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	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mechanicsville Specialty Care	104 East Fourth Street 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. Based on observations, clinical record review, staff interviews, and facility policy review the facility failed to provide dignity with cares for 1 out of 3 residents reviewed (Resident #2). The facility reported a census of 29 residents. Finding include:1. The Minimum Data Set (MDS assessment for Resident #2 dated 6/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderate cognitive impairment. The MDS assessment for Resident #2 dated 8/22/25 listed diagnoses of neurogenic bladder, spastic quadriplegic cerebral palsy, and urinary tract infection. The Care Plan for Resident #2 dated 4/10/25 identified a urinary catheter related to neurogenic bladder. On 9/03/25 at 9:58 AM, Resident #2 laid on his bed while the catheter drainage bag hung uncovered on the left side of his bed. The catheter bag held amber colored urine. On 9/04/25 at 9:11 AM, Resident #2 laid in his bed while his uncovered catheter bag hung on the left side of his bed. The empty dignity bag hung beside the uncovered drainage bag. On 9/04/25 at 12:57 PM, the Director of Nursing (DON) reported she expected the resident's catheter drainage bags kept in a dignity bag. On 9/04/25 at 2:00 PM, Staff C, Certified Nurse Aide (CNA) reported she floated all over the building today. She reported the catheter bags go in the blue (dignity) bag on the side of the bed. The facility provided a policy titled Dignity dated 2/2021. The policy directed 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.The policy revealed, 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; andc. allowing residents unrestricted access to common areas open to the public, unless this poses a safetyrisk for the resident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview and facility policy review the facility failed to administer the correct amount of water flush before the administration of the tube feeding for 1 of 1 resident reviewed (Resident #2). The facility reported a census of 29 residents. Finding include: The Minimum Data Set (MDS) assessment for Resident #2 dated 6/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderate cognitive impairmentThe Minimum Data Set (MDS) assessment dated [DATE] listed diagnoses of spastic quadriplegic cerebral palsy and urinary tract infection. The Care Plan for Resident #2 dated 2/24/25 directed he will remain free of side effects or complications related to tube feeding.The Physician's Orders Review History Report dated 8/4/25 directed enteral feed order every shift flush feeding tube with at least 70 milliliters (ML) of water before and after administration of feedings.The Medication Administration Record (MAR) for Resident #2 dated 9/25 directed every shift flush feeding tube with at least 70 ML of water before and after administration of feeding.On 9/03/25 at 11:18 AM, Staff B, Licensed Practical (LPN) flushed the tube feeding with 30 ML water and hooked up the gravity bag to the feeding tube. Staff B pushed Resident #2 into the lobby.On 9/04/25 at 12:12 PM, Staff B, LPN reported she thought she gave 30 ML as the per tube feeding flush yesterday at the 11:00 feeding. She opened the electronic record and reported he got 70 ML a shift so she gave 40 in the morning and 30 ML with the 11 feeding. On 9/04/25 at 12:57 PM, the Director of Nursing (DON) reported the MAR directed the water flushes for Resident #2 were scheduled 70 ML before and after each feeding. She reported she expected the nurses to administer the water flush as ordered on the MAR. The facility provided a policy titled Enteral Tube Feeding Via Gravity Bag dated 2018, directed at point #9 to administer at least 30 ML of water or the prescribed amount.