

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Caring Acres Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Hillcrest Drive Anita, IA 50020	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on clinical record review, facility record review, staff and resident interviews, and facility policy reviews the facility failed to ensure 1 of 3 residents (Resident #1) was free from abuse and psychological harm. Resident #1 reported to staff that Staff A CNA had provided peri-cares in a rough manner, had called her names and used curse words in front of her. The facility suspended Staff A while they completed their investigation and allowed her to come back to work as long as she did not provide cares to Resident #1. Staff reported when Staff A would come to work, Resident #1's demeanor would change: she would become guarded, shaky, stay by other staff member's side, tear up, was fearful for her safety. Resident #1 reported it made her mad because this is her home and she should not feel this way about a staff member in her home. The facility reported a census of 26 residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/30/24 at 5:00 PM. The IJ began on 7/23/24, the day Resident #1 reported her concerns. The facility removed the Immediate Jeopardy on 7/31/24 through the following actions:</p> <p>-Staff A, the Assistant Director of Nursing (ADON) and Director of Nursing (DON) were suspended on 7/30/24.</p> <p>-On 7/30/24 the facility began additional re-education for all employees relating to abuse, neglect, and exploitation. All employees currently working will be educated immediately. All other employees will be educated prior to their next scheduled shift.</p> <p>-When new team members begin employment, they will receive Dependent Adult Abuse Prevention and Reporting training as part of their initial onboarding. All other employees will receive Dependent Adult Abuse Prevention training annually, and with any allegation or investigation regarding abuse.</p> <p>-The facility has interviewed all alert residents related to abuse.</p> <p>-The Administrator will interview five random residents about abuse weekly for the next 12 weeks.</p> <p>-The Administrator will interview five random staff members per week for 12 weeks to verify knowledge related to abuse and reporting policies.</p> <p>-The resident impacted had a head to toe assessment completed, no evidence of any injuries noted.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 165217
		If continuation sheet Page 1 of 24

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The facility initiated head to toe skin assessments for all residents. Skin assessments will be completed by the end of the day on 8/2/24.</p> <p>-The resident impacted by the event had a post trauma assessment initiated on 7/31/24.</p> <p>-The resident will be on every shift charting for 72 hours. This documentation will be reviewed by the Administrator during morning clinical review, the day following.</p> <p>The scope lowered from J to G at the time of the survey after ensuring the facility implemented education and their policy and procedure.</p> <p>Findings include:</p> <p>According to the Admission Minimum Data Set (MDS) assessment tool with a reference date of 6/24/24, documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairments. Resident #1 had an admitted [DATE]. The MDS documented she did not display any physical, verbal, or other behavioral symptoms during the review period. The MDS documented she was frequently incontinent of urine and was always incontinent of bowel. The MDS listed the following diagnoses for Resident #1: acute cystitis with hematuria, anemia, neurogenic bladder, multidrug resistant organism, septicemia, urinary tract infection (UTI), cerebral palsy, anxiety, depression, psychotic disorder (other than schizophrenia), post-traumatic stress disorder (PTSD), borderline personality disorder, and mild intellectual disabilities.</p> <p>The Care Plan focus area with an initiation date of 6/19/24 documented Resident #1 had activities of daily living (ADL) performance deficit related to cerebral palsy and musculoskeletal impairment.</p> <p>The Care Plan focus area with an initiation date of 6/24/24 documented she has the potential to have manipulative behaviors at times. Staff are encouraged to explain all procedures to Resident #1 before starting and allow the resident to adjust to changes.</p> <p>Review of the facility's grievances revealed the following grievance was filed on Resident #1's behalf:</p> <p>a) Resident stated when staff entered room, she got upset stated I've been waiting for two hours to go to bed. Resident #1 stated Staff A said we have 20 something residents, please be considerate. Resident stated she continued to be agitated then stated Staff A said I'm not doing this, then walked out. The form was signed and dated by the SSD on 7/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The following progress note was documented on 7/24/24 at 5:37 PM by Staff C Licensed Practical Nurse (LPN): this nurse spoke with resident and spent much of the afternoon discussing her feelings about an incident that occurred last night. Resident #1 was visibly upset and had asked this nurse to go with her to talk to the Administrator. Staff C and Administrator told resident that she was heard and that the matter will be looked into. Resident #1 told this nurse that she felt safe at this time and that she did not want a certain person to take care of her. Staff C reassured resident that other staff could meet her needs and she would not have to have cares provided by the person who made her feel uncomfortable. She was informed a bit later by Staff C that there is an investigation and it has been turned in. Resident #1 thanked this nurse for giving her support and reassured that she could come to Staff C at any time and she could tell her anything that was bothering her. They all want her to feel safe.</p> <p>Review of Resident #1's clinical record revealed the following Encounter Psych Progress Note, with a visit date of 7/25/24. Current Symptoms/History of Present Illness: The resident is seen today as a follow-up medication assessment. The resident reports that she is doing well. She has been a bit down due to a situation that happened with staff. She tells the provider she wishes she was in her own apartment. She stated there have been situations around her care which turned into an investigation. She is flat and guarded. She was hesitant to talk but later opened up. She reported doing well beside that. Mental Status Exam: the resident's speech was normal, sharing conversation with normal laryngeal efforts. Appropriate mood and affect were seen on exam. Thought processes were logical, relevant, and thoughts were completed normally. Thought content was normal with no psychotic or suicidal thoughts. The resident's judgement was realistic with normal insight into present condition. Mental status included: correct time, place, person orientation, normal recent and remote memory, normal attention span and concentration ability. Language skills included the ability to correctly name objects. Fund of knowledge included normal awareness of current and past events.