STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165227	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birkwood Village of Fort Madison	1702 41st Street Fort Madison, IA 52627

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on interviews, clinical record review, and facility Human Resources documentation, the facility failed to ensure residents were treated in a dignified manner while speaking to residents and during incontinent care for 1 of 3 residents reviewed (Resident #50). The facility reported a census of 59 residents. Findings include: The Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #50 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. The MDS assessed the resident dependent on staff for assistance with toileting hygiene and frequently incontinent of bowel and bladder. The Care Plan, dated [DATE], revealed a focus area to address grieving related to the unexpected loss of her husband. The Interventions included encourage the resident to live one day at a time and encourage the resident to recognize grief situations. Staff H, Certified Nursing Assistant (CNA) personnel file revealed the following information: a. Documentation of termination on [DATE]. Reason indicated - outcome related to facility investigation of abuse accusations. b. Mandatory Reporter training for Dependent Adult Abuse completed on [DATE]. c. Training completed on the importance of effective communication in health care on [DATE] and [DATE]. d. Training on Resident's Rights completed on [DATE]. e. Signed acknowledgement of CNA job description dated [DATE]. f. Signed acknowledgement form stating understand the obligation to report potential abuse, and received/discussed the Abuse Prevention, Identification and Reporting Policy [[DATE]] on [DATE]. Per the undated, Facility Investigation documents regarding the incident involving Resident #50: (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On [DATE], Resident #50 reported to the ADON (Assistant Director of Nursing), Staff H, CNA talked to her in an aggressive accusatory manner about a relationship with a peer. Resident #50 claimed Staff H stated It's disgusting, your husband has only been dead for 2 weeks. Resident #50 claimed Staff H refused to answer the call light and jabbed a finger at her when talking. Resident #50 claimed Staff H made comments about her incontinence and with an aggressive, raised voice questioned her why she didn't use her call light to use the bed pan. Resident #50 did state she yelled at Staff H to shut up and get out. Resident #50 stated Staff H shut the call light off and said she can't help her and walked out of the room. Resident #50 reported Staff I, CNA was in the room during this incident. Resident #50 reported Staff H pushed her to propel her own wheelchair and told other staff not to help her. Resident #50 reported she felt intimidated by Staff H and denied any previous problems with Staff H. b. Staff H, during an interview for the facility investigation, confirmed she had a disagreement with Resident #50. Staff H reported Resident #50 asked her opinion on the relationship she formed with another resident. Staff H reported she told Resident #50, it was a bad idea, but they are both adults and can make their own decisions. At that time Staff H claimed Resident #50 yelled at her to shut up and get out, as Staff H left the room the nurse walked in and finished assisting with the transfer. Staff H went on to say that her and Resident #50 didn't mesh well and she felt that therapy encouraged her to encourage the resident to do more for herself it created animosity with the resident. Staff H stated that she removed herself from the situation. Staff H reported the day after the incident, she went into the room to shut off the call light and let her know staff was on lunch break and she wasn't allowed in the resident's room. In initial interview Staff H stated she wanted to report how Resident #50 treated her and she wanted to report what the resident done to her too. Staff H then stated the resident was going to get Staff H kicked on her hall and demanded the resident be moved to a different hallway. c. Staff I, during an interview for the facility investigation, could not verify if Staff H or Resident #50 commented first but Staff H commented on Resident #50 deceased husband and that she thought Resident #50 moving to fast with another resident. Staff I stated both Staff H and Resident #50 raised their voices. d. Investigation documentation revealed on [DATE], Staff H sent home and placed on administrative leave pending further investigation. No previous discipline in file for Staff H noted. No incident report or nurses note on topic and after thorough investigation the allegation of abuse considered substantiated, the employee terminated from the facility. Abuse isolated to one employee, no root cause analysis necessary. During an interview on [DATE] at 3:07 PM, Resident #50 stated she felt like she had a target on her back with Staff H worked at the facility. Resident #50 stated Staff H babbled about the resident and her tablemate and said she saw the tablemate kissing Resident #50 up and down the arm and Resident #50 should be ashamed of herself since her husband died 2 weeks ago. Resident #50 stated she felt angry, then upset, and then didn't know what to do. Resident #50 stated she didn't entirely feel safe and requested Staff H not to take care of her. Resident #50 stated she felt like Staff H was verbally abusive to her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:44 PM, Staff H, CNA stated before she was terminated she didn't go into Resident #50 room or speak to her. She stated her and Staff J, CNA switched residents. Staff H stated she didn't chart on Resident #50 or answer her call light. Staff H stated Resident #50 asked her about a relationship she had with another resident and Staff H kept saying she didn't want to get into it but Resident #50 persisted so Staff H told her she thought it was inappropriate and not respectful to her husband who died 2 weeks prior. Staff H stated Resident #50 told her to shut up and get out of her room so Staff H had Staff I come into the room and take over cares. Staff H stated a week and half or two weeks later she was called to the office and told she was verbally abusive and suspended. Staff H stated according to therapy Resident #50 needed to push herself and sometimes Resident #50 had full blown bowel movements or urinary incontinence and didn't even try to push the call light. Staff H stated when she found the big messes, she asked