STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165147	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henry County Health Center	401 South Van Buren Mount Pleasant, IA 52641

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 47336 Based on clinical record review, policy review and staff interviews, the facility failed to provide transfers using mechanical lifts in a dignified, and respectful manner for 2 of 3 residents reviewed (Resident #1 and Resident #4). The facility reported a census of 34 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 2/14/24, revealed Resident #1 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating intact cognition. The MDS revealed the resident required substantial/maximal assistance with lying to sitting on the side of the bed and chair/bed to chair transfers. The MDS revealed the resident required partial/moderate assistance with rolling from left to right and sitting to lying. The MDS revealed medical diagnoses of generalized muscle weakness and cerebral vascular accident (CVA), transient ischemic attack (TIA), or stroke. The Care Plan revealed a focus area for Activity of Daily Living (ADL) mobility dated 9/22/23. The interventions (no date provided) included providing assistance to support level of need; encouraging, cueing, and prompting to participate in ADLs; and up with assistance of 1 with the gait belt and walker. 2. The Facility BIMS list revealed Resident #4 scored a 11 out of 15 on the BIMS exam on 12/20/23, indicating moderately impaired cognition. The Care Plan revealed a focus area of ADL Mobility dated 10/1/23. The interventions (no date provided) included assist of 2 with brown hoyer [mechanical lift]. During an interview on 5/13/24 at 12:33 PM, Staff A, Certified Nursing Assistant (CNA) stated she witnessed a transfer from a wheelchair to the Sara Steady [brand name of a type of mechanical life which helps a person move from sitting to standing] with Staff B, CNA and Staff C, CNA. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff A stated Staff C stood Resident #1 up by the pockets of his pants and Staff B then put the flaps [two flaps provide a seat when lowered] down. She stated Staff C then moved Resident #1 to the bed and grabbed Resident #1 again by the pant pockets and pulled him forward, Staff B moved the flaps up, and told him to let go of the machine, but Staff C grabbed Resident #1 by the wrists with both hands and pushed him back and he landed on the bed. Staff A stated Staff B caught him on his back and lowered him down. Staff A stated that is when she walked out of the room. During an interview on 5/14/24 at 8:57 AM, Staff B stated she and Staff C went to lay Resident #1 in bed and they decided to use the Sara Steady [mechanical lift] to help him because the resident was kind of shaky earlier in the morning. Staff B stated the resident had trouble grabbing the bar, so Staff C grabbed him by the wrist and yanked him to the bar and counted to three. Resident #1 had issues getting up so Staff C grabbed his pants and yanked him up using his pants. Staff B stated they moved the wheelchair out of the way and then moved the Sara Steady out of the way after the resident sat on the bed. Staff C swung his legs on to the bed. Staff B stated the resident didn't roll the best, but he wanted to roll and Staff B tried to help him, but Staff C told the resident to roll and then said roll again and then Staff C proceeded to roll him again. Staff B stated the roll wasn't gentle but not forceful, but she got him to roll. Staff B stated Resident #1 appeared upset after and kept apologizing like he did something wrong. Staff B stated she transferred Resident #4 with the mechanical lift with Staff C another time. During that transfer, Staff C pushed the emergency button and Resident #4 plopped into her chair. Staff C stated the resident was probably a foot off the chair when the emergency button was used. Staff C stated she never saw someone use the emergency button before to get someone down faster. During an interview on 5/14/24 at 2:34 PM, Staff C stated she used the emergency brake when she did mechanical life transfers because the emergency brake would just drop them. She stated Resident #4 pulled down and kicked her feet and tried to put her feet down and when they lowered her the mechanical lift tipped and they complained it was hard on their back so when they would get her above the chair, they slowly ease her down with the brake and then pull the red button when she was approximately 3 or 4 inches from the chair and it would release her. Staff C stated Staff G, CNA done it a lot that way. Staff C stated she worked with Staff H, CNA and when Staff H did mechanical lift transfers she dropped the residents in the air all the time. During an interview on 5/15/24 at 10:33 AM, Staff D, CNA stated the staff shouldn't use the emergency brake with