</p> <p>The facility investigation included the following statements:</p> <p>a) Staff A Certified Nursing Assistant (CNA) wrote: she was working 2:00 PM-10:00 PM on 7/23/24. She had just finished the nurse's orders of passing snacks, ice water, doing rounds, and hourly check-ups on certain residents. She went to assist another resident when a CNA told her that the resident they need to lay down was upset. When Staff A arrived to the resident's room she said: hello, I heard that you were upset and I was wondering if there was anything I could do? Immediately the resident started screaming and yelling, I am not f***ing upset (said that two times), you guys waited forever to come lay me down. Staff A explained the resident, I am sorry, myself and the other CNA just got done with nurse's orders and both of us are getting tired, so we understand. After transporting the resident to bed, Staff A went to assist the CNA with rolling the resident. As soon as Resident #1 saw Staff A was touching her, she started yelling and scream don't f***ing touch me (was said about five times) with the occasional word bitch thrown in. After Staff A ensured the other CNA was at a good stopping point, Staff A told that staff member I can't handle this shit. Staff A then walked over to the other side of the room and grabbed a pillow for the resident's head, then stood around the other CNA, staying there to make sure she did not need any other assistance other than touching the resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>c) The ADON wrote the following statement: on the night of 7/23/24 at 9:30 PM she was passing medications down hall 2 when Staff B came to her and stated Resident #1 was upset, she was screaming at staff when entering her room about how long she had been waiting for staff to put her to bed. Staff A and Staff B apologized for the delay and that they were with other residents and doing the best they could. Resident #1 continued screaming at both CNA's telling them how much bullshit it was and that they were terrible. Staff B then stated Staff A made the comment, I can't deal with this right now. Resident #1 then began screaming at Staff A, don't f***ing touch me, don't f***ing touch me, don't f***ing touch me. Staff B she let Resident #1 know Staff A would not be doing her cares, that Staff B would but still needed Staff A's assistance to roll the resident so Staff B could provide cares. Resident #1 then stated why does that matter, no one cares. Staff B reassured her that they indeed do care. The ADON finished her medications a few minutes later and returned to the nurse's station when the Social Service Director (SSD) informed her that Resident #1 made a grievance that she waited two hours to put to bed and that Staff A was rude to her. The SSD stated she had just talked with Resident #1 and had not had a chance to write it up yet. The ADON questioned Staff A and she stated, Resident #1 was screaming at us for taking so long. She tried to explain why and they couldn't really help it but were trying the best they could. Resident #1 continued to scream at them, saying how awful they were. When they got her into bed, Resident #1 started screaming don't f***ing touch me like five times and Staff A said ok Staff B told Resident #1 that she needed her help rolling her to do cares. The ADON asked why the resident was yelling at Staff A not to touch her. Staff A stated because she was mad and does not like me, never has, she is like that with staff she does not like when she is upset. The ADON asked if she stated that she wasn't or can't going to deal with this right now and she indicated she had not made that statement. After question Staff A, the ADON went to speak with Resident #1. Upon entering the resident's room it was noted that resident was not in distress and was in a calm mood. The ADON stated that she had heard the resident was upset and asked what had happened. Resident #1 stated she was upset because she waited two hours to be laid down and told the staff it was bullshit. She added she should not have to wait that long, then Staff A told her she can't deal with this. Resident #1 indicated she did not like people talking like that to her. The ADON stated she understood and that she would speak with Staff A about the way she spoke to Resident #1 and they apologized. The ADON also took accountability for the staff taking so long to lay her down as she tasked them with passing snacks, fresh ice water, and the baths for the evening to ensure all duties were completed in a timely manner. Resident #1 stated that she understood stuff like that happens sometimes. The ADON then reiterated that this did not excuse Resident #1's comment and that it will be addressed. Resident #1 thanked the ADON, stated no when asked if there was anything else she would like to talk about or needed. Resident #1 still seemed to be in a calm, pleasant mood. After the conversation with Resident #1, the ADON went to the nurse's station and realized a resident needed a neuro check completed and went to find another resident on the floor. This nurse instructed Staff A to complete her charting and take out the trash before leaving as it was already 10:00 PM. Staff A was educated on importance of professionalism and instructed that in situations that are overwhelming, she needs to ensure resident safety then leave the room, go to the charge nurse and allow the charge nurse to intervene.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/30/24 at 1:16 PM Staff I CNA stated Resident #1 had reported to her that Staff A do not treat her well. Staff A does not listen to what Resident #1 wants or what she has to say. Resident #1 has reported to her Staff A has called her not nice things like: she was white trash but that was all Staff I could remember. Resident #1 reported to her that Staff A will not ask to wipe her, she just does it, she is not careful while wiping Resident #1 and is rough. Staff I has heard Resident #1 reporting soreness to her peri-area in the mornings but has not seen any marks. After Resident #1 talked with her she reported these concerns to Staff C and Staff E and they indicated it would be reported to the ADON and DON. When asked how Resident #1 is doing since Staff A returned back to work, she stated the resident is scared and stressed. Staff A is not allowed to take care of Resident #1 since this was reported.</p> <p>On 7/30/24 at 1:32 PM Staff C LPN stated when Resident #1 first admitted to the facility, it took her a bit to get comfortable with staff. Resident #1 was never mean but she did click with a few staff members right away. Resident #1 would come to Staff C for support until she got used to other staff members. Resident #1 would not want Staff A to do her peri-cares and recently had heard Resident #1 turned in concerns about Staff A. Resident #1 reported to her she felt management was not hearing her, like things were not changing and they were not listening to her. Staff C states specially she came in to work on a Wednesday and stated the night before (Tuesday) she asked Staff A to not wipe her and Staff A said, I don't give a f***, she did it anyway's. When Staff A first went in the resident's room, Resident #1 stated the staff member stated I am not putting up with her shit tonight. Staff C continued to talk with Resident #1 to give her support and comfort. Resident #1 went to talk therapy then was ready to talk with the Administrator about what she told Staff C. The resident stated when she spoke with the ADON she told her she would have a talk with Staff A about her attitude from that night. Staff A was suspended and when she returned she was not allowed to take care of Resident #1. When Staff A is in the facility, Resident #1's whole demeanor changes. The first shift staff members will stay until 7-7:30 PM to assist staff with her cares since Staff A is not allowed to care for her.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Caring Acres Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Hillcrest Drive Anita, IA 50020	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/30/24 at 1:51 PM Staff G stated Resident #1 told her last week that Staff A said to her she wished she never came here. Resident #1 reported last week while Staff A and Staff were assisting with getting the resident ready for bed, Staff A's tone was aggressive. Resident #1 told Staff A no and Staff A said, I don't f***ing care and helped anyway. The resident complained that Staff A was very rough with cares. When Staff G would care for the resident the day after Staff A did, she did not notice any marks but would complain of her peri-area being irritated and sore. When Staff G would work with Staff A she stated she was awful; very defiant with anything that was asked of her, she is very loud and sarcastic. Her mom is the ADON and she would even cuss at her while residents were present. Staff A has always been that way, but it has progressively gotten worse. The ADON would tell Staff A to knock her attitude off, watch your language but Staff A would just roll her eyes and walk away. Staff G denies ever hearing inappropriate comments made to Resident #1 by Staff A, she just knew Resident #1 did not want her taking care of her. When asked how Resident #1 acts now that Staff A is back to work, she stated other CNA's have reported that Resident #1 would not leave their sight while Staff A worked. She would park herself up front with other staff when she was usually out and about throughout the facility. Now Resident #1 is fixated on being with staff when Staff A is working. Staff G stated the resident used to sit in her room to listen to music, but she has not done that the last few days. The day shift staff stay over in to the evening shift to assist with Resident #1's cares when Staff A is working. This has upset Resident #1 because she does not feel like staff are listening to her and does not like going to bed before 7:00 PM just because Staff A is working. Resident #1 reported to Staff G that she feels like she has no choices or rights at this point. She mentioned this has been reported to a lot of people but nothing is being done. That's why she contacted outside entities.