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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165177	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Memorial Health Center	231 North Eighth Avenue West Hartley, IA 51346

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 1 out of 3 residents (Resident #1) reviewed from physical abuse. The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE]/24 for Resident #1 documented diagnoses of Alzheimer s Disease, anxiety disorder and non-traumatic brain dysfunction. The MDS showed the Brief Interview for Mental Status (BIMS) score of 02, indicating severe cognitive impairment. Review of facility Incident Report dated 4/3/34 at 1:15 a.m., revealed incident description according to staff statements 2 Certified Nursing Assistants (CNA's) Staff E, CNA and Staff F, CNA entered the residents room to provide incontinence care, when they attempted to remove the incontinent brief Resident #1 became agitated and started swinging and kicking. According to the initial statement, Staff F slapped the resident on the thigh. Review of facility investigation of self-report of incident occurring on 4/3/24 at approximately 1:15 a.m.-1:30a.m. revealed the following: a. Interview conducted with Staff E. According to her interview and written statement she went to assist with checking and changing 2 residents that require assistance of 2. Staff E and Staff F entered Resident #1's room and began the process of changing him. He did become combative. Staff E indicated Resident #1 swung out at her with his hands and made contact. During the final steps Staff D stated Staff F slapped Resident #1 with her hand and said stop it. Staff E stated when they were done, both CNA's entered the hallway and Staff F said sorry didn't mean to hit him but damn. After Staff E left the unit she informed the charge nurse that the act had occurred and the charge nurse stated yes to call the DON. b. Interview conducted with Staff F. According to her interview and written statement Staff F and Staff E entered Resident #1's room, Resident #1 was informed the CNA's were there to check and change him. Resident #1 was agreeable. When the CNA's attempted to remove the incontinent brief Resident #1 became agitated and started kicking and hitting. Staff F indicated when he first became agitated she held both his hands so he would not hit, he then began kicking with his feet and kicked Staff E with his feet in her ribs. According to Staff F, they finished the process and left the room. (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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NAME OF PROVIDER OR SUPPLIER Community Memorial Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 231 North Eighth Avenue West Hartley, IA 51346	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of written statement by Staff E, signed and undated revealed on April 3 at 1:15 a.m., went into help Staff F with the 2 gentlemen. Resident #1 was being combative. After the last time of Resident #1 hitting and kicking me Staff F slapped Resident #1 and told him to stop it. After we were done changing him Staff F said sorry didn't mean to hit him but damn. Review of written statement by Staff F signed and dated 4/4/24 revealed Staff E and Staff F went to change Resident #1, on the first check he was ok when we told him what we were going to do. Was ok until we went to change him. We opened the depend and that is when he started to hit and I grabbed his hands and Staff E went to change him and that was when he kicked her in her ribs and lost balance, went to the hall. Then we got finished, I told him that was not nice to kick her and he laughed about it. Cleaned up the room and left. Second check went a lot better. An electronic message (e-mail) to Staff G, Nurse Practitioner dated 4/5/24 at 11:32 a.m., revealed the facility had a self report of an aide slapping Resident #1 while providing care. Interview on 7/2/24 at 4:22 p.m., with Staff E, CNA revealed on 4/3/24 at approximately 1:15 a.m., she went to assist Staff F, CNA with Resident #1 with care. During cares Resident #1 was hitting and kicking at staff assisting him. Staff F slapped Resident #1 on the upper left leg between the hip and knee area. Staff E reported it to charge nurse on duty. Charge nurse stated she needed to call the DON right away. At 1:45 a.m. , placed a call to the DON. Staff E revealed she did not answer so she left a message. At 1:48 a.m., sent the DON a text message. Staff E revealed Staff F continued to work the rest of her shift and the other staff working assisted her as Staff E was busy with her residents. Review of Resident #1's Progress Notes lacked documentation of the incident occurring on 4/3/24. Review of the facility provided policy titled Abuse Prevention, Identification, Investigation and Reporting Policy dated July 2019 revealed the following information: a. All residents have the right to be free from abuse. b. Physical abuse includes but is not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment, including but not limited to, pinching, spanking, slapping of hands, flicking or hitting with an object. The risk for abuse may increase when a resident exhibits a behavior that make provoke a reaction by staff, residents or others such as physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects and resistive to care and services. Interview on 7/3/24 at 3:30 p.m., with the Administrator revealed he could not confirm or deny the incident occurred after their investigation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 1 of 1 residents reviewed for abuse (Resident #1). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE]/24 for Resident #1 documented diagnoses of Alzheimer's Disease, anxiety disorder and non-traumatic brain dysfunction. The MDS showed the Brief Interview for Mental Status (BIMS) score of 02, indicating severe cognitive impairment. Review of facility Incident Report dated 4/3/34 at 1:15 a.m., revealed incident description according to staff statements 2 Certified Nursing Assistants (CNA's) Staff E, CNA and Staff F, CNA entered the residents room to provide incontinence care, when they attempted to remove the incontinent brief Resident #1 became agitated and started swinging and kicking. According to the initial statement, Staff F slapped the resident on the thigh. Immediate action taken revealed a description reported to the charge nurse who instructed Staff E to report to the Director of Nursing. Call was placed to DON with no answer. When DON arrived on 4/3/24 at 6:30 a.m.,the incident was reported at that time. DON did not hear the phone and staff did not try another call. Review of facility provided documentation titled Investigation of Self-Report of incident occurring on 4/3/24 at approximately 1:15 a.m.-1:30 a.m Review of written statement by Staff E, undated revealed on April 3 at 1:15 a.m., I went into help Staff F with the 2 gentlemen. Resident #1 was being combative. After the last time of Resident #1 hitting and kicking me Staff F slapped Resident #1 and told him to stop it. After we were done changing him Staff F said sorry didn't mean to hit him but damn. Interview on 7/2/24 at 4:22 p.m., with Staff E, CNA revealed on 4/3/24 at approximately 1:15 a.m., she went to assist Staff F, CNA with Resident #1 with care. During cares Resident #1 was hitting and kicking at staff assisting him. Staff F slapped Resident #1 on the upper left leg between the hip and knee area. Staff E reported it to charge nurse on duty. Charge nurse stated she needed to call the DON right away. At 1:45 a.m. , placed a call to the DON. Staff E revealed she did not answer so she left a message. At 1:48 a.m., sent the DON a text message. Staff E revealed Staff F continued to work the rest of her shift and the other staff working assisted her as Staff E was busy with her residents. Review of facility intake information the facility submitted a self report on 4/3/24 at 11:52 a.m Review of the facility provided policy titled Abuse Prevention, Identification, Investigation and Reporting Policy dated July 2019 revealed the following information: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations to the Administrator or designated representative. b. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeal not later than two (2) hours after the allegation is made. Interview on 7/3/24 at 10:32 a.m., with the DON revealed the report should have been reported before it was to DIAL.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility investigation review, staff interviews, and facility policy review the facility failed to conduct a thorough investigation of an allegation of abuse. On 4/3/24, the nurse learned of a Certified Nurse Aide (CNA) slapping Resident #1 on the leg. After learning of this allegation of abuse, the facility allowed the CNA to finish working the scheduled night shift and to continue to work unattended behind closed doors with other residents. This failure resulted in residents living at the facility to be exposed to the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of April 9, 2024 on June 30, 2024 at 3:32 p.m The facility staff removed the IJ on July 3, 2024 through the following actions: a. On 6/30/24 the facility suspended Staff F, CNA b. Provided education on 7/3/24 and ongoing until all staff currently working have been retrained to include the following: i. Separate the alleged abuser from the resident identified and send the individual home. ii. Immediately notify the charge nurse who will notify the Director of Nursing (DON) or Administrator. 1. You must speak directly with on of these 2 individuals. 