mechanical lift transfers. Staff D stated Staff G used it one time with her when they transferred Resident #4 in the mechanical lift. Staff D stated she told Staff G not to do it again. Staff D stated staff used the emergency brake with Resident #4 because of her weight and the emergency stop hurried up the transfer. Staff D stated the arm of the mechanical lift drops and almost hit the resident in the head because it got really close to the resident's face when you use the emergency stop. During an interview on 5/16/24, Staff E, CNA stated everyone knew Staff C had been rough. Staff E stated one time she worked with Staff C for a two person pivot transfer and Staff C turned the resident so fast, Staff E almost tumbled onto the resident. Staff E stated she told Staff C to go slower. Staff E asked how Staff C took the information and she stated she felt the information went right through Staff C head. Staff E asked if she ever saw staff use the emergency brake when doing mechanical lift transfers and she stated one time she worked with Staff G, CNA and they used it on Resident #4. Staff E stated they were not supposed to use the emergency brake when transferring residents. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/24 at 10:00 AM, Staff F, CNA stated she witnessed Staff C push a resident onto the toilet during a transfer. Staff F stated she gave Staff C a look and turned and walked away and told the nurse the next day. During an interview on 5/16/24 at 1:32 PM, the Director of Nursing (DON) stated she was shocked about the incident with Staff C. She stated no one said anything else about Staff C. The DON stated she came to the conclusion Resident #1 wasn't treated appropriately and if Staff C could treat the residents like that around coworkers, what was she doing when she took care of the residents by herself. The DON stated they knew they needed to report the incident and couldn't keep Staff C at the facility, so they terminated her. During an interview on 5/16/24 at 1:32 PM, the DON stated the emergency brake should not used with mechanical lift transfers, unless something malfunctioned. The Facility Resident's [NAME] of Rights (no date indicated) revealed the following: a. Resident's Rights: The resident had a right to a dignified existence, self- determination, and communication with and access to persons and services inside and outside the facility. 1. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. b. Planning and Implementing Care: The resident had a right to be informed of, and participate in, his or her treatment 1. The right to receive the services and/or items included in the plan of care. 2. The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. c. Safe Environment: The resident had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The EZ Way Smart Lift [specific brand of mechanical lift at the facility] Operator's Instructions dated 8/10/18 revealed the following: a. Lower patient into the wheelchair, toilet, or chair. 1. Position the wheelchair under the resident and lock the wheels of the wheelchair. If transferring the resident to the chair or toilet, position the resident over the chair or toilet. Use the handles located on the back of the sling, position the resident so he/she properly aligned to be lowered to the chair, toilet, or wheelchair. 2. Push the down bottom on the hand control. 3. Stand behind the resident and hold onto the center handle located on the back of the sling (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. When the resident's weight supported by the wheelchair, chair, or toilet, continue lowering the lift to release the tension on the loops.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47336 Based on clinical record review, policy review and interview, the facility failed to report a staff to resident alleged assault within the required 24 hour time frame for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 34 residents. Findings include: A review of a Facility Reported Incident revealed a submission date of 4/12/24 at 4:02 PM for an allegation of abuse that occurred on 4/9/24 at approximately 1:00 PM. The incident summary revealed Staff A, CNA (Certified Nurse Aide) came to the DON (Director of Nursing) on 4/9/24 and stated that during a transfer she observed Staff C, CNA grab the resident by the waist band and pull him up from the wheelchair. She stated once the paddles [two paddles that when lowered form a seat] on the lift were in place, Staff C let go of the resident and then he flopped down onto the paddles [seat]. When transferring Resident #1 to bed, Staff C told the resident to stand up. Resident #1 stated he was trying and to give him a minute. Staff C then leaned forward and grabbed the resident by the pockets of his pants to stand him. Staff A reported Staff B, CNA assisted in the room and she moved the paddles from behind the