STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 34817 Based on record review, facility investigation file review, resident and staff interview, facility record review, and policy review the facility failed to protect the residents right to be free from abuse for three of four residents reviewed for abuse (Resident #10, #38, and #203). Resident #10 reported to Staff C, Licensed Practical Nurse (LPN), on 8/8/24 between 8-10 PM, she was experiencing pain after she had pericare completed on her. The resident reported Staff A, Certified Nursing Assistant (CNA) was rough with her while doing pericare and had gone deep in her buttock. She felt the area was bruised. Facility staff were aware of the allegation and allowed staff to continue to work. On 10/23/24, Staff B, CNA, reported to the Director of Nursing (DON) that Staff A, CNA, was rough when she provided cares to Resident #38 on 10/21/24, and told the resident I'll punch you if you punch me, I'll pinch you if you pinch me. Staff A continued to work with residents until she was suspended on 10/23/24. There is evidence that a serious adverse outcome would likely occur due to the facility failed to protect residents from allegations of abuse and allowed staff to continue to work. This placed all residents at risk for abuse. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents. The facility needed to take immediate action to ensure the residents didn't experience abuse. On 11/21/24 at 4:45 PM, the Iowa Department of Inspections, Appeals, and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy situation existed at the facility. The IJ was determined on 7/10/24. The facility staff removed the immediacy on 11/22/24 after the facility staff completed the following: a. All facility staff education provided on Abuse and Neglect Standards and Reporting on 11/21/24. The facility will continue to educate facility staff on Abuse and Neglect upon hire, as needed, and increase education associated with abuse scenario training monthly for 3 months. b. Residents were interviewed related to abuse concerns completed on 11/21/24. c. All active employee files were reviewed on 11/22/24 for mandatory abuse education and disciplinary actions associated with allegations or potential abuse/neglect. The scope lowered from K to D at the time of the survey after the surveyor ensured the facility implemented education and their abuse policy and procedures. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility reported a census of 49 residents. Findings include: 1. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had diagnoses of cerebral vascular disease (CVA) (stroke), hemiplegia, anxiety disorder, and chronic pain. The MDS recorded the resident had a Brief Interview for Mental Status (BIMS) of 13 indicating intact cognition. The MDS documented the resident had no behaviors, understood others and made herself understood, and able to express wants. The resident had dependence for dressing, hygiene, and bed mobility. Resident #10's Care plan revised 6/17/24 revealed the resident had limitations in ability to perform activities of daily living (ADLs) related to contractures, hemiplegia, and pain. The resident also presented with fear/anxiety related to unfamiliar lack of understanding of treatments. The Care Plan recorded the resident made false allegations at times (initiated 5/21/18). The Care Plan directed staff to implement measures to reduce fear and anxiety (initiated 11/10/17), notify the charge nurse of any allegations made right away (added to care plan 5/21/18), explain all procedures to the resident before starting and allow the resident time to adjust to changes (added 8/14/24), re-approach the resident and have alternative staff assist the resident if needed (added 8/14/24). The facility's investigation file contained the following: a. An incident summary: On 8/8/24, sometime between 8 PM- 10 PM, the nurse was notified Resident #10 experienced pain after completion of pericare. Resident #10 stated she felt the aide was rough with her and as they were doing pericare, the aide went deep in her buttock, and she felt like she was bruised. The nurse assessed the resident's periarea with no signs of bruising or bleeding observed. The resident denied pain. The nurse immediately provided pericare education to the CNA's on the evening shift. The DON and Administrator completed an interview with the resident who stated she had no concerns about pericare or the care she was receiving. Interviews completed with staff who were in the room. The CNA performing the care stated that the bowel movement was dried on the buttock and when she attempted to wipe it off, the resident said ouch. The other CNA in the room stated she was assisting the other resident in the room when she heard Resident #10 say ouch. She then stated she heard the CNA say I am sorry and continued with the pericare. The DON completed competencies with Staff A related to pericare with no concerns. Skin assessments were completed with no concerns. The Administrator initiated staff re-education on abuse and neglect standards and reporting completed by 9/6, and ongoing education provided through annual in-service. Residents with BIMS 12 or higher were interviewed and asked if they had been mistreated and if they feel safe. No concerns were noted. Social Services will follow up with Resident # 10 to assure she had no further concerns and felt safe. b. A written statement by Staff A, dated 8/8/24, revealed on 8/8/24, Staff O and I were doing Resident #10's care. Resident #10 was like you are hurting me. I told her you have dry bowel movement (BM) and I have to clean you up. She said ok, can you use the cream after you are done cleaning me? I said yes and I did but she (Resident #10) was so abusive. Resident #10 told the nurse. The nurses and the other CNA on that day checked her to see if she was hurt. There were no marks on her. While giving out snacks, I took a snack to the resident and forgot to open it. Because of that she (Resident #10) called me a black niga. I reported it to the nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. A typed statement by Staff G, LPN, dated 8/31/24 revealed the CNA told me a resident was complaining of pain after pericare. I went to get the other nurse on duty and went into the resident's room to assess the situation. I evaluated the resident's skin and her pain but had no concerns. I spoke with the CNAs about pericare. Later that evening, the CNA told me that the same resident called her a racial name. I went to talk to the resident and she stated it was because the aide was rough with her during pericare. Again, I asked the resident about pain and she denied having pain. d. A typed statement by Staff O, CNA, dated 8/31/24 revealed I was in the room with Staff A and Resident #10 while I performed cares on the other resident (in the room). I heard Resident #10 say ouch during pericare. I stopped what I was doing and I heard Staff A apologize to Resident #10 while pericare completed. I asked Staff A why Resident #10 said ouch. Staff A said she was wiping the BM. When I finished my cares I went and told the nurse immediately. The nurse went into the room to talk to the resident. After that, the nurse talked to me, and the other CNA's about pericare. e. An undated written statement by the former Administrator and DON revealed when interviewing the resident, the resident denied any roughness during pericare and stated she had no concerns with the pericare that was provided. She denied using any racial slur. She stated she felt safe and doesn't have any further concerns. f. Staff meeting dated 8/3/24 about abuse and neglect presented by the former Administrator. A Progress Note documented by Staff G, LPN, on 8/9/24 at 2:42 AM revealed the resident reported to staff that a caregiver was rough with her. Resident stated that as staff were doing pericare, the aide went deep in her buttock and she felt like she was bruised from staff cleaning her. This nurse called other staff on duty to do a proper assessment focusing on the periarea. No bruising or bleeding noted. The resident denied pain at the time of assessment. Staff reported to this writer that resident was very mean to her while doing pericare with another staff. As staff returned to pass snacks, the resident called staff attention by using an N word You black Nigger, open my snack. Staff reported that she opened the snack and decided to let this writer know. A Social Service Progress Note dated 9/5/24 at 10:52 AM, revealed social services followed up to ensure the resident was receiving the level of care she is accustomed to. The resident expressed no issues or concerns at this time. During an interview on 11/21/24 at 11:10 AM, Resident #10 stated no when the surveyor asked the resident if any staff had been rough with her while provided cares. The resident stated she didn't remember any time staff had been rough when they cleaned her up. The resident did not have any concerns with Staff A. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview 11/21/24 at 12:05 PM, Staff G, LPN, reported she had worked at the facility since the beginning of 2024, and worked the 6 PM - 6 AM shift. Staff G reported Resident #10 could be very needy, and constantly called for things, even though the nurses went in to see what she needed. The resident sometimes refused things. Staff G reported she had received mandatory reporter training. She had not witnessed staff being rough or unkind to any of the residents, but if she did she would separate the resident from the staff person. Staff G stated she would also notify her supervisor or the Administrator immediately if she had a concern about abuse. On the day Resident #10 reported a concern regarding her cares, Resident #10 told Staff G a staff person was being mean to her since the staff CNA's came in at 2:00 PM that day. The concern had not been reported to Staff G until around 8 PM when staff passed snacks (to the resident). Staff G reported she went and talked to the resident. She called the nurse from the opposite hall and did a full assessment with the other nurse present. She did not see any bruising. Resident #10 said her bottom was hurting. Staff G stated she had not witnessed Staff A being mean or rough with a resident at any time. Staff G acknowledged she wrote a note and put it in the mailbox for the Administrator and placed a copy of what she wrote in the unit manager's mailbox that night. The DON, Administrator, or Unit Manager did not call her until 8/26 about the incident. The DON and Administrator at that time called her and asked about the incident. During an interview on 11/21/24 at 1:04 PM, Staff A, reported she had worked at the facility for 4 months. Staff A reported she received one week of orientation at facility. Orientation entailed learning about the residents, what the residents needed, and how to take care of them. Staff A reported she had a problem with Resident #10 because the resident didn't like or want her. Resident #10 only wanted certain staff taking care of her. Staff A reported Resident #10 was always abusive to her. She let the nurse know about it. Staff A reported she took snacks to Resident #10 that day. Resident #10 told her she didn't bring her crackers and called Staff A a black niger. Staff A reported this made her cry and she told the nurse. During an interview 11/21/24 at 1:55 PM, the DON reported she had worked at the facility since 6/15/24. The DON acknowledged she had observed Staff A when she did a pericare audit otherwise she had not seen Staff A perform cares on Resident #10. The DON helped with the investigation regarding Resident #10 when the incident was reported. Resident #10 had reported staff wiped her too hard. The nurse on duty talked to Resident #10. Resident #10 said she wanted staff to wipe her more gently. The DON reported she did an audit and went over the pericare competency with Staff A. Resident #10 stated at the time she had no concerns with Staff A taking care of her. The DON stated she didn't know the exact date when the incident was reported to the State. The DON reported abuse education provided to staff at the time of hire and as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview 11/21/24 at 2:25 PM, the Unit Manager reported she had worked at the facility since 11/26/23. The unit manager acknowledged she had watched Staff A do cares and had not witnessed her coming across as rough. Staff A was good with residents and had good interactions. Nothing that made her step back and think she needed to do re-education. The unit manager reported when she became aware of a concern, she talked to Resident #10 and asked her to explain what happened. Resident #10 told her she didn't like how staff rolled her and thought staff wiped her too hard. The unit manager thought the resident had BM stuck to her bottom and perhaps some pubic hair got pulled as staff cleaned the area. The unit manager reported she was not called on the day of the incident in 8/2024, but she thought she read something in Resident #38's progress note. The unit manager reported she was out of the building during the week of the state fair, and off for 10 days. If something such as a note was put in her mailbox she would not have gotten it until she came back to work 10 days later. In an interview on 11/21/24 at 4:03 PM. Staff J, LPN, reported she had worked at the facility since 4/18/24, and worked the 6 PM to 6 AM shift. Staff J confirmed she had taken the mandatory reporter abuse training and received information about abuse in meetings. Staff J acknowledged she had not witnessed any staff being unkind or rough, but she would report to the DON or on-call manager right away if she did. On the day, Resident #10 voiced concern about a CNA doing cares, Staff J stated she was not working on that side of the building, but the nurse working the North Hall came and got her and told her Resident #10 had told her Staff A was rough with her when the CNA performed peri care. Staff J and Staff G performed a skin assessment on the resident. They didn't observe any scratches, redness, or bruising. The incident took place about 2-3 months ago. During an interview 11/25/24 at 12:41 PM, the interim Administrator reported she had worked at the facility from 7/2024 to the end of 9/2024 or beginning of 10/2024. The interim Administrator reported toward the end on 8/2024, she saw a progress note about an alleged abuse that happened 2-3 weeks prior to that. She reported to DIAL, notified the police and the resident's physician, and started an investigation. Resident #10 had a history of false allegations. It was listed on her care plan. The interim Administrator confirmed Staff A never told her a resident called her a derogatory name or N word until she was investigating this incident. On 11/21/24 at 10:04 AM, the Administrator provided timecards to the surveyor. Review of Staff A's timecard report revealed Staff A worked 8/8/24 from 2:03 PM - 10:26 PM. 2. The Quarterly MDS assessment dated [DATE] revealed Resident #38 had diagnoses of stroke, hemiplegia, aphasia, and schizophrenia. The resident had impaired short term and long-term memory but able to recall the current season, location of room, and staff names and faces. The MDS indicated the resident had no behaviors. The MDS recorded the resident had dependence on staff for dressing and hygiene, and required substantial to maximum assistance for bed mobility. The Care Plan revised 2/29/24 revealed Resident #38 had a CVA affecting the right side of her body and the ability to speak. The resident had limited range of motion due to contractures to her arms and legs. The resident had impaired cognitive function, communications and impaired thought processes and difficulty communicating and understanding others. The Care Plan directed staff to provide assistance of two for bed mobility and dressing, cue as needed, and ask yes/no questions in order to determine the resident's needs. The Facility's Investigation File revealed the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. Summary of event: On Wednesday, 10/23/24 at 2:17 PM, Staff B, CNA, came to the DON and reported an allegation of abuse. Staff B reported Staff A was rough and used more than necessary strength to turn and reposition a resident when she provided cares on 10/21/24 evening. Staff B stated Staff A said to Resident #38 during care If you punch me, I'll punch you and if you pinch me, I'll pinch you. DON educated Staff B that suspected abuse and neglect must be reported immediately to ensure the resident's safety. Staff B returned to work on 10/24/24 after abuse education provided. An investigation was initiated immediately. The DON interviewed Resident #38. Yes and No questions asked due to the residents communication deficits. The resident nodded her head yes when asked if someone was rough with her on Monday night and if she felt safe in the facility. Resident #38 then refused further questioning. The alleged incident was