</p> <p>On 7/30/24 at 2:41 PM Staff D stated after Resident #1 voiced concerns, she reported it. On Wednesday 7/24/24 she had given the resident a bath. During her bath, the resident was bawling, Staff D indicated she had to hold back her own tears. Resident #1 asked Staff A to not do peri-cares and she did them anyway's. The resident reported Staff A will go in to help her but works very fast and does not respect what Resident #1 says. Staff A told her to shut the f*** up and that she did not care about her bullshit. When asked if any other residents voiced concerns about Staff A, she stated while assisting Resident #4 she wanted her feet moved. Staff A told her to shut the f*** up and I don't care about your bullshit. Staff D looked at Staff A and said she had crossed the line and it was not funny nor was it a joke. Staff A stated it's fine, I gave her a good bath and shaved her legs. Staff A spends a lot of time on her phone. When residents try to talk with her she will not pay attention. She will yell at nurses and her mom, who is the ADON. Will tell her to shut up in front of residents while in the dining room. The DON is aware of their concerns, she has told her about them. When they try to report concerns to the ADON, she gets mad at staff. Staff D stated Resident #1 will walk in to the building in a bad mood, then she is disrespectful with residents. These residents would be happier without her here because she is so disgusting and horrible to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/30/24 at 2:59 PM Staff B stated she worked the night of the alleged incident. Resident #1 reported she was ready for bed. Staff B informed her she will need to get help, Staff A was doing a bath at that time. Resident #1 then stated, I told you two f***ing hours ago I wanted to go to bed. Staff A stated I am not dealing with your shit. Resident #1 stated and I am not dealing with your f***ing attitude. Once they got her to bed, Staff B asked if she was ok and Resident #1 stated it does not f***ing matter. She then looked at Staff A and said you are not f***ing touching me. Staff B indicated Resident #1 did not need her brief changed. Once they left the room, Staff B told the ADON what had happened. The ADON told her she would talk to her. She works with Staff A and there are times she thinks she is joking but she's not. Staff B stated she did not think the comment she made to Resident #1 had meaning behind it. She was having a tough day that day.</p> <p>On 7/30/24 at 3:21 PM Staff F CNA stated Resident #1 came to her, Staff G CNA and Staff D scared of Staff A because she had been physically and verbally abusive to her. Resident #1 stated Staff A called her a bitch and wished she was never born. She had told Staff A not do care on her and Staff A said I don't f***ing care and did them anyway's. Staff E denies observing this but stated Staff A can be really nasty to residents, really mean. If they are assisting Resident #4, the resident will ask for something and Staff A would say I don't care, it's not my problem. Her mom is the ADON and she will tell her to shut the f*** up in front of residents. When asked if residents had voiced concerns about Staff A she stated Staff D had turned her in for incidents with her and Resident #4. When asked how Resident #1 has been since this alleged incident she stated she is very scared. If Staff A comes in to the building you can see she is scared and said to be fearful of her safety. This has been brought to management's attention and Staff A is not allowed to work with Resident #1. Herself and Resident #1 are worried about retaliation</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on clinical record review, resident and staff interviews, and facility policy review the facility failed to protect 1 of 3 residents (Resident #1) from psychosocial harm during and after the investigation of an allegation of abuse. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>According to the Admission Minimum Data Set (MDS) assessment tool with a reference date of 6/24/24, documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairments. Resident #1 had an admitted [DATE]. The MDS documented she did not display any physical, verbal, or other behavioral symptoms during the review period. The MDS documented she was frequently incontinent of urine and was always incontinent of bowel. The MDS listed the following diagnoses for Resident #1: acute cystitis with hematuria, anemia, neurogenic bladder, multidrug resistant organism, septicemia, urinary tract infection (UTI), cerebral palsy, anxiety, depression, psychotic disorder (other than schizophrenia), post-traumatic stress disorder (PTSD), borderline personality disorder, and mild intellectual disabilities.</p> <p>The Care Plan focus area with an initiation date of 6/19/24 documented Resident #1 had activities of daily living (ADL) performance deficit related to cerebral palsy and musculoskeletal impairment.</p> <p>The Care Plan focus area with an initiation date of 6/24/24 documented she has the potential to have manipulative behaviors at times. Staff are encouraged to explain all procedures to Resident #1 before starting and allow the resident to adjust to changes.</p> <p>Review of the facility's grievances revealed the following grievance was filed on Resident #1's behalf:</p> <p>a) Resident stated when staff entered room, she got upset stated I've been waiting for two hours to go to bed. Resident #1 stated Staff A said we have 20 something residents, please be considerate. Resident stated she continued to be agitated then stated Staff A said I'm not doing this, then walked out. The form was signed and dated by the SSD on 7/23/24.</p> <p>The following Progress Note was documented on 7/24/24 at 5:37 PM by Staff C Licensed Practical Nurse (LPN): this nurse spoke with resident and spent much of the afternoon discussing her feelings about an incident that occurred last night. Resident #1 was visibly upset and had asked this nurse to go with her to talk to the Administrator. Staff C and Administrator told resident that she was heard and that the matter will be looked into. Resident #1 told this nurse that she felt safe at this time and that she did not want a certain person to take care of her. Staff C reassured resident that other staff could meet her needs and she would not have to have cares provided by the person who made her feel uncomfortable. She was informed a bit later by Staff C that there is an investigation and it has been turned in. Resident #1 thanked this nurse for giving her support and reassured that she could come to Staff C at any time and she could tell her anything that was bothering her. They all want her to feel safe.