resident, Staff C then let go of the resident and let him fall back onto the bed. Staff C then took the resident by the hand/wrist and removed his hands from the lift. Staff B reported that Staff C was rough with residents in the way of not telling the resident what was happening or guiding them, or counting to three. When using a mechanical lift, Staff B witnessed Staff C transfer residents and placed them on top of the bed or chair and use the emergency button to lower them instead of using the control to lower them. During an interview on 5/13/24 at 12:33 PM, Staff A, CNA stated she reported the incident she witnessed with Resident #1 to the DON an hour after it happened. During an interview on 5/14/24 at 8:57 AM, Staff B, CNA stated she reported the incident that occurred with Resident #1 to the DON the day after it happened. During an interview on 5/16/24 at 1:32 PM, the DON confirmed she didn't report the alleged abuse in a timely manner. She stated it needed to be reported within 24 hours. She stated one of the witnesses should of came to her as soon as the incident occurred. The Facility Abuse Prevention, Identification, Investigation, and Reporting Policy dated 3/27/24 revealed the following information: a. Allegations of resident abuse needed reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Director of Nursing, the Administrator, or designated representative. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. If a staff member or employee required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the Iowa Department of Inspections and Appeals immediately and in no event later than 24 hours of any allegations, even on a weekend or holiday.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47336 Based on clinical record review, policy review, and staff interviews the facility failed to thoroughly investigate a staff to resident alleged abuse for 1 of 3 residents reviewed for abuse (Resident #1). The facility reported a census of 34 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 2/14/24, revealed Resident #1 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The MDS revealed the resident required substantial/maximal assistance with lying to sitting on the side of the bed and chair/bed to chair transfers. The MDS revealed the resident required partial/moderate assistance with rolling from left to right and sitting to lying. The MDS revealed medical diagnoses of generalized muscle weakness and cerebral vascular accident (CVA), transient ischemic attack (TIA), or stroke. The Care Plan revealed a focus area for Activity of Daily Living (ADL) mobility dated 9/22/23. The interventions (no date provided) included providing assistance to support level of need; encouraged, cued, and prompted to participate in ADLs; and up with assistance of 1 with the gait belt and walker. The Self Report revealed submission date of 4/12/24 at 4:02 PM for an allegation of abuse that occurred on 4/9/24 at approximately 1:00 PM. The incident summary revealed Staff A, CNA (Certified Nurse Aide) came to the DON (Director of Nursing) on 4/9/24 and stated that she observed Staff C, CNA transferring the resident. Staff A stated she observed Staff C grab the resident by the waist band and pulled him up from the wheelchair. She stated once the paddles on the lift were in place, Staff C let go of the resident and then he flopped down onto the paddles. Resident #1 transferred to bed and Staff C told the resident to stand up , and Resident #1 stated he was trying and to give him a minute. Staff C then leaned forward and grabbed the resident by the pockets of his pants to stand him. Staff B, CNA assisted in the room and she moved the paddles from behind the resident , Staff C then let go of the resident and let him fall back onto the bed. Staff C then took the resident by the hand/wrist and removed his hands from the lift. Staff B reported that Staff C was rough with residents in the way of not telling the resident what was happening or guiding them, or counting to three. When used a Hoyer lift, Staff B witnessed Staff C transfer residents and placed them on top of the bed or chair and used the emergency button to lower them instead of using the control to lower them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Staff A Witness Statement dated 4/11/24 revealed on 4/9/24, Staff A walked into a resident's room to tell another CNA she given the nurse the weights they needed. When Staff A went into Resident #1 room Staff C and Staff B were in the process of doing a transfer using the Sara Steady [type of mechanical lift] and Resident #1 had a hard time standing so Staff C leaned forward and grabbed his pants at the hips to pull him forward, when Staff B put the flaps [two flaps when put down form a seat] down, Staff C let go of Resident #1 and he fell backwards onto the lift. They moved him from the wheelchair over to the bed. Staff