	104 East Fourth Street Box 430 Mechanicsville, IA 52306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34821 Based on observations, clinical record review, resident, and staff interviews, the facility failed to treat a resident with respect and dignity for one reported interaction with a nurse for one out of one residents reviewed (Resident#7). The facility reported a census of 34 residents. Findings include: The Minimum Data Set (MDS) Assessment for Resident # 7 dated 7/5/24, included diagnoses of Parkinson's disease, and non Alzheimer's dementia. The Brief Interview for Mental Status (BIMS) reflected a score of 13, intact cognition. The MDS identified Resident#7 independent with toileting, transfers, ambulation, and dressing. The Care Plan for Resident#7 listed an intervention dated 7/18/24, at times I can have an outburst and yell at my family or staff. Attempt to redirect me when I have an outburst or give me some alone time so I can settle down and proceed with my day. Resident #7's Nurses Behavior Progress Note dated 7/31/2024 at 11:15 PM, reflected Resident#7 wanted Staff A, Registered Nurse (RN) to send her to emergency room (ER) after Staff A found her slipping out of her recliner she sat in. Resident #7 told Staff A I am sick I am dying I need ER Resident #7 called the sheriff and kicked the Staff A, called staff vulgar disgusting names. The Nurses Behavior Note dated 7/31/2024 at 11:47 PM, read Resident#7 called her daughter and wanted out, her daughter then called Staff S and directed do anything you can to calm her down . Resident#7 refused to take her 10:00 PM medication Oxycodone when offered. Nurses Behavior Note dated 7/31/2024 at 11:52 PM, reflected Staff A will let Resident#7 simmer down, Resident#7 reported that this is her home. Staff A thought Resident #7 may calm down. The Nurses Progress Note dated 8/1/2024 at 12:14 AM, revealed Resident #7 left via Ambulance cart. Resident#7 packed 3 bags and held her purse, blanket Resident#7 walked to the ambulance cart to get secured in left in stable condition. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation file provided by the Administrator included: a statement from Resident #7 taken by the Director of Nursing (DON) undated, revealed Resident #7 failed to remember calling her daughter or the sheriff. Resident #7 stated she failed to understand why the nurse kept yelling at her to go to bed. Resident #7 told the nurse to leave her room. The Witness Statement by Staff A, RN dated 7/31/24, reflected she entered the room and Resident#7 sat almost off the recliner. She asked Resident#7 to go to bed. The statement reflected the Staff B, Certified Nurses Aid (CNA) told Staff A, Resident#7 doesn't need to go to bed. Resident#7 asked to go to ER stated I was sent to hospital in March and they said there was nothing more they can do I was going to die. Resident#7 called Staff A vulgar names kicked Staff A on the right calf, bruising her, told Staff A she was going to call the police, and her daughter. Resident#7 called her daughter, the sheriff and her physician. The physician called back with orders to send Resident#7 to the ER for evaluation. The statement reflected Staff B, heard Staff A state rather loudly to Resident#7 exactly what Resident#7 told her that nothing more could be done and sent to the nursing home to live out her life. The Statement by Staff B dated 8/1/24 at 12:50 AM, identified she saw Resident#7 in her chair asleep. Staff B reported Resident#7 looked slouched some but after she looked further she saw one of the legs on the chair was up 30-40 degrees keeping her in the chair. The statement continue Staff B left her there because sometimes she sleeps there and she fell a few days before getting out of her bed and into her chair in the night. The Statement revealed Staff A told her Resident#7 needed to go to bed. Staff B told Staff A Resident#7 slept in the chair at times and she's sound asleep so she continued to help others. Staff B wrote she heard screaming and shouting from Resident#7's room, Resident#7 asked Staff A to leave and kicked at her shin. Staff A argued, told Resident#7 she needed to get out of the chair. Staff B said Staff A told her she's just a CNA and cant tell her what to do. Staff B removed herself from the situation. The Statement revealed the screaming continued so she went back to check on Resident#7 and saw the nurse wheeled herself back and forth on the resident's walker as Resident#7 walked around her room shaking upset looking for phone numbers. Resident#7 said it's her right to call an ambulance as she sat back down. Staff A abruptly got up from the walker stood over Resident#7 and said you are here to die, you are at this facility to die. Staff B's statement reflected she told the nurse she shouldn't talk to residents like that. Before Staff A could say anything the Sheriff called and ended the conversation. The facility interview undated reflected Staff E, CNA reported Staff B told her on 7/31/24 at 11:29 PM, Staff A's upset because she wanted Resident#7 to go to her bed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Investigation reflected on 7/31/24 around 10 PM, Staff B saw Resident#7 asleep in her chair, which she occasionally did. At around 10:30 PM Staff A entered Resident#7's and noticed she appeared as if she may slide off the recliner. Staff