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's clinical record revealed the following Encounter Psych Progress Note, with a visit date of 7/25/24. Current Symptoms/History of Present Illness: The resident is seen today as a follow-up medication assessment. The resident reports that she is doing well. She has been a bit down due to a situation that happened with staff. She tells the provider she wishes she was in her own apartment. She stated there have been situations around her care which turned into an investigation. She is flat and guarded. She was hesitant to talk but later opened up. She reported doing well beside that. Mental Status Exam: the resident's speech was normal, sharing conversation with normal laryngeal efforts. Appropriate mood and affect were seen on exam. Thought processes were logical, relevant, and thoughts were completed normally. Thought content was normal with no psychotic or suicidal thoughts. The resident's judgement was realistic with normal insight into present condition. Mental status included: correct time, place, person orientation, normal recent and remote memory, normal attention span and concentration ability. Language skills included the ability to correctly name objects. Fund of knowledge included normal awareness of current and past events.</p> <p>The facility investigation included the following statements:</p> <p>a) Staff A Certified Nursing Assistant (CNA) wrote: she was working 2:00 PM-10:00 PM on 7/23/24. She had just finished the nurse's orders of passing snacks, ice water, doing rounds, and hourly check-ups on certain residents. She went to assist another resident when a CNA told her that the resident they need to lay down was upset. When Staff A arrived to the resident's room she said: hello, I heard that you were upset and I was wondering if there was anything I could do? Immediately the resident started screaming and yelling, I am not f***ing upset (said that two times), you guys waited forever to come lay me down. Staff A explained the resident, I am sorry, myself and the other CNA just got done with nurse's orders and both of us are getting tired, so we understand. After transporting the resident to bed, Staff A went to assist the CNA with rolling the resident. As soon as Resident #1 saw Staff A was touching her, she started yelling and scream don't f***ing touch me (was said about five times) with the occasional word bitch thrown in. After Staff A ensured the other CNA was at a good stopping point, Staff A told that staff member I can't handle this shit. Staff A then walked over to the other side of the room and grabbed a pillow for the resident's head, then stood around the other CNA, staying there to make sure she did not need any other assistance other than touching the resident.</p> <p>b) Staff B CNA wrote the following statement: on 7/23/24 Staff A and I went to assist Resident #1 to bed. At the time we went in, she was very upset and was yelling at the fact that she did ask two hours prior to be put in bed. Staff B and her were busy doing baths, passing snack cart out and putting other residents to bed. Resident #1 yelled I asked you two f***ing hours ago. Staff A replied with I'm not putting up with your shit tonight. Resident #1 then replied with I am not dealing with your attitude either. Resident #1 was screaming while being put in bed due to her being in pain. After being put in bed, Resident #1 looked at Staff A and said you are not f***ing touching me. Staff B told Resident #1 she had to help roll her to get the sling out from under her. Resident #1 rolled her eyes. Due to the resident screaming while being put in bed, Staff B did ask Resident if she was ok. Resident #1 replied, it didn't matter. Resident #1 was assured she did care if she was ok. Resident #1 did not say anything after that, so Staff B walked out. Staff B told the nurse and she said she would go talk to Resident #1 about it. The ADON (nurse on duty that night) did talk to her and Staff A about the next time letting Resident #1 calm down then reproach her. She signed and dated her statement on 7/25/24.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c) The ADON wrote the following statement: on the night of 7/23/24 at 9:30 PM she was passing medications down hall 2 when Staff B came to her and stated Resident #1 was upset, she was screaming at staff when entering her room about how long she had been waiting for staff to put her to bed. Staff A and Staff B apologized for the delay and that they were with other residents and doing the best they could. Resident #1 continued screaming at both CNA's telling them how much bullshit it was and that they were terrible. Staff B then stated Staff A made the comment, I can't deal with this right now. Resident #1 then began screaming at Staff A, don't f***ing touch me, don't f***ing touch me, don't f***ing touch me. Staff B she let Resident #1 know Staff A would not be doing her cares, that Staff B would but still needed Staff A's assistance to roll the resident so Staff B could provide cares. Resident #1 then stated why does that matter, no one cares. Staff B reassured her that they indeed do care. The ADON finished her medications a few minutes later and returned to the nurse's station when the Social Service Director (SSD) informed her that Resident #1 made a grievance that she waited two hours to put to bed and that Staff A was rude to her. The SSD stated she had just talked with Resident #1 and had not had a chance to write it up yet. The ADON questioned Staff A and she stated, Resident #1 was screaming at us for taking so long. She tried to explain why and they couldn't really help it but were trying the best they could. Resident #1 continued to scream at them, saying how awful they were. When they got her into bed, Resident #1 started screaming don't f***ing touch me like five times and Staff A said ok Staff B told Resident #1 that she needed her help rolling her to do cares. The ADON asked why the resident was yelling at Staff A not to touch her. Staff A stated because she was mad and does not like me, never has, she is like that with staff she does not like when she is upset. The ADON asked if she stated that she wasn't or can't going to deal with this right now and she indicated she had not made that statement. After question Staff A, the ADON went to speak with Resident #1. Upon entering the resident's room it was noted that resident was not in distress and was in a calm mood. The ADON stated that she had heard the resident was upset and asked what had happened. Resident #1 stated she was upset because she waited two hours to be laid down and told the staff it was bullshit. She added she should not have to wait that long, then Staff A told her she can't deal with this. Resident #1 indicated she did not like people talking like that to her. The ADON stated she understood and that she would speak with Staff A about the way she spoke to Resident #1 and they apologized. The ADON also took accountability for the staff taking so long to lay her down as she tasked them with passing snacks, fresh ice water, and the baths for the evening to ensure all duties were completed in a timely manner. Resident #1 stated that she understood stuff like that happens sometimes. The ADON then reiterated that this did not excuse Resident #1's comment and that it will be addressed. Resident #1 thanked the ADON, stated no when asked if there was anything else she would like to talk about or needed. Resident #1 still seemed to be in a calm, pleasant mood. After the conversation with Resident #1, the ADON went to the nurse's station and realized a resident needed a neuro check completed and went to find another resident on the floor. This nurse instructed Staff A to complete her charting and take out the trash before leaving as it was already 10:00 PM. Staff A was educated on importance of professionalism and instructed that in situations that are overwhelming, she needs to ensure resident safety then leave the room, go to the charge nurse and allow the charge nurse to intervene.