reported to DIAL and Physician, police, and POA notified on 10/23/24. The Unit Manager completed a skin assessment on Resident #38 on 10/23/24. No new skin concerns noted. No pain concerns noted. The unit manager obtained a statement from Staff A. Staff A was immediately suspended pending investigation. Staff A stated she provided care to Resident #38 prior to and after supper. She stated Staff B assisted in lift transfer into chair prior to supper and out of chair after supper. Staff A stated no concerns were voiced during or after cares. Residents with BIMS 12 or higher were interviewed, and no concerns voiced regarding mistreatment and they felt safe in the facility. Staff education provided on abuse, neglect and exploitation policy and timely reporting of abuse. Education regarding when, where, and who to report suspected, confirmed or alleged abuse. b. A written staff statement by Staff B, CNA, dated 10/23/24 revealed on Monday 10/21/24 while working with Staff A CNA on the South Hall. We were getting Resident #38 up for dinner and Staff A appeared to use excessive force while turning Resident #38 to put the sling under her. Resident #38 yelled Hey! and began swinging her elbow at Staff A. Staff A told Resident #38 if you punch me, I will punch you, if you pinch me, I will pinch you. After we got the sling under Resident #38, we got her up into a chair and I told Staff A I'll finish up with her, you can go. c. A typed statement by the Unit Manager dated 10/23/24 revealed the unit manager spoke with Staff A, CNA, regarding reporting abuse. Staff A stated she had no issue with the resident. Staff A stated she had gotten the resident ready for supper by herself and asked for help with the Hoyer (mechanical lift) transfer. Staff A stated Staff B helped her with the transfer. Staff A transferred the resident back to the room via wheelchair and assist of one after supper. Staff B assisted resident back to bed via the mechanical lift. Staff A stated the resident had no complaints with the transfer. Staff B helped her with evenings cares. Staff A stated she did the pericare and resident had no complaints of pain, discomfort or signs of fear. d. Staff H, CNA, was interviewed on 10/24/24 at 2:10 PM and stated there were no complaints from Resident #38 throughout the shift and she did not hear of anything else occurring throughout the shift. e. Staff I, CNA, was interviewed on 10/24/24 at 2:15 PM and stated there were no complaints from Resident #38 throughout the shift. She worked with Staff H on the North hall all night and she did not hear of anything else occurring throughout the shift. f. Staff J, LPN, was interviewed on 10/24/24 at 6:15 PM. Staff J stated there was nothing reported to her when she came on for her shift or throughout the rest of the evening shift. She was not told of any complaints from Resident #38 and stated she did not notice any behavior differences following administering her evening medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Incident Report dated 10/23/24 revealed a CNA came to the DON's office and reported on 10/21 around supper time another CNA was rough with the resident when repositioning the resident and made the statement If you punch me, I will punch you, if you pinch me, I will pinch you. Resident nodded yes that a staff member was rough with her and nodded no that she does not feel unsafe when asked about the event. Staff and resident involved were interviewed. CNA suspended pending investigation and due to delay in reporting despite having received dependent adult abuse reporting education. No resident injuries observed at the time of the incident. In an interview on 11/20/24 at 1:24 PM, Resident#38 stated yea when asked if staff treated her well. The resident denied staff had threatened to pinch or punch her, and no staff had been unkind or rough with her. In an interview on 11/20/24 at 2:47 PM, Staff B, CNA, reported she had worked at the facility since 9/2024 but had been a CNA for [AGE] years. She had mandatory reporter training prior to being hired at the facility. Staff B reported Resident#38 didn't have any behaviors but could get a little tempermental. The resident was contracted and stiff on her right side, and she could be in a lot of pain. Staff B reported on the day of the incident, she went into the resident's room with Staff A, CNA, to get Resident #38 up for dinner. Resident#38 required assistance of two staff and a mechanical lift. When getting the resident up, she could exhibit being a little stiff from lying in bed. The resident threw her elbow up when Staff A moved the resident to pull the sling under her. Staff B reported whenever Resident #38 moved her right elbow up, it meant you're hurting me. Staff B thought Staff A turned the resident in an aggressive way. Staff A told the resident if you punch me, I will punch you, if you pinch me, I will pinch you. Staff B told Staff A we're not going to do that. Staff A and Staff B transferred Resident #38 from the bed to her wheelchair, and Staff B finished getting the resident dressed. Staff B told Staff A she would take care of Resident #38 the rest of the evening. Staff B stated she did not contact the DON or Administrator at the time to report the incident. She told the nurse that was working on that hall she would need her assistance with Resident #38 the rest of the evening. The nurse asked why and she told the nurse she was not comfortable with the way Staff A spoke with the resident. Staff B acknowledged she was not familiar with the process and what she needed to do when the incident happened. Staff B stated she spoke with the DON on 10/23 about what happened. The DON had her write a statement and then asked her to go home. She returned to the facility the next day. Staff B reported Staff A was also sent home on 10/23 but she doesn't know what happened to her after that. Staff B confirmed Staff A continued to work on the same hall with assigned residents on the evening of the alleged incident with Resident#38. Staff B reported Resident #38 did not seem to be in more pain than usual or appear more tearful or upset during the rest of the shift. Staff B demonstrated with the surveyor how Resident #38 was in bed and how Staff A yanked on resident's arm to roll her. Staff A placed her hands on resident's upper arm and another hand on her leg to roll the resident onto her side to get the sling under her. When Staff A grabbed the resident's arm and yanked her, the resident's elbow went up and the resident yelled out. After they got the resident transferred into the wheelchair, Staff B told Staff A she (Staff B) would take care of the resident the rest of the evening. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview 11/21/24 at 1:55 PM, the DON reported she had worked at the facility since 6/15/24. The DON reported Staff B came to the DON's office on 10/23/24 and told her Staff A handled Resident #38 in a rough way, and told her she would punch or pinch her. The DON reported she spoke with Resident #38. The resident shook her head yes when she asked her if someone had been rough with her. The resident said she felt safe though. The DON reported she talked to the Administrator. Staff B was suspended because she needed to report the incident when it happened. Staff A was also suspended. The DON stated she had observed Staff A during a pericare audit, but otherwise she had not observed Staff A perform cares on a resident. The DON reported the Unit Manager obtained a statement from Staff A. Staff education provided on abuse and neglect provided at the time of hire and as needed. During an interview 11/21/24 at 2:25 PM, the Unit Manager reported she had worked at the facility since 11/26/23. The unit manager acknowledged she had watched Staff A do cares and had not witnessed her coming across as rough. Staff A was good with residents and had good interactions. Nothing that made her step back and think she needed to do re-education. The unit manager reported she was not called on the day of the incident in 8/2024, but she thought she read something in Resident #38's progress note. The unit manager reported she was out of the building during the week of the state fair, and off for 10 days. If something such as a note was put in her mailbox she would not have gotten it until she came back to work 10 days later. In an interview on 11/21/24 at 4:03 PM. Staff J, LPN, reported she had worked at the facility since 4/18/24, and worked the 6 PM to 6 AM shift. Staff J confirmed she took the mandatory