C kept telling Resident #1 to stand up and hold on to the lift. Resident #1 was really shaky and having a hard time and Resident #1 said he was trying and to give him a minute. Staff C got frustrated and leaned forward and when Staff B moved the flaps, Staff C let go of Resident #1 and he fell back onto the bed without being lowered because Staff B didn't have time to put her hands on Resident #1. Staff C then grabbed Resident #1 hand/wrist and jerked his hands off of the lift and Staff B had Resident #1 upper half supported as the lift moved and Staff A left the room. Staff A reported to the DON because Staff C was so rough and Staff A thought Resident #1 would have bruises because the resident was so fragile. The Staff B Witness Statement dated 4/11/24, revealed on 4/9/24, Staff C and Staff B went to go lay down Resident #1. Resident #1 very unsteady and shaky in the morning, so we decided to use the Sara Steady for transfers. Staff B and Staff C counted to three and got him stood up and Resident #1 had trouble standing up enough to get the pads under his butt so Staff C proceeded to grab his pants and yank him up to be placed on the pads. They got him moved in front of his bed, Resident #1 stood up to be sat down on the bed. Once the resident sat down on the bed, Staff C grabbed his wrist and yanked then off of the bar on the lift. Staff B moved the lift out of the way and she grabbed his legs with no warning and tossed them into bed. Resident #1 needed check and changed so Staff B got the stuff ready and Staff C looked at Resident #1 and told Resident #1 to roll, Staff C said roll and then proceeded to roll Resident #1 herself. Both CNAs changed him and when it was time to roll back towards us, Staff C rolled Resident #1 without warning. Resident #1 kept apologizing like it was his fault. Staff C was very rough with the resident. While doing a lot of the Hoyer transfers, she waited until the resident placed either on top of the bed or chair and used the emergency drop. When Staff C completed regular transfers, she rarely let the resident know what she did and didn't count to three. When Staff C sat the residents, she didn't wait patiently and sat them down as soon as they were close to the bed. The Progress Notes lacked documentation of an assessment after the alleged incident that occurred on 4/9/24. The Facility lacked documentation for any other staff or residents interviewed pertaining to the incident that occurred on 4/9/24. During an interview on 5/14/24 at 1:50 PM, the DON stated if she would of known about the incident immediately she would of removed Staff C. She stated when she found out about the incident, Staff C already left the building, so she looked at the schedule to see when her next workday was and knew she had a few days to investigate. The DON stated she assessed Resident #1 wrists and didn't see anything. She stated she didn't chart it. She stated she spoke with the Assistant Administrator and they knew they needed to report the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 4:35 PM, the DON stated she didn't have any additional notes from the investigation and the facility didn't interview any additional staff or residents after the incident. The Facility Abuse Prevention, Identification, Investigation, and Reporting Policy dated 3/27/24 revealed the following information: a. Should an incident or suspected incident of resident abuse be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident. b. The Administrator or designee completed documentation of the allegation of resident abuse and collect any supporting documents relative to the alleged incident. c. The investigations should include consideration of the following, based on circumstances of the allegations as applicable: 1. Review the completed documentation of the allegation of resident abuse 2. Review the resident's medical record to determine events leading up to the incident 3. If there is an indication of injury has or may have occurred, a physical assessment must be completed by the DON or charge nurse immediately. 4. Documentation of any physical assessment conducted will be made in the resident's medical record and a copy of this documentation included in the abuse investigation file 5. The DON or designated nurse notified the resident's attending physician of the alleged incident. The responsible family member or responsible party, as documented in the resident's chart notified of the incident and advised of the status of the investigation and the actions and reporting being taken. 6. Interview staff members (on all shifts) who had contact with the resident during the period of the alleged incident. 7. Interview the resident's roommate, family members, and visitors as appropriate. 8. In circumstances where the allegation involves an employee, interview other residents to whom the accused employee provided care or services