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d) The Administrator's statement indicated Staff C entered his office shortly before 3:00 PM on 7/24/24. She stated that she had heard from Staff D CNA had reported a concern to her and that Resident #1 wanted to talk with him. Resident #1 requested Staff C to be with her. Resident #1 came in and said she was very upset with Staff A and the way she's been treatment her. Resident #1 stated Staff A was rude to her but did not want to say what Staff A had said to her. She indicated she reported the incident to the ADON and the SSD. We continued talking but she did not feel comfortable saying anymore. She was assured that is was absolutely fine bringing her concerns to him and that he really wanted to help. The Administrator told her that he wanted her to be happy here because it's her home. Resident #1 asked if Staff A could not be present in her room or provide her care, he agreed. Resident #1 left the room and Staff C returned after and told him that Resident #1 said Staff A said she was not putting up with her shit tonight and that Staff B heard it too.</p> <p>e) On 7/26/24 the Director or Nursing statement indicated herself and Staff E charge nurse entered Resident #1's room and obtained her consent to speak with her about her report of alleged verbal abuse that occurred on 7/23/24 during the evening shift. Resident #1 stated Staff A was mad at her because the ADON made her pass snacks and waters before putting people to bed. She had asked Staff A if she could go to bed and she copped an attitude with her. Resident #1 stated it was really, really bad and she was so vulgar and mean. Resident #1 stated I don't want to tell you what she said. The DON explained the importance of knowing the details. Resident #1 stated Staff A called her a white trash bitch, trailer trash, a ****ing imbecile, told her she never should have been born and she should be dead by now. Resident #1 denied that the statement I am not putting up with your shit tonight was made by any employees to her. Resident #1 was calm and in a pleasant mood prior to the DON and Staff E leaving her room. The DON called Staff B to confirm if any of the above statements were witnessed or heard while her and Staff A were providing cares to Resident #1. Staff B denied hearing any of those and stated the worst thing she heard was Staff A say shit.</p> <p>f) The SSD statement indicated she entered Resident #1's room to do assessments with her. Resident was lying in bed. Once the first assessment was completed, Resident #1 stated she was rude. When asked who was rude, she stated Staff A. When they came in, Resident #1 was upset because she waited two hours to be put to bed. Resident #1 stated Staff A told her there's 20 something other residents and to be considerate. She then stated that Staff A said more but did not state what else was said. Resident #1 stated Staff A said I'm not doing this and walked out of the room. The SSD stated she would write up a grievance and that they would talk to Staff A. Resident #1 thanked her and they finished the assessments. When the SSD left the room, Resident #1 was smiling and appeared content.</p> <p>Review of Staff A's July 2024 timecard, revealed she worked on 7/23/24 from 6:00 PM-10:30 PM. Staff A's timecard revealed she worked 7/26/24, 7/27/24, 7/28/24, and 7/29/24.</p> <p>On 7/30/24 at 1:16 PM Staff I CNA stated Resident #1 is stressed and scared when Staff A is working. She was allowed to come back to work but could not care for Resident #1.</p> <p>On 7/30/24 at 1:32 PM Staff C LPN stated Staff A has returned back to work since the alleged incident. She indicated when Staff A walks in to the building, Resident #1 gets guarded and will shake.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/30/24 at 1:51 PM Staff G CNA stated Resident #1 used to sit in her room and listen to music. Since this incident with Staff A, the resident will not sit in her room while Staff A is in the building. Staff have told her that Resident #1 would not leave their sight when Staff A was working. She would place herself upfront with staff present when Staff A was working. Resident #1 told her she is very upset about this and feels like they are not listening to her, that she has no choices, no rights at this point because Resident #1 had reported her concerns but nothing happened.</p> <p>On 7/30/24 at 3:21 PM Staff F CNA stated since Staff A has returned to work, if she comes in the building Resident #1 becomes very scared. Staff A worked yesterday (7/23/24) in the kitchen, Resident #1 held on to Staff F's hand and it was shaking, the resident began to tear up. Resident #1 stated she is fearful of her safety with Staff A is working. Resident #1 reported she is worried about retaliation because of all the family of Staff A that works at the facility.</p> <p>On 7/30/24 at 8:41 PM Staff A stated she returned back to the facility after she completed education about abuse. She has not been allowed to take care of Resident #1 she since returned to work on 7/26/24. When asked if she cares for other residents by herself, she stated yes unless they require the assistance of two staff then someone helps her.</p> <p>On 8/2/24 at 2:39 PM the Administrator stated Staff A was suspended while they completed the investigation of the alleged incident. What happened was affecting Resident #1 so they educated Staff A and gave her a final warning before returning back to work. When Staff A returned, she was instructed she could not take care of Resident #1. When asked if staff have been checking in on Resident #1 since the alleged allegation, he stated the SSD was but Resident #1 would not talk with her. Currently they have other staff members checking on her. When asked how the residents in his facility should be treated he stated with dignity, respect and treated kindly. This is their house, their rules and should be treated how they want to be treated; basic decency.</p> <p>The facility provided a documented tilted Abuse Prevention Program, Investigation F600, F602, F603, F607, F610 with an origination date of July 2023. The document indicated residents will be protected from further abuse, neglect, exploitation or mistreatment while the investigation is in process.</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on clinical record review, facility investigative file review, resident and staff interviews, and facility policy review the facility failed to report 1 of 3 resident's (Resident #1) allegation of abuse to the appropriate staff members to ensure timely reporting to the State Agency. On 7/23/24 at roughly 8:30 PM Staff A and Staff B had assisted Resident #1 with getting ready for bed. Resident #1 told staff she was upset and yelling that she had asked two hours prior to be put to bed. Staff explained to her they were assisting others with baths, passing the snack cart out and assisting others to bed. Resident #1 yelled I asked you two f***ing hours ago. Staff A replied with I am not putting up with your shit tonight. Resident #1 replied I am not dealing with your attitude either. Staff B reported this to the Assistant Director of Nursing (ADON) (Staff A's mother) and she indicated she would go talk to Resident #1. After speaking with Staff A and Resident #1, the ADON continued with her duties: neuro checks on a resident and found that another resident had fallen on the floor. On 7/24/24 at 3:00 PM Staff C Licensed Practical Nurse (LPN) went to the Administrator's office with Resident #1 to talk about the concerns that was reported to her by Staff D CNA. The facility then reported the allegation to the State Agency (SA) on 7/24/24 at 5:13 PM. The facility reported a census of 26 residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/30/24 at 5:00 PM. The IJ began on 7/23/24, the day Resident #1 reported her concerns. The facility removed the Immediate Jeopardy on 7/31/24 through the following actions:</p> <ul style="list-style-type: none"> -Staff A, the Assistant Director of Nursing (ADON) and Director of Nursing (DON) were suspended on 7/30/24. -On 7/30/24 the facility began additional re-education for all employees relating to abuse, neglect, and exploitation as well as reporting requirements. The facility originally began reeducation on 7/24/24 following the initial report All employees currently working will be educated immediately. All other employees will be educated prior to their next scheduled shift. -When new team members begin employment, they will receive Dependent Adult Abuse Prevention and Reporting training as part of their initial onboarding. All other employees will receive Dependent Adult Abuse Prevention training annually, and with any allegation or investigation regarding abuse. -The facility has interviewed all alert residents related to abuse. -The Administrator will interview five random residents about abuse weekly for the next 12 weeks. -The Administrator will interview five random staff members per week for 12 weeks to verify knowledge related to abuse and reporting policies. -Regional Director of Clinical Services had reviewed documentation of current residents, retrospectively back to 12:00 AM on 7/19/24 with no findings of abuse evident. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Caring Acres Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Hillcrest Drive Anita, IA 50020	