reporter abuse training and received information about abuse in meetings. Staff J acknowledged she had not witnessed any staff being unkind or rough, but she would report to the DON or on-call manager right away if she did. Staff J reported Resident #38 sometimes resisted care. She tells the resident they are there to help her, or she will leave and go back and help her. Resident # 38 liked staff to hold her hand. Her legs were stiff and it could be hard to move her. Staff J stated she always helped the aide when they asked. The CNA did not tell her about the incident with Resident #38 and a CNA. Staff J stated a couple of residents had concerns about a certain staff person taking care of them. When a resident voiced a concern, she switched out the assignment. On 11/21/24 at 10:04 AM, the Administrator provided timecards to the surveyor. The Administrator reported Staff A punched in on 11/4/24 but didn't punch out. She talked to Staff A when she arrived and did not allow her to work that day. They placed Staff A on suspension. Review of timecard report dated 10/1/24 to 11/21/24 revealed Staff A worked the following: 10/21/24 2:10 PM- 11:04 PM 10/22/24 2:16 PM- 11:03 PM 10/23/24 2:05 PM - 2:48 PM. 11/4/24 1:56 PM - 2:00 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Staff A's employee file revealed dependent adult abuse mandatory reporter training completed on 5/30/24. The file also contained the facility's Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating policy, Identifying Types of Abuse, and the facility's Coordinating/Implementing Abuse, Neglect, and Exploitation Policies and Procedures signed by Staff A on 6/17/24. The file also contained a suspension action form dated 7/11/24 for when a resident reported abuse. Staff A was suspended pending investigation. The facility's Abuse, Neglect, Exploitation and Misappropriation-Prevention Program revised 4/2021 documented the residents had the right to be free from abuse, neglect, and exploitation. This includes freedom from corporal punishment, verbal, mental, and sexual or physical abuse. Staff orientation and training provided on abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. Measures implemented to address factors that may lead to abusive situations, for example: provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation, help staff understand how cultural and ethnic differences can lead to misunderstanding and conflicts, and instruct staff regarding appropriate ways to address interpersonal conflicts. Abuse allegations investigated within timeframes required by federal requirements. Resident protected from any further harm during investigations. A facility's Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigation Policy revised 9/2022 revealed any suspicion of resident abuse must be reported immediately to the Administrator and other officials according to state laws. The administrator is responsible for determining what actions (if any) are needed for the protection of residents when an allegation of abuse reported. The administrator [NAME] [TRUNCATED]

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 34817 Based on record review, facility investigation file review, resident and staff interviews, and facility policy review, the facility failed to ensure all allegations of abuse including allegations of staff to resident verbal threats and rough treatment, and inappropriate touching of a resident's buttocks by Staff A were reported timely to the facility administration for three of four residents reviewed for abuse (Resident #10, #38, and #28). The incident of alleged abuse that occurred on 8/8/24 was not reported to the Department of Inspections, and Appeals and Licensing (DIAL) until 8/30/24. The allegation of abuse on 10/21/24 was not reported to DIAL until 10/23/24. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents. There was evidence that a serious adverse outcome was likely to occur due to the facility failed to protect residents from allegation of abuse and allowed staff to continue to work. This placed all residents at risk for abuse. The facility needed to take immediate action to ensure that all abuse allegations are reported in a timely manner. On 11/21/24 at 4:45 PM, the Iowa Department of Inspections and Appeals staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy situation existed at the facility. The IJ was determined on 8/8/24. The facility staff removed the immediacy on 11/25/24 after the facility staff completed the following: a. All facility staff education on Abuse and Neglect Standards and Reporting initiated on 11/21/24. Facility will continue to educate facility staff on Abuse and Neglect upon hire, as needed, and increase education associated with abuse scenario training monthly for 3 months. b. Residents were interviewed related to abuse concerns was completed on 11/21/24. c. All active employee files were reviewed on 11/22/24 for mandatory abuse education and disciplinary actions associated with allegations or potential abuse/neglect. d. Progress notes, grievances, and critical events reviewed routinely by facility staff to identify potential abuse, neglect, and exploitation opportunities, and act upon these immediately. The facility implemented an event tracking log to review these items routinely, and allow key staff to view approaching timelines, and trend and track the events. The scope lowered from a K to D at the time of the survey after ensuring the facility implemented education and their policy and procedure. The facility reported a census of 49 residents. Findings include: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had diagnoses of cerebral vascular disease (CVA) (stroke), hemiplegia, anxiety disorder, and chronic pain. The MDS recorded the resident had a Brief Interview for Mental Status (BIMS) of 13 indicating intact cognition. The MDS documented the resident had no behaviors, able to express her wants, understood others and made herself understood. The resident had dependence on staff for dressing, hygiene, and bed mobility. Resident #10's Care Plan revised 6/17/24 revealed the resident had limitations in her ability to perform activities of daily living (ADLs) related to contractures, hemiplegia, and pain. The resident also presented with fear/anxiety related to lack of understanding of treatments. The Care Plan recorded the resident made false allegations at times (initiated 5/21/18). The care plan directed staff to implement measures to reduce fear and anxiety (initiated 11/10/17), notify the charge nurse of any allegations made right away (added to care plan 5/21/18), explain all procedures to the resident before starting and allow the resident time to adjust to changes (added 8/14/24), re-approach the resident and have alternative staff assist the resident if needed (added 8/14/24). The facility's investigation file contained the following: a. Incident Summary: Resident #10 admitted to the facility on [DATE]. Resident requires assistance of two for bed mobility and ADL care, assistance of one for check and change, and assistance of two for transfers. BIMS on 6/7/24 was 13. On 8/8/24, sometime between 8 PM- 10 PM, the nurse was notified Resident #10 experienced pain after completion of pericare. Resident #10 stated she felt the aide was rough with her and as they were doing pericare, the aide went deep in her buttock, and she felt like she was bruised. The nurse assessed the resident's periarea with no signs of bruising or bleeding observed. The resident denied pain. The nurse immediately provided pericare education to the CNA's (certified nursing assistant) on the evening shift. The Director of Nursing (DON) and Administrator completed an interview with the resident who stated she had no concerns about pericare or the care she was receiving. Interviews also completed with staff who were in the room. The CNA performing the care stated that the bowel movement (BM) was dried on the resident's buttock and when she attempted to wipe it off, the resident said ouch. The other CNA in the room stated she was assisting the other resident in the room when she heard Resident #10 say ouch. She heard the CNA say I am sorry and continued with the pericare. The DON completed competencies with Staff A related to pericare, with no concerns. Skin assessments were completed with no concerns notes. The resident denied pain. Administrator initiated staff re-education on abuse and neglect standards and reporting completed by 9/6/24, and ongoing education provided through annual in-service. Residents with BIMS 12 or higher were interviewed and asked if they had been mistreated and if they felt safe. No concerns were noted. Social Services will follow up with Resident # 10 to assure she had no further concerns and felt safe. