

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16E728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Mercyone Centerville Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE One St Joseph Drive Centerville, IA 52544	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471</p> <p>Based on clinical record review and staff interview the facility failed to maintain accurate advance directive records for 2 of 16 residents reviewed (Residents #8 and #9). The facility reported census of 18.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had diagnoses of Coronary Artery Disease, Hemiplegia, and Cerebrovascular Accident (CVA). The MDS documented the resident scored 13 on a Brief Interview for Mental Status (BIMS) exam, which is indicated cognitively intact.</p> <p>Record review, on [DATE] at 02:15 PM, revealed the resident's chart did not contain the Iowa Physician's Orders for Scope of Treatment (IPOST).</p> <p>During an interview on [DATE] at 12:32 PM The DON looked in the chart unable to find the IPOST. The DON stated they would try to locate it.</p> <p>During an interview on [DATE] at 12:20 PM The DON stated she obtained a new IPOST.</p> <p>47582</p> <p>2. The Minimum Data Set (MDS) dated [DATE] documented Resident #9 entered the facility on [DATE] and was admitted to Hospice Care on [DATE]. The MDS also documented a Brief Interview for Mental Status (BIMS) of 10 indicating moderate cognitive impairment.</p> <p>On [DATE] at 11:15 AM, during a record review of Resident #9's physical chart, it was noted the Iowa Physician Orders for Scope of Treatment (IPOST), documented a Do Not Attempt Resuscitation (DNR) choice for the Cardiopulmonary Resuscitation (CPR) category. The IPOST was signed and dated on [DATE] by Resident #9 and did not include the physician signature.</p> <p>The electronic health record (EHR) review revealed an active order for DNR code status dated [DATE].</p> <p>(continued on next page)</p>

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: 16E728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Mercyone Centerville Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE One St Joseph Drive Centerville, IA 52544	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:40 PM, the Director of Nursing (DON) confirmed the IPOST for Resident #9 did not include a physician's signature. The DON further stated Resident #9 had a DNR code status and the IPOST had to be signed by the physician. The DON stated she was going to obtain the signature from the physician shortly.</p> <p>On [DATE] at 1:00 PM, the DON reported that she notified the physician and obtained a signature on IPOST for Resident #9.</p> <p>Review of the facility provided policy Advanced Directives revised on ,d+[DATE] documented IPOST is an official order from the physician and signed by the physician, resident and witness.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16E728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Mercyone Centerville Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE One St Joseph Drive Centerville, IA 52544	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35434</p> <p>Based on observation, clinical record review, policy review, and staff interview, the facility failed to utilize a gait belt in order to ensure a safe transfer for 1 of 6 transfers observed (Resident #1). The facility reported a census of 18 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment tool, dated 3/16/24, listed diagnoses for Resident #1 which included a history of falling, anxiety disorder, and diabetes. The MDS stated the resident required substantial/maximal assistance for toilet transfers and listed the Brief Interview for Mental Status (BIMS) score as 3 out of 15, indicating severely impaired cognition.</p> <p>An 8/4/23 Post Fall Huddle Form/Variance stated staff heard the resident yell and found her sitting the floor next to her bed.</p> <p>12/6/23 Health Status Notes stated staff heard the resident yelling and found her prone (on her stomach) on the floor near the bed. The resident bled from a laceration (cut) on the left forehead, transferred to the ER, and received 4 stitches.</p> <p>A 12/6/23 Post Fall Huddle Form/Variance stated staff heard the resident yelling and found her lying face down on the floor near the bed. The facility added a monitor to the room while in isolation.</p> <p>A 5/5/24 Post Fall Huddle Form/Variance stated staff heard the resident yelling and her alarm went off. The resident developed a goose egg and transferred to the ER.</p> <p>A 5/5/24 Health Status Note stated the resident admitted to acute care for a urinary tract infection (UTI) and acute kidney damage.</p> <p>On 5/14/24 at 12:54 p.m. Staff B Certified Nursing Aide (CNA) and Staff C CNA assisted the resident to stand up from the wheelchair and sit on the commode. The staff members did not utilize a gait belt. After the resident was finished, Staff B and Staff C each stood on one side of the resident and held her under her arms as she stood up. Staff B provided perineal cares (cleansing of private areas) and they pulled up her pants. The resident then took a few steps and sat down in her wheelchair. The staff members did not use a gait belt but there was one hanging on the wall by the bathroom door.</p> <p>Review of the Care Plan revealed the following:</p> <p>A 7/27/20 entry stated the resident was at risk for falls related to impaired mobility, a fluctuation in her ability to transfer, poor weight bearing at times, and an inability to follow directions related to lethargy (a lack of energy).</p> <p>An 11/20/21 entry stated the resident walked with staff assistance and a walker.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16E728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Mercyone Centerville Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE One St Joseph Drive Centerville, IA 52544	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Falls Prevention, revised 4/2024, stated staff should use gait belts with any patient transfers based on risk factor category assessments.</p> <p>On 5/15/24 at 2:16 p.m., the Director of Nursing (DON) stated staff should utilize a gait belt with Resident #1.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16E728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Mercyone Centerville Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE One St Joseph Drive Centerville, IA 52544	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50471</p> <p>Based on observation, policy review, and staff interview the facility failed to follow infection control measures to prevent cross contamination during food service for 1 of 2 meals observed. The facility reported a census of 18 residents.</p> <p>Finding include:</p> <p>Observation of the noon meal service on 5/13/2024 at 11:50 AM revealed the following concerns:</p> <p>A. Staff D (Cook), did not wear gloves and handled buns with bare hands which she then served to residents.</p> <p>B. Staff D sneezed on her right arm while she held a plate of food in her left hand. She did not wash her hands then served the plate to a resident.</p> <p>A review of the facility provided policy titled Hand Hygiene revised on January, 2017 documented the following procedure: hands shall be washed before handling food, after sneezing, coughing, or blowing the nose.</p> <p>On 5/16/2024 at 10:27 AM, the Director of Food and Nutritional Services stated in the above situation staff should discard the food, wash their hands, and prepare a new plate of food for the resident.</p>