STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165156	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Dodge Health and Rehabilitation	728 14th Avenue North Fort Dodge, IA 50501

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. 25858 Based on clinical record review, policy and procedure review, resident and staff interviews the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 1 out of 3 residents reviewed, (Resident #1). The facility identified a census of 55 residents. Findings include: 1. The Admission Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 4/4/24, documented diagnoses for which included hypertension, diabetes mellitus, anxiety, depression, muscle weakness and cognitive communication deficit. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no cognitive impairment, and able to be understood and has the ability to understand others, and dependent with toileting hygiene and lower body dressing. The Plan of Care with a initiated date 5/4/24, stated the resident was at risk for re-traumatization related to history of trauma due to previous verbal abuse occurring in the past. Interventions include: *Approach in a calm manner. *Care givers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. *Assist to identify strengths, positive coping skills and reinforce these. *Encourage to express feelings. *Monitor/record mood to determine if problems seem to be related to external causes. *Needs encouragement/assistance/support to maintain as much independence and control as possible. Likes to stay organized and know the plan for the day. (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	An Abuse Report dated 5/3/24 at 11:45 a.m., documented, Reported by Staff A, Certified Nursing Assistant (CNA) that Staff B, CNA, spoke to Resident #1 inappropriately and Resident #1 was upset. Resident #1 reports she had an accident and had her call light on for assistance. Staff B, stated to her we need to get you on the commode so you will stop shitting your pants. I don't have time for this and walked out of the room. This nurse and administrator went and spoke with Resident #1, condolences and support given. Resident calm and at ease when we left. Called Staff B, CNA, in to administrators office and this nurse and administrator told of the investigation to be completed and she is to be sent home. No injuries observed at time of incident. The Progress Notes dated 5/3/24 at 5:16 p.m., documented Social Services Note Text: 1:1 time spent with Resident #1 reassuring her that she is safe here and needs will be met. Resident is tearful and expresses appreciation for the reassurance. She has no further concerns at this time. The Self Report dated 5/23/24 at 4:27 p.m., documented, Allegation of Abuse, On Friday 5/3/24 at 11:45 a.m. , Resident #1 reported that Staff B, CNA, spoke to her after she put her call light on in her room, asking to get cleaned up after an accident. She then states Staff B, CNA, stated to her that she needed to start using the commode so she will stop shitting herself. This nurse along with the administrator went to Resident #1 room and spoke with the resident. Spoke with the resident and apologized for the situation and support given. Resident was calm and at ease when we left the room. Then called Staff B, CNA, into the administrators office, was told the incident was being investigated and she will be off work until the investigation was completed. Staff B, CNA, was immediately sent home. Interview on 7/16/24 at 11:10 a.m., Staff D (Regional Market Leader) and Staff E (Clinical Market Leader) stated that the expectation of the staff are to treat all residents with dignity and respect at all times. Interview on 7/17/24 at 9:00 a.m., Resident #1, confirmed and verified that Staff B, CNA, made a comment that Resident #1, had shit their pants again, and maybe getting on a commode would assist in eliminating all the stool. The Dignity and Privacy Policy/Procedure dated 10/2015, documented that it is the policy of the facility that all residents be treated with dignity, respect and privacy. 1. Staff shall display respect for Residents when speaking with, care for, or talking about them, as constant affirmation of their individuality and dignity as human beings. 3. Residents will be appropriately dressed in clean clothes arranged comfortably on their persons, and be well groomed. 6. Violation of the Residents right to dignity and respect should be promptly reported to the Director of Nursing Services and/or Administrator.

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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. 25858 Based on clinical record review, facility self report, staff interview and review of policy and procedures, the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse of a resident and/or residents are reported per facility policy to the Iowa Department of Inspection and Appeals within 2 hours, (Resident #1). The facility reported a census of 55 residents. Findings include: 1. The Admission Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 4/4/24, documented diagnoses for which included hypertension, diabetes mellitus, anxiety, depression, muscle weakness and cognitive communication deficit. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no cognitive impairment, and able to be understood and has the ability to understand others, and dependent with toileting hygiene and lower body dressing. The Plan of Care with a initiated date 4/9/24, stated the resident has performance deficit related to limited mobility, Musculoskeletal impairment, pain, trauma, and limited range of motion. Interventions include: *Is dependent on staff for all chair to bed/chair transfers with use of hoyer lift and sling. *Is dependent on staff for all toilet transfers. *Is dependent on staff for going from lying to sitting on side of bed. *Is dependent on staff for lower body dressing. *Is dependent on staff for toilet hygiene. An Abuse Report dated 5/3/24 at 11:45 a.m., documented, Reported by Staff A, Certified Nursing Assistant (CNA) that Staff B, CNA, spoke to Resident #1 inappropriately and Resident #1 was upset. Resident #1 reports she had an accident and had her call light on for assistance. Staff B, stated to her we need to get you on the commode so you will stop shitting your pants. I don't have time for this and walked out of the room. This nurse and administrator went and spoke with Resident #1, condolences and support given. Resident calm and at ease when we left. Called Staff B, CNA, in to administrators office and this nurse and administrator told of the investigation to be completed and she is to be sent home. No injuries observed at time of incident. The Progress Notes dated 5/3/24 at 5:16 p.m., documented Social Services Note Text: 1:1 time spent with Resident #1 reassuring her that she was safe here and needs will be met. Resident was tearful and expresses appreciation for the reassurance. She had no further concerns at this time. (continued on next page)

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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	The Self Report dated 5/23/24 at 4:27 p.m., documented, Allegation of Abuse, On Friday 5/3/24 at 11:45 a.m. , Resident #1 reported that Staff B, CNA, spoke to her after she put her call light on in her room, asking to get cleaned up after an accident. She then stated Staff B, CNA, stated to her that she needed to start using the commode so she will stop shitting herself. This nurse along with the administrator went to Resident #1 room and spoke with the resident. Spoke with the resident and apologized for the situation and support given. Resident was calm and at ease when we left the room. Then called Staff B, CNA, into the administrators office, was told the incident was being investigated and she will be off work until the investigation was completed. Staff B, CNA, was immediately sent home. Interview on 7/16/24 at 11:10 a.m., Staff D (Regional Market Leader) and Staff E (Clinical Market Leader) confirmed and verified that the facility failed to notify DIAL of the allegation of abuse according to the facility policy and procedure and that it was the expectation of the facility to notify DIAL with in the 2 hour time frame. Interview on 7/16/24 at 11:45 a.m., Staff C, (former administrator) confirmed and verified that the facility failed to notify DIAL of the allegation of abuse that occurred on 5/3/24, according to the facility policy and procedure and it is an expectation to follow those policies. The Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment dated 12/23, stated it is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. 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 medical symptoms. Resident must not be subjected to abuse by anyone, including but not limited to, Facility staff, other residents, consultants or volunteers. If there is an allegation or suspicion of abuse, the facility will make a report to the appropriate agencies as designated by State and Federal laws. Procedure: In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: *Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately. *Not later than two (2) hours after the allegation is made if events that cause the allegation involves abuse or results in serious bodily injury *Not later than twenty-four (24) hours if the event that causes the allegation does not involve abuse and does not result in serious bodily injury. *Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: *The administrator of the facility *The State Survey Agency