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. A written statement by Staff A, CNA, dated 8/8/24, revealed on 8/8/24, Staff O and I were doing Resident #10's care. Resident #10 was like you are hurting me. I told her you have dry BM and I have to clean you up. The resident said ok, can you use the cream after you are done cleaning me? I said yes and I did but she (Resident #10) was so abusive. Resident #10 told the nurse. The nurses and the other CNA on that day checked her to see if she was hurt. There were no marks on her. I took a snack to the resident and forgot to open it. Because of that she (Resident #10) called me a black niga. I reported it to the nurse. c. A typed statement by Staff G, Licensed Practical Nurse (LPN), dated 8/31/24 revealed the CNA told me a resident was complaining of pain after pericare. I went to get the other nurse on duty and went into the resident's room to assess the situation. I evaluated the resident's skin and her pain but noted no concerns. I spoke with the CNAs about pericare. Later that evening, the CNA told me that the same resident called her a racial name. I went to talk to the resident and she stated it was because the aide was rough with her during pericare. Again, I asked the resident about pain and she denied having pain. d. A typed statement by Staff O, CNA, dated 8/31/24 revealed I was in the room with Staff A and Resident #10 while I performed cares on the other resident (in the room). I heard Resident #10 say ouch during pericare. I stopped what I was doing and I heard Staff A apologize to Resident #10 while pericare completed. I asked Staff A why Resident #10 said ouch. Staff A said she was wiping the BM. When I finished my cares I went and told the nurse immediately. The nurse went into the room to talk to the resident. After that, the nurse talked to me and the other CNA's about pericare. e. An undated written statement by the former Administrator and DON revealed when interviewing the resident, the resident denied any roughness during pericare and stated she had no concerns with the pericare that was provided. She denied using any racial slur. She stated she felt safe and doesn't have any further concerns. f. Staff meeting dated 8/3/24 about abuse and neglect presented by the former Administrator. A Progress Note documented by Staff G, LPN, on 8/9/24 at 2:42 AM revealed the resident reported to staff that a caregiver was rough with her. Resident stated that as staff were doing pericare, the aide went deep in her buttock and she felt like she was bruised from staff cleaning her. This nurse called other staff on duty to do a proper assessment focusing on the periarea. No bruising or bleeding noted. The resident denied pain at the time of assessment. Staff reported to this writer that resident was very mean to her while doing pericare with another staff. As staff returned to pass snacks, the resident called staff attention by using an N word You black Nigger, open my snack. Staff reported that she opened the snack and decided to let this writer know. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview 11/21/24 at 12:05 PM, Staff G, LPN, reported she had worked at the facility since the beginning of 2024, and worked the 6 PM - 6 AM shift. Staff G reported Resident #10 could be very needy, and constantly called for things, even though the nurses went in to see what she needed. The resident sometimes refused things. Staff G reported she had received mandatory reporter training. Staff G stated she would notify her supervisor or the Administrator immediately if she had a concern about abuse. On the day Resident #10 reported a concern regarding her cares, Resident #10 told Staff G a staff person was being mean to her since the staff CNA's came in at 2:00 PM that day. The concern had not been reported to Staff G until around 8 PM when staff passed snacks (to the resident). Staff G reported she went and talked to the resident. She called the nurse from the opposite hall and did a full assessment with the other nurse present. She did not see any bruising. Resident #10 said her bottom was hurting. Staff G stated she had not witnessed Staff A being mean or rough with a resident at any time. Staff G acknowledged she did not report the incident to her supervisor or the Administrator. It slipped her mind to call the Administrator or DON right away. She wrote a note and put it in the mailbox for the Administrator and placed a copy of what she wrote in the unit manager's mailbox that night. The DON, Administrator, or Unit Manager did not call her until 8/26. The DON asked her about the incident and why she did not call right away. The Administrator at that time also called her and asked about the incident. Staff G apologized to the Administrator and said there was a lot going on that night, and she just didn't call. During an interview on 11/21/24 at 1:04 PM, Staff A, CNA, reported she had worked at the facility for 4 months. Staff A reported she received one week of orientation at the facility. Orientation entailed learning about the residents, what the residents needed, and how to take care of them. Staff A reported she had a problem with Resident #10 because the resident didn't like or want her. Resident #10 only wanted certain staff taking care of her. Staff A reported Resident #10 was always abusive to her. She let the nurse know about it. Staff A reported she took snacks to Resident #10 that day (8/8/24). Resident #10 told her she didn't bring her crackers and called Staff A a black niger. Staff A reported this made her cry and she told the nurse. Staff also stated some staff didn't like her but she came to work and did her job. Some staff took 5-6 breaks a shift or took an hour break, and then she didn't get a break, and she was the only person left on the unit to do the work. She reported to the Administrator the other CNA took an hour break and Staff A didn't get a break. This was reported the week just prior to her getting suspended when she was accused of being rough with Resident #10. During an interview 11/21/24 at 1:55 PM, the DON reported she had worked at the facility since 6/15/24. The DON acknowledged she had observed Staff A when she did a pericare audit otherwise she had not seen Staff A perform cares on Resident #10. The Unit Manager reported she got a statement from Staff A. The DON helped with the investigation regarding Resident #10 when the incident was reported. Resident #10 had reported staff wiped her too hard. The nurse on duty talked to Resident #10. Resident #10 said she wanted staff to wipe her more gently. The DON reported she did an audit and went over the pericare competency with Staff A. Resident #10 stated at the time she had no concerns with Staff A taking care of her. The DON stated she didn't know the exact date when the incident was reported to the State. Education provided to staff on abuse and neglect, and any concerns needed to be reported right away to the Administrator or DON. The DON reported staff educated about abuse at the time of hire and as needed. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview 11/21/24 at 2:25 PM, the Unit Manager reported she had worked at the facility since 11/26/23. The unit manager acknowledged she had watched Staff A do cares and had not witnessed her coming across as rough. Staff A was good with residents and had good interactions. Nothing that made her step back and think she needed to do re-education. The unit manager reported when she became aware of a concern, she talked to Resident #10 and asked her to explain what happened. Resident #10 told her she didn't like how staff rolled her and thought staff wiped her too hard. The unit manager thought the resident had BM stuck to her bottom and perhaps some pubic hair got pulled as staff cleaned the area. In an interview on 11/21/24 at 4:03 PM. Staff J, LPN, reported she had worked at the facility since 4/18/24, and worked the 6 PM to 6 AM shift. Staff J confirmed she had taken the mandatory reporter abuse training and received information about abuse in meetings. Staff J acknowledged she had not witnessed any staff being unkind or rough, but she would report to the DON or on-call manager right away if she did. On the day, Resident #10 voiced concern about a CNA doing cares, Staff J stated she was not working on that side of the building, but the nurse working the North Hall came and got her and told her Resident #10 had told her Staff A was rough with her when the CNA performed pericare. Staff J and Staff G performed a skin assessment on the resident. They didn't observe any scratches, redness, or bruising. The incident took place about 2-3 months ago. During an interview 11/25/24 at 12:41 PM, the interim Administrator reported she had worked at the facility from 7/2024 to the end of 9/2024. The interim Administrator reported toward the end on 8/2024, she saw a progress note about an alleged abuse that happened 2-3 weeks prior to that. She reported to DIAL, notified the police and the resident's physician, and started an investigation. Resident #10 had a history of false allegations. It was listed on her care plan. The interim Administrator confirmed Staff A never told her a resident called her a derogatory name or N word until she was investigating this incident. The facility's Abuse, Neglect, Exploitation and Misappropriation-Prevention Program revised 4/2021 residents had the right to be free from abuse, neglect, and exploitation. This includes freedom from corporal punishment, verbal, mental, and sexual or physical abuse. Abuse allegations reported and investigated within timeframes required by federal requirements. A facility's Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigation Policy revised 9/2022 revealed all reports of resident abuse reported to local, state and federal agencies as required by current regulations. Any suspicion of resident abuse must be reported immediately to the Administrator and other officials according to state laws. The Administrator or individual making the abuse allegation must report suspicion of abuse to the state licensing/certification agency responsible for surveying and licensing the facility immediately within two hours of an allegation involving abuse or serious bodily injury or within 24 hours of an allegation that does not involve abuse 2. The MDS assessment dated [DATE] revealed Resident #38 had diagnoses of stroke, hemiplegia, aphasia, and schizophrenia. The resident had impaired short term and long-term memory but able to recall the current season, location of room, and staff names and faces. The MDS indicated the resident had no behaviors. The MDS recorded the resident had dependence on staff for dressing and hygiene, and required substantial to maximum assistance for bed mobility. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Care Plan revised 2/29/24 revealed Resident #38 had a CVA affecting the right side of her body and the ability to speak. The resident had limited range of motion due to contractures to her arms and legs. The resident had impaired cognitive function, communications and impaired thought processes and difficulty communicating and understanding others. The Care Plan directed staff to provide assistance of two for bed mobility and dressing, cue as needed, and ask yes/no questions in order to determine the resident's needs. The Facility's Investigation File revealed the following: a. A summary of events: On Wednesday, 10/23/24 at 2:17 PM, Staff B, CNA, came to the DON and reported an allegation of abuse. Staff B reported Staff A was rough and used more than necessary strength to turn and reposition a resident when she provided cares on 10/21/24 evening. Staff B stated Staff A said to Resident #38 during care If you punch me, I'll punch you and if you pinch me, I'll pinch you. DON educated Staff B that suspected abuse and neglect must be reported immediately to ensure the resident's safety. Staff B was suspended and immediately received education about reporting abuse and neglect both suspected and actual. Staff B returned to work on 10/24/24 after abuse education provided. An investigation was initiated immediately. The DON interviewed Resident #38. Yes and No questions asked due to the residents communication deficits. The resident nodded her head yes when asked if someone was rough with her on Monday night and if she felt safe in the facility. Resident #38 then refused further questioning. The alleged incident was reported to DIAL. Physician, police, and POA notified on 10/23/24. The Unit Manager completed a skin assessment on Resident #38 on 10/23/24. No new skin concerns noted. No pain concerns noted. The unit manager obtained a statement from Staff A. Staff A was immediately suspended pending investigation. Staff A stated she provided care to Resident #38 prior to and after supper. She stated Staff B assisted in lift transfer into chair prior to supper and out of chair after supper. Staff A stated no concerns were voiced during or after cares. Residents with BIMS 12 or higher were interviewed, and no concerns voiced regarding mistreatment and they felt safe in the facility. Staff education provided on abuse, neglect and exploitation policy and timely reporting of abuse. Education regarding when, where, and who to report suspected, confirmed or alleged abuse. b. A written staff statement by Staff B, CNA, dated 10/23/24 revealed on Monday 10/21/24 while working with Staff A CNA, on the South Hall. We were getting Resident #38 up for dinner and Staff A appeared to use excessive force while turning Resident #38 to put the sling under her. Resident #38 yelled Hey! and began swinging her elbow at Staff A. Staff A told Resident #38 if you punch me, I will punch you, if you pinch me, I will pinch you. After we got the sling under Resident #38, we got her up into a chair and I told Staff A I'll finish up with her, you can go. c. A typed statement by the Unit Manager dated 10/23/24 revealed the unit manager spoke with Staff A, CNA, regarding reporting abuse. Staff A stated she had no issue with the resident. Staff A stated she had gotten the resident ready for supper by herself and asked for help with the hoyer (mechanical lift) transfer. Staff A stated Staff B helped her with the transfer. Staff A transferred the resident back to the room via wheelchair and assist of one after supper. Staff B assisted resident back to bed via the mechanical lift. Staff A stated the resident had no complaints with the transfer. Staff B helped her with evenings cares. Staff A stated she did the pericare and resident had no complaints of pain, discomfort or signs of fear. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. Staff H, CNA, was interviewed on 10/24/24 at 2:10 PM and stated there were no complaints from Resident #38 throughout the shift and she did not hear of anything else occurring throughout the shift. e. Staff I, CNA, was interviewed on 10/24/24 at 2:15 PM and stated there were no complaints from Resident #38 throughout the shift. She worked with Staff H on the North hall all night and she did not hear of anything else occurring throughout the shift. f. Staff J, LPN, was interviewed on 10/24/24 at 6:15 PM. Staff J stated there was nothing reported to her when she came on for her shift or throughout the rest of the evening shift. She was not told of any complaints from Resident #38 and stated she did not notice any behavior differences following administering her evening medications. An Incident Report dated 10/23/24 revealed a CNA came to the DON's office and reported on 10/21 around supper time another CNA was rough with the resident when repositioning the resident and made the statement If you punch me, I will punch you, if you pinch me, I will pinch you. Resident nodded yes that a staff member was rough with her and nodded no that she does not feel unsafe when asked about the event. Interviews completed with the staff and the resident involved. CNA suspended pending investigation and due to delay in reporting despite having received dependent adult abuse reporting education. Staff re-educated on needing to report any suspected and/or actual abuse and neglect immediately. No resident injuries observed at the time of the incident. In an interview on 11/20/24 at 1:24 PM, Resident # 38 stated yea when asked if staff treated her well. The resident denied staff had threatened to pinch or punch her, and no staff had been unkind or rough with her. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/20/24 at 2:47 PM, Staff B, CNA, reported she had worked at the facility since 9/2024 but had been a CNA for [AGE] years. She had mandatory reporter training prior to being hired at the facility. Staff B reported Resident # 38 didn't have any behaviors but could get a little tempermental. The resident was contracted and stiff on her right side, and she could be in a lot of pain. Staff B reported on the day of the incident, she went into the resident's room with Staff A, CNA, to get Resident #38 up for dinner. Resident #38 required assistance of two staff and a mechanical lift. When getting the resident up, she could exhibit being a little stiff from lying in bed. The resident threw her elbow up when Staff A moved the resident to pull the sling under her. Staff B reported whenever Resident #38 moved her right elbow up, it meant you're hurting me. Staff B thought Staff A turned the resident in an aggressive way. Staff A told the resident if you punch me, I will punch you, if you pinch me, I will pinch you. Staff B told Staff A we're not going to do that. Staff A and Staff B transferred Resident #38 from the bed to her wheelchair, and Staff B finished getting the resident dressed. Staff B told Staff A she would take care of Resident #38 the rest of the evening. Staff B stated she did not contact the DON or Administrator at the time to report the incident. She told the nurse that was working on that hall she would need her assistance with Resident #38 the rest of the evening. The nurse asked why and she told the nurse she was not comfortable with the way Staff A spoke with the resident. Staff B acknowledged she was not familiar with the process and what she needed to do when the incident happened. Staff B stated she spoke with the DON on 10/23 about what happened. The DON had her write a statement and then asked her to go home. She returned to the facility the next day. Staff B reported Staff A was also sent home on 10/23 but she doesn't know what happened to her after that. The DON gave her phone number and told her to call right away if this came up in the future, because she needed to report it right away. Staff B confirmed Staff A continued to work on the same hall with assigned residents on the evening of the alleged incident with Resident #38. Staff B reported Resident #38 did not seem to be in more pain than usual or appear more tearful or upset during the rest of the shift. Staff B demonstrated with the surveyor how Resident #38 was in bed and how Staff A yanked on resident's arm to roll her. Staff A placed her hands on resident's upper arm and another hand on her leg to roll the resident onto her side to get the sling under her. When Staff A grabbed the resident's arm and yanked her, the resident's elbow went up and the resident yelled out. After they got the resident transferred into the wheelchair, Staff B told Staff A she (Staff B) would take care of the resident the rest of the evening. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview 11/20/24 at 4:17 PM, Staff K, Registered Nurse (RN) reported she had worked at the facility since 7/2024 as an agency nurse. She worked the 6 AM to 6 PM shift. Staff K stated she noticed Resident #38 had a behavior once while Staff K applied lotion to her feet and the resident almost kicked her. Sometimes the resident refused to [NAME] down or get changed. Staff K confirmed she oversaw staff when she worked. Staff are kind to the residents but sometimes the CNA laughed at the resident whenever a resident tried to express themselves, and it agitated the resident. Staff K stated she pulled staff aside and talked to the CNA and explains to them not to do that because it could agitate the resident and escalated the resident's behaviors. Staff K stated she didn't recall a time when a CNA came and asked her to help with Resident #38 the rest of the evening. There were times when she had to help the CNAs because the resident wouldn't let them put a sling under her. Staff K confirmed she had training for dependent adult abuse in the past year. Staff K reported if she witnessed staff being unkind or rough with a resident she would immediately separate the resident from staff, talk to the resident to see what happened, ensure the resident's safety, and let the Administrator know. Staff K acknowledged she had not received any hands on training or education about abuse while she worked at the facility as agency. Staff K reported if someone reported to her a staff person said to a resident, If you punch me, I will punch you, if you pinch me, I will pinch you, she would consider this a concern for abuse and she would report it immediately to the Administrator or DON right away. She is not aware of any staff person saying to a resident if you punch me, I will punch you. If you pinch me, I will pinch you. She doesn't recall any CNA asking her to help with Resident #38 during the rest of her shift in the past month because didn't feel comfortable with another CNA helping this resident. In an interview on 11/20/24 at 4:50 PM, Staff B confirmed she told Staff J, LPN, to help her with cares or things needed for Resident #38 on 10/21/24. Staff H, CNA, failed to respond back to voice and text messages sent on 11/21/24 at 9:26 AM by the surveyor. In an interview 11/21/24 at 9:30 AM, Staff I, CNA, reported she had worked at the facility since 9/2024. She works the 2-10 PM shift. Staff I reported she had computer-based training on abuse. Staff I stated she helped Resident #38 get up. The resident didn't like putting her arm into her shirt but she helped pull her arm through the shirt for her. Sometimes the resident wouldn't let her change her, but she would just ask her and Resident #38 allowed her to change her. Staff I reported she had not witnessed staff being rough or unkind to residents when she had worked, but if she did, she would report it to the DON right away. During an interview 11/21/24 at 12:05 PM, Staff G, LPN, stated she would notify her supervisor or the Administrator immediately if she had a concern about abuse. Staff G reported she witnessed Resident #38 being combative when she first came to the facility, especially when staff changed her but otherwise she had not observed any behaviors. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview 11/21/24 at 1:04 PM, Staff A reported she took care of Resident #38 like she was her grandmother. Staff A stated she talked to Resident #38 and asked her why she didn't smile. She tried to make her smile. She treated residents like they were her own parents. Staff A confirmed she had not witnessed staff being rough toward other residents. Staff A stated staff don't like her. She came to work and did her job. Staff A reported some staff wanted to take 5-6 breaks a shift, or took an hour break, then she didn't get a break. She was left to do the work. Staff A reported she talked to the Administrator about not getting a break because the other CNA's took an hour break. She reported it the week before they accused her of this incident. After she reported her concern, the facility suspended her. Staff A denied saying to a resident: if you punch me I will punch you, if you pinch me, I will pinch you. Staff A reported Resident #38 required assistance of two staff. The resident held Staff A's arm as she helped turn the resident. The resident's nails were sharp. Staff A reported Resident #38 doesn't talk, nor did she abuse or fight staff. Staff A acknowledged she had not worked at the facility since 10/23/24. In an interview 11/21/24 at 1:55 PM, the DON reported she had worked at the facility since 6/15/24. The DON reported Staff B came to the DON's office on 10/23 and told her Staff A handled Resident #38 in a rough way, and told her she would punch or pinch her. The DON reported she spoke with Resident #38. The resident shook her head yes when she asked her if someone had been rough with her. The resident said she felt safe though. The DON reported she talked to the Administrator. Staff B was suspended because she needed to report the incident when it happened. Staff A was also suspended. The DON reported Staff A had good rapport with residents when she worked her, so she was surprised by the statement from Staff B. The DON stated she had observed Staff A during a pericare audit, but otherwise she had observed Staff A perform cares on a resident. The DON reported the Unit Manager obtained a statement from Staff A. Staff education provided on abuse and neglect and that concerns for abuse needed to be reported right away to the Administrator or DON. Abuse education provided at the time of hire and as needed. During an interview 11/21/24 at 2:25 PM, the Unit Manager reported she had worked at the facility since 11/26/23. The unit manager acknowledged she had watched Staff A do cares and had