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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The scope lowered from J to D at the time of the survey after ensuring the facility implemented education and their policy and procedure.</p> <p>Findings include:</p> <p>According to the Admission Minimum Data Set (MDS) assessment tool with a reference date of 6/24/24, documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairments. Resident #1 had an admitted [DATE]. The MDS documented she did not display any physical, verbal, or other behavioral symptoms during the review period. The MDS documented she was frequently incontinent of urine and was always incontinent of bowel. The MDS listed the following diagnoses for Resident #1: acute cystitis with hematuria, anemia, neurogenic bladder, multidrug resistant organism, septicemia, urinary tract infection (UTI), cerebral palsy, anxiety, depression, psychotic disorder (other than schizophrenia), post-traumatic stress disorder (PTSD), borderline personality disorder, and mild intellectual disabilities.</p> <p>The Care Plan focus area with an initiation date of 6/19/24 documented Resident #1 had activities of daily living (ADL) performance deficit related to cerebral palsy and musculoskeletal impairment.</p> <p>The Care Plan focus area with an initiation date of 6/24/24 documented she has the potential to have manipulative behaviors at times. Staff are encouraged to explain all procedures to Resident #1 before starting and allow the resident to adjust to changes.</p> <p>Review of the facility's grievances revealed the following grievance was filed on Resident #1's behalf:</p> <p>a) Resident stated when staff entered room, she got upset stated I've been waiting for two hours to go to bed. Resident #1 stated Staff A said we have 20 something residents, please be considerate. Resident stated she continued to be agitated then stated Staff A said I'm not doing this, then walked out. The form was signed and dated by the SSD on 7/23/24.</p> <p>The following Progress Note was documented on 7/24/24 at 5:37 PM by Staff C Licensed Practical Nurse (LPN): this nurse spoke with resident and spent much of the afternoon discussing her feelings about an incident that occurred last night. Resident #1 was visibly upset and had asked this nurse to go with her to talk to the Administrator. Staff C and Administrator told resident that she was heard and that the matter will be looked into. Resident #1 told this nurse that she felt safe at this time and that she did not want a certain person to take care of her. Staff C reassured resident that other staff could meet her needs and she would not have to have cares provided by the person who made her feel uncomfortable. She was informed a bit later by Staff C that there is an investigation and it has been turned in. Resident #1 thanked this nurse for giving her support and reassured that she could come to Staff C at any time and she could tell her anything that was bothering her. They all want her to feel safe.</p> <p>The facility investigation included the following statements:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a) Staff A Certified Nursing Assistant (CNA) wrote: she was working 2:00 PM-10:00 PM on 7/23/24. She had just finished the nurse's orders of passing snacks, ice water, doing rounds, and hourly check-ups on certain residents. She went to assist another resident when a CNA told her that the resident they need to lay down was upset. When Staff A arrived to the resident's room she said: hello, I heard that you were upset and I was wondering if there was anything I could do? Immediately the resident started screaming and yelling, I am not f***ing upset (said that two times), you guys waited forever to come lay me down. Staff A explained the resident, I am sorry, myself and the other CNA just got done with nurse's orders and both of us are getting tired, so we understand. After transporting the resident to bed, Staff A went to assist the CNA with rolling the resident. As soon as Resident #1 saw Staff A was touching her, she started yelling and scream don't f***ing touch me (was said about five times) with the occasional word bitch thrown in. After Staff A ensured the other CNA was at a good stopping point, Staff A told that staff member I can't handle this shit. Staff A then walked over to the other side of the room and grabbed a pillow for the resident's head, then stood around the other CNA, staying there to make sure she did not need any other assistance other than touching the resident.</p> <p>b) Staff B CNA wrote the following statement: on 7/23/24 Staff A and I went to assist Resident #1 to bed. At the time we went in, she was very upset and was yelling at the fact that she did ask two hours prior to be put in bed. Staff B and her were busy doing baths, passing snack cart out and putting other residents to bed. Resident #1 yelled I asked you two f***ing hours ago. Staff A replied with I'm not putting up with your shit tonight. Resident #1 then replied with I am not dealing with your attitude either. Resident #1 was screaming while being put in bed due to her being in pain. After being put in bed, Resident #1 looked at Staff A and said you are not f***ing touching me. Staff B told Resident #1 she had to help roll her to get the sling out from under her. Resident #1 rolled her eyes. Due to the resident screaming while being put in bed, Staff B did ask Resident if she was ok. Resident #1 replied, it didn't matter. Resident #1 was assured she did care if she was ok. Resident #1 did not say anything after that, so Staff B walked out. Staff B told the nurse and she said she would go talk to Resident #1 about it. The ADON (nurse on duty that night) did talk to her and Staff A about the next time letting Resident #1 calm down then reproach her. She signed and dated her statement on 7/25/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>c) The ADON wrote the following statement: on the night of 7/23/24 at 9:30 PM she was passing medications down hall 2 when Staff B came to her and stated Resident #1 was upset, she was screaming at staff when entering her room about how long she had been waiting for staff to put her to bed. Staff A and Staff B apologized for the delay and that they were with other residents and doing the best they could. Resident #1 continued screaming at both CNA's telling them how much bullshit it was and that they were terrible. Staff B then stated Staff A made the comment, I can't deal with this right now. Resident #1 then began screaming at Staff A, don't f***ing touch me, don't f***ing touch me, don't f***ing touch me. Staff B she let Resident #1 know Staff A would not be doing her cares, that Staff B would but still needed Staff A's assistance to roll the resident so Staff B could provide cares. Resident #1 then stated why does that matter, no one cares. Staff B reassured her that they indeed do care. The ADON finished her medications a few minutes later and returned to the nurse's station when the Social Service Director (SSD) informed her that Resident #1 made a grievance that she waited two hours to put to bed and that Staff A was rude to her. The SSD stated she had just talked with Resident #1 and had not had a chance to write it up yet. The ADON questioned Staff A and she stated, Resident #1 was screaming at us for taking so long. She tried to explain why and they couldn't really help it but were trying the best they could. Resident #1 continued to scream at them, saying how awful they were. When