A asked the Resident#7 to go to bed. Staff B went back to Resident#7's room and told the nurse she doesn ' t have to go to bed. Staff B told her Resident#7 looked like she may slid out of her chair. Resident#7 became irritated and started to call Staff A names and kicked at the nurse on the calf. Resident#7 stated she wanted to go to ER. Staff A tried asking what she wanted to go to hospital for and Resident#7 said nobody cared and does nothing for her and she is going to die. Resident#7 stated she was sent to the hospital in March, and they told her there was nothing more they could do for her, and she was going to die. Staff A repeated what Resident#7 said to her that nothing more could be done and sent to the nursing home to live out her life. Staff B went back to the resident room due to it being loud and overheard Staff A repeating what Resident#7 said. Staff B told Staff A she shouldn ' t say that to Resident#7. Resident#7 reported the need to call the sheriff, daughter and her physician. Staff A tried asking what she wanted to go to hospital for and she said nobody cares and does nothing for her and she is going to die. Resident#7 called the police, physician while nurse and CNA were in room. The physician called facility and ordered the Resident#7 sent to ER. The Investigation continued to reflect Staff B called the DON around 11 PM but didn ' t get a hold of her so she sent her a couple text messages. On 8/6/24 at 1:30 PM, Staff B reported Staff A wanted Resident#7 put to bed. Staff B said she didn't want to wake Resident#7. Staff B revealed while she worked 3 rooms down the hall, she heard yelling. Resident#7 told Staff A she didn't want to to go to bed Resident # 7 told the nurse she was a fat cow. Staff B said Resident#7 walked around her room upset and shaking looking for her phone numbers. Resident#7 wanted Staff A to call 911 and Staff A told Resident #7 she's here to die. Staff B reported she went answered the phone and the sheriff wanted to know if they were needed or if it was an accidental call or of they wanted them to come to the facility. Staff B stated she asked Staff A if they were sending Resident#7 out and the nurse yelled at her because she took the phone call. On 8/6/24 at 5:36 PM, Staff A reported she got to Resident#7 at about 11:20 PM She looked about ready to slip off the chair. Resident#7 needed the neurological assessment from after a fall the other night. Staff A reported she asked Resident#7 to get into bed and had a pain pill for her. Staff B came in the room and said she didn't need to go to bed, she's fine. Resident#7 woke up, reported her pain high and she needed to go to the ER. Staff A stated Resident#7 wanted to got to ER, and wouldn't let her do the neurological assessment, just wanted wanted her cell phone to call her daughter, sheriff and her physician. Staff A said the Sheriff, the Physician and Resident#7's daughter called her. Staff A indicated Resident#7 didn't like her tone of voice, Staff A said something like Resident#7's placement here at the facility for end of life care. Staff A stated her comment scared Staff B, who thought she was abusive by saying such thing. Staff A confirmed she told Resident#7 she's here for the rest of her life. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/07/24 at 8:08 AM, Resident #7 walked in her room independently with her walker. Resident#7 reported on 7/31/24 she didn't feel well Staff A told her to get into the bed, said she was fine, no reason to go to the ER in the night. Resident#7 reported she kicked at the nurse because the nurse grabbed at her shoulder, gave a little push to get up. Resident#7 said she was yelled at the nurse she was sick and needed to go to the hospital, the nurse told her she was fine and to go to bed. She said the nurse left the room and she called the sheriff and he brought the ambulance her. Resident #7 reported Staff A didn't want to call the physician in the night and said she needed to sleep till the am. Resident#7 said Staff A seemed mean, bossy, pushy, aggressive interactions to her. Resident #7 said she was scared at the time, not sure the authority she had if she would get tied down to the bed. On 8/06/24 at 10:58 AM the Administrator revealed the Physician won't say Resident#7 can't make her own decision with the BIMS of 13. 08/08/24 at 11:05 AM the Administrator reported she expected the staff to treat the residents with respect and dignity. The Administrator provided the policy titled Dignity dated 2/2021 Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident ' s facility stay. 3. Individual needs and preferences of the resident are identified through the assessment process. 4. Residents may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with this facility. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: a. groomed as they wish to be groomed (hair styles, nails, facial hair, etc.); b. encouraged to attend the activities of their choice, including religious, political, civic, recreational, or social activities; c. encouraged to dress in clothing that they prefer; d. allowed to choose when to sleep, eat and conduct activities of daily living; and e. provided with a dignified dining experience. 6. Residents ' private space and property are respected at all times. Staff do not handle or move a resident ' s personal belongings without the resident ' s permission. 