2. Numbers for these 2 individuals are posted in the staffing book. iii. If it is a charge nurse responsible for the abuse, you must call the DON or Administrator immediately. iv. The DON or Administrator will begin the investigation and the employee will be contacted once a comprehensive investigation is completed. The scope lowered from a K to E at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE]/24 for Resident #1 documented diagnoses of Alzheimer ' s Disease, anxiety disorder and non-traumatic brain dysfunction. The MDS showed the Brief Interview for Mental Status (BIMS) score of 02, indicating severe cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility Incident Report dated 4/3/34 at 1:15 a.m., revealed incident description according to staff statements 2 Certified Nursing Assistants (CNA's) Staff E, CNA and Staff F, CNA entered the residents room to provide incontinence care, when they attempted to remove the incontinent brief Resident #1 became agitated and started swinging and kicking. According to the initial statement, Staff F slapped the resident on the thigh. Immediate action taken revealed a description reported to the charge nurse who instructed Staff E to report to the Director of Nursing. Call was placed to DON with no answer. When DON arrived on 4/3/24 at 6:30 a.m.,the incident was reported at that time. DON did not hear the phone and staff did not try another call. Review of Resident #1's Progress Notes lacked documentation of the incident occurring on 4/3/24. Review of facility investigation of self-report of incident occurring on 4/3/24 at approximately 1:15 a.m.-1:30a. m. revealed the following: a. Interview conducted with Staff E. According to her interview and written statement she went to assist with checking and changing 2 residents that require assistance of 2. Staff E and Staff F entered Resident #1's room and began the process of changing him. He did become combative. Staff E indicated Resident #1 swung out at her with his hands and made contact. During the final steps Staff D stated Staff F slapped Resident #1 with her hand and said stop it. Staff E stated when they were done, both CNA's entered the hallway and Staff F said sorry didn't mean to hit him but damn. After Staff E left the unit she informed the charge nurse that the act had occurred and the charge nurse stated yes to call the DON. b. Interview conducted with Staff F. According to her interview and written statement Staff F and Staff E entered Resident #1's room, Resident #1 was informed the CNA's were there to check and change him. Resident #1 was agreeable. When the CNA's attempted to remove the incontinent brief Resident #1 became agitated and started kicking and hitting. Staff F indicated when he first became agitated she held both his hands so he would not hit, he then began kicking with his feet and kicked staff E with his feet in her ribs. According to Staff F, they finished the process and left the room. c. Based on the information the facility is unable to confirm or deny that the incident occurred. d. A mandatory staff meeting will be held on March 18, 2024 for all nursing department staff on adult abuse. Staff F will complete Iowa Department of Health and Human Services mandatory adult abuse before her next scheduled shift. She will also not be scheduled in the dementia unit for 90 days at the end of that period if she has not had any further violations, she can be scheduled in the dementia unit. Review of written statement by Staff E, signed and undated revealed on April 3 at 1:15 a.m., went into help Staff F with the 2 gentlemen. Resident #1 was being combative. After the last time of Resident #1 hitting and kicking me Staff F slapped Resident #1 and told him to stop it. After we were done changing him Staff F said sorry didn't mean to hit him but damn. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of written statement by Staff F signed and dated 4/4/24 revealed Staff E and Staff F went to change Resident #1, on the first check he was ok when we told him what we were going to do. Was ok until we went to change him. We opened the depend and that is when he started to hit and I grabbed his hands and Staff E went to change him and that was when he kicked her in her ribs and lost balance, went to the hall. Then we got finished, I told him that was not nice to kick her and he laughed about it. Cleaned up the room and left. Second check went a lot better. An electronic message (e-mail) to Staff G, Nurse Practitioner dated 4/5/24 at 11:32 a.m., revealed the facility had a self report of an aide slapping Resident #1 while providing care. Interview on 7/2/24 at 4:22 p.m., with Staff E, CNA revealed on 4/3/24 at approximately 1:15 a.m., she went to assist Staff F, CNA with Resident #1 with care. During cares Resident #1 was hitting and kicking at staff assisting him. Staff F slapped Resident #1 on the upper left leg between the hip and knee area. Staff E reported it to Charge Nurse on duty. Charge Nurse stated she needed to call the DON right away. At 1:45 a.m., placed a call to the DON. Staff E revealed she did not answer so she left a message. At 1:48 a.m., sent the DON a text message. Staff E revealed Staff F continued to work the rest of her shift and the other staff working assisted her as Staff E was busy with her residents. Review of Staff F's time sheet revealed the following information: a. On 4/2/24 punched in at 10:00 p.m. and punched out 4/3/24 at 6:00 a.m. b. Staff F did not have any time clock punches from 4/4/24-4/8/24 c. Staff F returned to work as of 4/9/24 punched in at 9:45 p.m. and