they got her into bed, Resident #1 started screaming don't f***ing touch me like five times and Staff A said ok Staff B told Resident #1 that she needed her help rolling her to do cares. The ADON asked why the resident was yelling at Staff A not to touch her. Staff A stated because she was mad and does not like me, never has, she is like that with staff she does not like when she is upset. The ADON asked if she stated that she wasn't or can't going to deal with this right now and she indicated she had not made that statement. After question Staff A, the ADON went to speak with Resident #1. Upon entering the resident's room it was noted that resident was not in distress and was in a calm mood. The ADON stated that she had heard the resident was upset and asked what had happened. Resident #1 stated she was upset because she waited two hours to be laid down and told the staff it was bullshit. She added she should not have to wait that long, then Staff A told her she can't deal with this. Resident #1 indicated she did not like people talking like that to her. The ADON stated she understood and that she would speak with Staff A about the way she spoke to Resident #1 and they apologized. The ADON also took accountability for the staff taking so long to lay her down as she tasked them with passing snacks, fresh ice water, and the baths for the evening to ensure all duties were completed in a timely manner. Resident #1 stated that she understood stuff like that happens sometimes. The ADON then reiterated that this did not excuse Resident #1's comment and that it will be addressed. Resident #1 thanked the ADON, stated no when asked if there was anything else she would like to talk about or needed. Resident #1 still seemed to be in a calm, pleasant mood. After the conversation with Resident #1, the ADON went to the nurse's station and realized a resident needed a neuro check completed and went to find another resident on the floor. This nurse instructed Staff A to complete her charting and take out the trash before leaving as it was already 10:00 PM. Staff A was educated on importance of professionalism and instructed that in situations that are overwhelming, she needs to ensure resident safety then leave the room, go to the charge nurse and allow the charge nurse to intervene.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>d) The Administrator's statement indicated Staff C entered his office shortly before 3:00 PM on 7/24/24. She stated that she had heard from Staff D CNA had reported a concern to her and that Resident #1 wanted to talk with him. Resident #1 requested Staff C to be with her. Resident #1 came in and said she was very upset with Staff A and the way she's been treatment her. Resident #1 stated Staff A was rude to her but did not want to say what Staff A had said to her. She indicated she reported the incident to the ADON and the SSD. We continued talking but she did not feel comfortable saying anymore. She was assured that is was absolutely find bringing her concerns to him and that he really wanted to help. The Administrator told her that he wanted her to be happy here because it's her home. Resident #1 asked if Staff A could not be present in her room or provide her care, he agreed. Resident #1 left the room and Staff C returned after and told him that Resident #1 said Staff A said she was not putting up with her shit tonight and that Staff B heard it too.</p> <p>e) The SSD statement indicated she entered Resident #1's room to do assessments with her. Resident was lying in bed. Once the first assessment was completed, Resident #1 stated she was rude. When asked who was rude, she stated Staff A. When they came in, Resident #1 was upset because she waited two hours to be put to bed. Resident #1 stated Staff A told her there's 20 something other residents and to be considerate. She then stated that Staff A said more but did not state what else was said. Resident #1 stated Staff A said I'm not doing this and walked out of the room. The SSD stated she would write up a grievance and that they would talk to Staff A. Resident #1 thanked her and they finished the assessments. When the SSD left the room, Resident #1 was smiling and appeared content.</p> <p>The facility investigative file included the following summary:</p> <p>a) Resident #1 is a [AGE] year-old cognitively impaired female who was admitted to the facility on [DATE] with a primary diagnosis of acute cystitis without hematuria and spastic diplegic cerebral palsy.</p> <p>b) At 3:00 PM on 7/24/24, Resident #1 reported to the Administer that Staff A had been verbally abusive to her at approximately 9:30 PM on 7/23/24. She could not verbalize the actual statements that Staff A had made to her at that time. When asked if anyone else was present or aware, she stated that Staff B witnessed the incident and that she had reported it to the ADON and SSD the night prior. The DON was immediately notified, and the Administrator initiated an abuse investigation.</p> <p>c) Investigation Findings:</p> <p>1) On 7/24/24 at approximately 2:00 PM during care, Resident #1 told Staff D that Staff A had yelled at her the night before and that she told her to shut up. She also stated that Resident #1 had reported this to the ADON and the SSD. Staff D immediately reported this to Staff C charge nurse.</p> <p>2) Staff C followed up with Resident #1 after she finished her talk therapy, at approximately 2:45 PM. Resident #1 told Staff C that Staff A had cursed at her. According to Resident #1's statement to her, Staff A had told her they did not have time for her shit. At that time, she brought Resident #1 to the Administrator, initiating the abuse investigation. Resident #1's initial statement to the Administrator was that Staff A had been verbally abusive to her. When asked what she had said, Resident #1 stated she could not repeat it. She stated it was too terrible for her to report. She also stated that she told Staff A to not touch her after she assisted her to bed. Resident #1 repeated that she no longer felt comfortable with Staff A providing her care. Resident #1 stated she reported her concerns to the ADON and the SSD and Staff B had witnessed all their interactions that night.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3) Staff B stated that Resident #1 was upset and yelling at both staff as they entered her room. They had a hectic night and she had to wait longer than she wanted to be assisted to bed. Staff B confirmed that Staff A told Resident #1 that she wasn't putting up with her shit tonight. She reported this to her charge nurse, ADON that night.</p> <p>4) The ADON stated that Staff B did inform her of the incident but that Staff A had said she could not deal with this right now to the resident. Staff B stated to her that Resident #1 was upset throughout her cares, but they had tried to reassure her. The ADON followed up with Resident #1 and found her to be calm and not in distress. The ADON let her know that if Staff A had been rude to her that that was not acceptable and that she would follow up with Staff A to address the incident. Resident #1 had no further concerns at that time and stated stuff like that happens sometimes. At no time was Resident #1 upset or voicing concerns about verbal abuse.</p> <p>5)The SSD stated that the evening of 7/23/24, Resident #1 had brought concerns that Staff A had been rude. When she asked what had happened, Resident #1 told her she had to wait two hours to be put to bed and that Staff A had told her that she needed to be more considerate of the other residents. She also stated that Staff A had said, I am not doing this and walked out of the room. The SSD told her she would fill out a grievance form for her and the team would follow up with Staff A. Resident #1 voiced no other concerns at that time and SSD left her smiling and content.