7. Staff are expected to knock and request permission before entering residents ' rooms. 8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Staff inform and orient residents to their environment. Procedures are explained before they are performed and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings. 10. Staff protect confidential clinical information. Examples include the following: a. Verbal staff-to-staff communication (e.g., change of shift reports) are conducted outside the hearing range of residents and the public. b. Signs indicating the resident ' s clinical status or care needs are not openly posted in the resident ' s room unless specifically requested by the resident or family member. Discreet posting of important clinical information for safety reasons is permissible (e.g., taped to the inside of the closet door). continues on next page (C) 2001 MED-PASS, Inc. (Revised February 2021) c. In the interest of public health, posting the resident ' s isolation status or transmission-based precautions is permissible as long as the type of infection remains confidential. d. The display of the resident ' s name on the door or the presence of memorabilia among the resident ' s belongings is not considered a violation of the resident ' s privacy or dignity. 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered; b. promptly responding to a resident ' s request for toileting assistance; and c. allowing residents unrestricted access to common areas open to the public, unless this poses a safety risk for the resident. 13. Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: a. addressing the underlying motives or root causes for behavior; and b. not challenging or contradicting the resident ' s beliefs or statements.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48374 Based on observations, staff interviews and facility policy review, the facility failed to prevent exposure for cross contamination during meal service and failed to follow safe food handling practices. The facility identified a census of 33 residents. Findings include: On 08/06/24 at 12:19 PM, observed Staff C, [NAME] leave the meal serving area to go to the dining room. The cook left the serving scoops in the potatoes, corn, rice casserole and the tongs in the chicken and did not cover any of food items on the steam table before leaving. At 12:23 PM Staff C returned to the kitchen, scratched her face and resumed plating resident's food without washing her hands. On 08/07/24 at 12:35 PM, The Dietary Manager advised the test tray would be the last tray on the cart with the room trays and then placed the thermometer and alcohol wipes on the test tray. The cook took the thermometer off the test tray to check the temperature of the chicken noodle soup. The thermometer was not cleaned before or after temping the soup and being placed back on the test tray. Staff D, Dietary aid then took the thermometer outside the kitchen doorway to the beverage preparation area and checked the temperature of the white milk. The thermometer was then placed on the stainless steel prep table. It was not sanitized before or after testing the milk. The dietary aid then placed the thermometer back on the test tray, beside the alcohol wipes and delivered the room trays. The dietary aid then temped all food items on the test tray without sanitizing the thermometer and served the test tray to the surveyor. On 08/07/24 at 01:28 PM Staff C was queried regarding cross-contamination and hand sanitation. Staff C advised hands should be washed frequently and anytime going from one task to another or different area. Staff C advised she was not aware she had scratched her face upon returning to the kitchen and agreed she should have washed her hands. When queried about sanitizing the thermometer Staff C advised it should have been sanitized between food items to prevent cross contamination. On 08/07/24 01:43 PM The dietary manager was interviewed regarding hand sanitation and cross contamination. The dietary manager articulated appropriate hand hygiene and cross-contamination prevention. She advised the facility conducts random hand washing audits and all workers are required to have yearly refresher training. In addition it is her expectation the thermometer is sanitized before and after each use and stored in the protective sleeve between use. On 08/07/24 at 02:15 PM The facility administrator was queried regarding hand hygiene and cross-contamination. It is her expectation that all workers practice appropriate hand hygiene at all times. She advised the worker should have washed her hands when she returned to the kitchen. She also advised it is her expectation the thermometer be kept in the sleeve whenever not is use and sterilized before and after each use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The undated facility policy titled Handwashing/Hand Hygiene informed that the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The undated facility policy titled Food Preparation and Service informed food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. Appropriate measures are used to prevent cross contamination. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food borne illness. Food thermometers used to check food temperatures are clean, sanitized and calibrated for accuracy.