not witnessed her coming across as rough. Staff A was good with residents and had good interactions. Nothing that made her step back and think she needed to do re-education. The unit manager reported she was not called on the day of the incident in 8/2024, but she thought she read something in Resident #38's progress note. The unit manager reported she was out of the building during the week of the state fair, and off for 10 days. If something such as a note was put in her mailbox she would not have gotten it until she came back to work 10 days later. In an interview on 11/21/24 at 4:03 PM. Staff J, LPN, reported she had worked at the facility since 4/18/24, and worked the 6 PM to 6 AM shift. Staff J confirmed she had taken the mandatory reporter abuse training and received information about abuse in meetings. Staff J acknowledged she had not witnessed any staff being unkind or rough, but she would report to the DON or on-call manager right away if she did. Staff J reported Resident #38 sometimes resisted care. She tells the resident they are there to help her, or she will leave and go back and help her. Resident # 38 liked staff to hold her hand. Her legs were stiff and it could be hard to move her. Staff J stated she always helped the aide when they asked. [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37074 Based on record review, resident council notes, employee file review, staff and resident interviews and facility policy review the facility failed to answer call lights in a timely manner. The facility reported a census of 49 residents. Findings include: Review of the resident council minutes revealed the following notes: a) meeting date 8/29/24 at 2:00 PM documented 11 of the 11 residents that attended the meeting stated call light times are getting better, staff will continue with call light audits. b) meeting date 9/26/24 at 2:00 PM documented 6 of the 6 residents that attended the meeting stated call light times are getting better, staff will continue with call light audits. c) meeting date 10/23/24 at 2:00 PM documented 10-10 residents shared the concerns with call lights, staff will continue with call light audits. Review of Staff A's Certified Nursing Assistant (CNA) employee file revealed a disciplinary action form that documented seven call lights were on over 20 minutes on her assigned hall throughout the shift. The form was signed and dated by Staff A on 8/22/24. A document titled Past Calls on 8/21/24 documented the following call light response times: 23 minutes, 27 minutes, 26 minutes, 23 minutes, 21 minutes, 18 minutes, 19 minutes, 21 minutes, 28 minutes, 24 minutes, 18 minutes and 32 minutes. A second disciplinary action form documented extended call lights on her assigned hall on 10/14/24. They have discussed about extended call lights in the past as well. The form was signed and dated by Staff A on 10/15/24. A document titled Past Calls on 10/14/24 documented the following call light response times: 23 minutes, 31 minutes, 21 minutes, 22 minutes, 32 minutes, 39 minutes, 36 minutes, 19 minutes, 22 minutes, 19 minutes, 16 minutes, 35 minutes, 16 minutes, 17 minutes, 19 minutes, 46 minutes, and 37 minutes. Review of Staff B's CNA employee file revealed a disciplinary action record form dated 10/4/24 that stated see attached. The attached form titled Past Calls dated 10/2/24 documented the following call light response times: 28 minutes, 18 minutes, 59 minutes, 26 minutes, 1 hour and 54 minutes, 20 minutes, 22 minutes, 24 minutes, and 31 minutes. On 11/18/24 at 11:38 AM Resident # 202 reported it took staff at least 20 minutes to respond to her call light and provide assistance. On 11/19/24 at 8:12 AM Resident #10 reported sometimes it takes a while for them to come to clean me up, it makes me angry. On 11/19/24 at 9:06 AM Resident #40 stated that the weekends are horrible for staffing, they are very slow to answer the call lights on the weekends. She just doesn't feel they have enough staff, though it has been getting better. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided a policy titled Answer the Call Light, with a revision date of September 2022, documented the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Staff are to answer the resident call system timely. 34817 2. A Past Calls report dated 9/20/24 to 11/19/24 revealed call light response greater than 15 minutes for the following: a. Room North (N) 10: 9/20 - 9/30/24: 16 times, with the longest response time 2 hours and 33 minutes 10/1 - 10/31/24: 35 times, with the longest response time 2 hours and 12 minutes 11/1 - 11/18/24: 5 times, with the longest response time 33 minutes The majority of call light response times greater than 15 minutes occurred on the evening (2 PM - 10 PM) and night (10 PM - 6 AM) shifts. b. Room N20 9/20 -9/30/24: 6 times with the longest response time 2 hours and 17 minutes 10/1 - 10/31/24: 42 times with the longest response time 3 hours and 3 minutes 11/1 - 11/18/24: 17 times with the longest response time 1 hour and 1 minute. The majority of call light response times greater than 15 minutes occurred on the night (10 PM - 6 AM) and evening (2 PM - 10 PM) shifts. During an interview 11/26/24 at 8:40 AM, the Regional Director of Operations reported call light response times were part of the facility's Quality Assurance Performance Improvement (QAPI) process. The Regional Director of Operations reported the call light report was reviewed daily. Residents and staff are interviewed about any extended call light times to determine what happened. She wrote a note on the call light report about why staff response time was greater than 15 minutes. The Regional Director of Operations stated staff sometimes forgot to turn the call light off. The Regional Director of Operations explained in 9/2024, the average call light response that was greater that 15 minutes was 12 %, but now the response times were 10-11%. This didn't quantify how long call lights were on, but it gave her a metric to look at. She had seen significant improvement in call light response since 3/2024. The call light policy included an expectation for call lights answered within a reasonable timeframe. The benchmark was for staff to respond to call lights within 15 minutes but sometimes a resident required more than 15 minutes of care from staff. During an interview 11/26/24 at 9:30 AM, the Regional Director reported staff provided education about reasonable timeframes on call lights, and staff disciplinary done whenever they had concerns about call light response times. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Answering the Call Light policy revised 9/2022 revealed call lights answered timely. The Facility Assessment updated 8/8/2024 revealed the facility made a good faith effort to ensure sufficient staffing to meet the needs of residents at any given time based on the resident population and their needs. The facility retained enough staff to maintain a 24-hour licensed facility 7 days a week. The day and evening shifts staffed with 2 nurses and 6 aides, and the overnight shift staffed with 2 nurses and 3 aides. 49990 3. A Past Calls report dated 9/20/24 to 11/19/24 revealed call light response greater than 15 minutes for the following: a. Room Central (C) 4: 09/20-09/30/2024: 6 times. With the longest call light on 09/29/2024 being 1 hour 48 minutes and 17 seconds. 10/01-10/31/2024: 11 times. With the longest call light on 10/17/2024 being 1 hour 15 minutes and 48 seconds. 11/01-11/18/2024: 2 times. With the longest call light on 11/12/2024 being 37 minutes and 29 seconds. b. Room North (N) 5: 09/20-09/30/2024: 0 Times. 10/01-10/31/2024: 3 times. With the longest call light on 10/09/2024 being 24 minutes and 24 seconds. 11/01-11/18/2024: 5 times. With the longest call light on 11/14/2024 being 39 minutes and 34 seconds. c. Room South (S) 18: 09/20-09/30/2024: 6 times. With the longest call light on 09/23/2024 being 48 minutes and 32 seconds. 10/01-10/31/2024: 27 times. With the longest call light on 10/12/2024 being 38 minutes and 46 seconds. 11/01-11/18/2024: 10 times. With the longest call light on 11/12/2024 being 31 minutes and 11 seconds. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/26/24 at 11:48 AM with the Director of Nursing (DON), she stated it is her expectation that call lights are answered in a reasonable time frame. When asked directly what she felt was a reasonable time frame meant, she stated it means as fast as possible, then clarified the expectation is within 15 minutes.