punched out 4/10/24 at 6:15 a.m. Review of the facility provided policy titled Abuse Prevention, Identification, Investigation and Reporting Policy dated July 2019 revealed under initial or immediate protection during facility investigation; a. Upon receiving a report of an allegation of resident abuse the facility shall immediately implement measures to prevent further potential abuse of residents from occuring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating them employee accused of abuse from all residents through the following or a combination of the following, if practicable: i. Suspending the employee ii. Segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility iii. And in rare instances separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. Following the completion of the facility investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee may be allowed to return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused. This separation must be maintained until the Department concludes its investigation and issues the written results of its investigation. Note if the DIA determines there was abuse (even though the facility did not substantiate the abuse), there is risk that DIA could cite the facility with Immediate Jeopardy, for allowing an abuser to have access to other residents while the matter is being investigated. Interview on 7/3/24 at 10:32 a.m., with the DON revealed the staff member should have been separated immediately from the resident and should not have worked the rest of the night shift.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to provide accurate resident records for 1 of 4 residents (Residents #1). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE]/24 for Resident #1 documented diagnoses of Alzheimer's Disease, anxiety disorder and non-traumatic brain dysfunction. The MDS showed the Brief Interview for Mental Status (BIMS) score of 02, indicating severe cognitive impairment. Review of facility Incident Report dated 4/3/34 at 1:15 a.m., revealed incident description according to staff statements 2 Certified Nursing Assistants (CNA's) Staff E, CNA and Staff F, CNA entered the residents room to provide incontinence care, when they attempted to remove the incontinent brief Resident #1 became agitated and started swinging and kicking. According to the initial statement, Staff F slapped the resident on the thigh. An electronic message (e-mail) to Staff G, Nurse Practitioner dated 4/5/24 at 11:32 a.m., revealed the facility had a self report of an aide slapping Resident #1 while providing care. Interview on 7/2/24 at 4:22 p.m., with Staff E, CNA revealed on 4/3/24 at approximately 1:15 a.m., she went to assist Staff F, CNA with Resident #1 with care. During cares Resident #1 was hitting and kicking at staff assisting him. Staff F slapped Resident #1 on the upper left leg between the hip and knee area. Staff E reported it to charge nurses on duty. Review of Resident #1's Progress Notes lacked documentation of the incident from the incident occurring on 4/3/24. Review of facility provided policy titled Charting and Documentation policy and procedure dated 6/1/24 revealed the following: a. All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, function or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's cognition and response to care. b. The following information is to be documented in the resident medical record i. Changes in the resident condition. ii. Events, incidents or accidents involving the resident. Interview on 7/3/24 at 10:32 a.m., with the Director of Nursing (DON) revealed the incident with Resident #1 should have been documented in his medical chart.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44474 Based on record review, interview, and facility policy the facility failed to have the Infection Preventionist at quarterly meetings for their quarterly Quality Assessment and Assurance (QAA) meetings. The facility reported a census of 50. Findings include: Review of the facility document titled Quality Assurance Process Improvement (QAPI) sign in sheet 2024: a. Document dated January lacked the signature of the Infection Preventionist. b. Document dated February lacked the signature of the Infection Preventionist. c. Document dated March lacked the signature of the Infection Preventionist. d. Document dated April lacked the signature of the Infection Preventionist. e. Document dated May lacked the signature of the Infection Preventionist. Review of the facility provided policy titled Quality Assurance Process Improvement dated July 1, 2024 revealed the Administrator is responsible for assuring that this facilitiy's QAPI program complies with federal, state, and local regulatory agency requirements. Interview on 7/3/24 at 10:32 a.m., with the Director of Nursing (DON) revealed Staff D, Registered Nurse is the Infection Preventionist (IP) and is usually working the floor as a nurse during QAPI meetings so she has not attended them. The DON further revealed she has been working on getting her IP certification but does not currently have it.