</p> <p>On 7/30/24 at 2:18 PM Resident #1 stated she turned Staff A in because she has been very abusive to a lot of people at the facility, herself included. She works the evening shift, 2:00 PM-10:00 PM, is only 16 and the daughter of the ADON. The ADON will cover Staff A's butt and a lot of her family works here too so they will also cover up for her. She gets special treatment because of that. Resident #1 stated from her stand-point Resident #1 is very verbally abusive. When asked what has happened, she indicated Staff A has called her a whore, bitch and white trash. She has called her these things to her face. Staff A has also told Resident #1 is not allowed to have feelings or emotions. Staff A has told her she is not allowed to get her in trouble or say anything. When asked how this made her feel, Resident #1 said it pisses her off when Staff A acts like this. This is supposed to be her home, she's not supposed to feel this way about anyone that works here. When Resident #1 does peri-care she does it very hard. She's never been told of any injuries but is sore after Staff A cares for her. She has asked her to please not care for her. Staff A's response to that was I don't f***ing care, I'll f***ing do it anyway's. Last week, while Staff A and Staff B were assisting her to bed, Staff B told the resident I am not dealing with your shit. Resident #1 indicated she has talked with the Administrator, the ADON, DON and SSD about her concerns. All staff tell her when she reports concerns is, they will talk with her. Staff A is back to working at the facility but she is not allowed to care for Resident #1. Resident #1 reported feeling uncomfortable around her presence, does not want her looking at her.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/30/24 at 3:34 PM the ADON stated she was passing medications on hall 2 when Staff B came to her and said just a heads up, Resident #1 is not in a good mood. She was upset because they took so long to get her to bed. Resident #1 was screaming at them and Staff A made a comment that upset her further. When asked what comment it was, she stated I don't know, something along the lines of I can't deal with this shit right now. Resident #1 screamed back at her don't f***ing touch me, don't touch me. Once she was done with her medication pass, she spoke to Staff A. She reported Resident #1 was yelling at them, saying this place was awful, literally screaming in their faces how long she had been waiting. Resident #1 was yelling at Staff A to not touch her. Staff A was asked if she made the comment can't deal with this shit, she could not remember if she cussed. The ADON told her you can't talk like that to residents, if you get frustrated you can't talk like that. The ADON stated it sounds like it was a slip of the tongue kind of thing. She told Staff A to take the trash out and finish charting. The ADON went in to speak with Resident #1. She indicated she was upset because she waiting forever to get to bed. Staff A told Resident #1 she can't deal with this shit right now and Resident #1 told Staff A to not touch her. The ADON explained to the resident what Staff A said was not ok and it would be handled. The ADON explained she told the staff members to get snacks passed and baths done before getting residents to bed. Resident #1 voiced understanding, was fine and did not want to talk about anything else. When asked who she reported this alleged incident to, she stated to be honest she intended to let the DON know but when she got to the nurse's station two other residents needed her attention. She had one resident that had fallen and one that was crawling in and out of bed. She indicated she was notified of the allegation on 7/23/24 roughly at 9:30-9:40 PM. The DON found out about the allegation the next morning but not from her, from someone else. When asked what she should have done with the information that Staff B shared with her, she acknowledged she should have contacted the DON right away.</p> <p>On 7/30/24 at 2:59 PM Staff B stated she worked the night of the alleged incident. Resident #1 reported she was ready for bed. Staff B informed her she will need to get help, Staff A was doing a bath at that time. Resident #1 then stated, I told you two f***ing hours ago I wanted to go to bed. Staff A stated I am not dealing with your shit. Resident #1 stated and I am not dealing with your f***ing attitude. Once they got her to bed, Staff B asked if she was ok and Resident #1 stated it does not f***ing matter. She then looked at Staff A and said you are not f***ing touching me. Staff B indicated Resident #1 did not need her brief changed. Once they left the room, Staff B told the ADON what had happened. The ADON told her she would talk to her. She works with Staff A and there are times she thinks she is joking but she's not. Staff B stated she did not think the comment she made to Resident #1 had meaning behind it. She was having a tough day that day.</p> <p>On 7/31/24 at 2:54 PM the SSD stated when Staff A and B exited Resident #1's room, she went in to her room to complete assessments for her MDS. Resident #1 told the SSD that her and Staff A got in to it. When asked what happened, the resident told her, Staff A and Staff B came in and she was upset. The resident indicated she yelled because she had to wait to be put to bed. Staff A told her to please be considerate of the 20 other residents in the facility. The resident reported more words were exchanged. Staff A said I am not doing this tonight and left the room. The SSD stated she filled out a grievance on it as she did not think it was abuse. She informed Resident #1 that she would fill out a grievance and let the ADON know. The SSD denied that Resident #1 reported Staff A had cursed that day.</p> <p>On 7/31/24 at 12:51 PM the DON stated she was made aware of the alleged incident on 7/24/23, it had taken place on the evening shift of 7/23/24. Staff C had reported to her that Resident #1 was in the Administrators office informing him of the events that took place on 7/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 8/2/24 at 2:39 PM the Administrator stated a CNA had reported that Resident #1 complained about Staff A being rude to her the night before. After Resident #1 completed talk therapy, she came to his office and talked with her. She was very nervous and could not give a lot of information at that time. She indicated Staff A was rude, very upset by it and did not want her taking care of her anymore. After they spoke with Resident #1 she reported Staff A was not going to put up with her shit. This cued him to start looking in to this. The DON was not aware of this and the only thing they knew of was a grievance on Resident #1's behalf. The SSD completed the grievance and said it was filed the night before but it did not have, not putting up with her shit, on the form. They had confirmed that Staff A had used very inappropriate language. Staff A denied saying this but to her co-worker out of frustration because the nurse was riding them hard that night. The next day Resident #1's story changed when she spoke with the DON and Staff E. She had denied Staff A had said she was not going to put up with her shit but added new allegations of verbal stuff. Resident #1 stated Staff A told her she wished she was, not born. The Administrator stated in his mind at this point, he was convinced something had happened. Whatever happened was inappropriate and not intended to be abusive. What happened was affecting Resident #1 so they educated Staff A and gave her a final warning before returning back to work. When asked if the ADON should have reported this on 7/23/24 he stated in retrospect, she should have dug more in to what had happened. He stated no matter what, if someone has a concern, he should be contacted directly.</p> <p>The facility provided a document titled F609, Reporting of Abuse Allegations. All suspected violations and all substantiated incidents of abuse, neglect, exploitation or mistreatment, including injuries of unknown sources and misappropriation will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, abuse, including injuries of unknown source, and misappropriation of resident property. Should a suspected violation or a reasonable suspicion or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse, or suspected crimes, or suspected evidence of humiliating or demeaning photographs or recordings) be reported, the facility Administrator, or his/her designee in their absence.</p>		