Resident #50 why she didn't use her call light, like she was supposed to do. During an interview on [DATE] at 5:35 PM, Staff K, RN (Registered Nurse) stated Staff H and Resident #50 didn't get along. Staff K stated the last incident with Staff H and Resident #50, she was called into the room and Staff H came out and Resident #50 stated she didn't want Staff H in her room anymore. Staff K stated immediately Staff H and Staff J traded residents and Staff K thought the issue solved. Staff K thought the incident happened a few weeks prior to the DON (Director of Nursing) questioning her. Staff K stated Staff H came to her and told Staff K that she didn't think the relationship between Resident #50 and another resident appropriate. Staff K stated she told her they were adults and could do what they wanted. During an interview on [DATE] at 9:29 AM, Staff J, CNA stated she had resident tell her staff were rough with them. Staff J stated the residents named Staff H. Staff J stated one weekend she worked with Staff H and Staff H asked her to switch residents with her because Staff H thought Resident #50 a b word. Staff J stated Resident #50 told her Staff H told Resident #50 she was being inappropriate with another resident. Staff J also stated that Staff H stated Resident #50 asked for her opinion so she gave it. Staff J stated that her and Staff H went to the ADON (Assistant Director of Nursing) after the incident and told her they switched residents and the ADON thought it an appropriate alternative to keep the staff member and resident apart. Staff J stated the situation got worse because Staff H refused to take care of Resident #50 and would turn off her call light while Resident #50 on the bed pan so she reported it to the DON. During an interview on [DATE] at 11:47 AM, Staff D, CNA stated Resident #50 told her that Staff H didn't speak to her very politely and refused to do cares on her. Staff D stated she witnessed Staff H refuse cares for Resident #50 when they worked Hall 4 together and Staff D would go and help Resident #50. During an interview on [DATE] at 12:24 PM, Staff I, CNA stated she witnessed an incident when Staff H found out about Resident #50 talking with another resident and Staff H went into Resident #50 room and in a loud voice told Resident #50 she should be ashamed of herself and should be grieving for her husband. Staff I stated she witnessed another incident when Staff H performed incontinent cares on Resident #50 and asked the resident why she didn't use the bed pan and Staff H told the resident if they could work a phone, they could use a bed pan. Staff I stated after the comment, Resident #50 told Staff H to shut up and get out of her room and from then on Staff H refused to do cares on Resident #50. Staff I stated a week or two later, Staff H was suspended. Staff H stated a few times after the incident Resident #50 asked what she did to deserve care like that. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:10 PM, the ADON stated when she interviewed Resident #50, the resident stated Staff H refused to answer her call light and accused her of being inappropriate for giving her husband's ring to someone else. The ADON stated Resident #50 expressed she didn't feel comfortable with Staff H doing her cares anymore. The ADON stated during her investigation, the staff mentioned Staff H could be short and abrasive with people. The ADON stated when she interviewed Staff H initially, Staff H called Resident #50 a curse word and stated she was going to get her fired. The ADON stated her conclusion at the end of the investigation stated the knew they didn't want Staff H taking care of their residents anymore and Staff H bedside manner not appropriate. During an interview on [DATE] at 4:06 PM, the DON stated Staff H exhibited behaviors were not appropriate for the facility and she wished the staff would of came to her sooner. The DON stated Resident #50 became very upset and crying when she spoke to her after the incident. During an interview on [DATE] at 4:22 PM, the Interim Administrator stated her conclusion of the investigation was Staff H could no longer work at the facility. She stated she was a huge advocate for their residents and even if a resident was not being nice, the staff needed to be nice to them. The Certified Nurse Aide Job Description, signed on [DATE], included the following essential functions: a. Provide resident cares in a manner that promoted resident comfort and security while allowed time for the resident participation and rehabilitation. b. Follow resident rights policies at all times

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, facility policy review, and staff interviews, the facility failed to follow their abuse policy when staff did not notify management of concerns with potential abuse of 1 of 2 residents reviewed (Resident #50). The facility reported a census of 59 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed resident dependent with toileting hygiene and frequently incontinent of bowel and bladder. A review of facility investigation notes revealed on 5/28/24, Resident #50 reported to the Assistant Director Nursing (ADON) Staff H, Certified Nursing Assistant (CNA) talked to her in an aggressive, accusatory manor in regards to a discussion about a relationship with another peer. The investigation revealed: a. Staff H confirmed she had a disagreement with Resident #50. b. Staff I, CNA stated Staff H and Resident #50 raised their voices during the disagreement. c. Staff H sent home on 5/28/24 and placed on administrative leave pending further investigations. The facility submitted a Self Report on 5/28/24 at 2:08 PM revealed the following information: a. Reporting Type: Allegation of Abuse b. Approximate Date Time Occurred: 5/28/24 at 12:10- PM c. Location occurred: Resident's Room d. Date Aware: 5/28/24 e. Incident Summary: Resident reported to ADON that the CNA assigned to the hall she lived on wasn't nice to her. Stated that the CNA had told her that it was disrespectful to her husband who had only been dead 2 weeks and you already have a new boyfriend. Resident stated that this CNA had told other CNAs not to come and help her because she needed to exercise. f. Corrective Action Description: CNA has been suspended pending our investigation During an interview on 6/17/24 at 3:11 PM, Resident #50 stated she felt Staff H verbally abusive to her for a good 2 to 3 months and it really bothered her what Staff H said about her husband of [AGE] years. Resident #50 stated she just put up with it and then told staff after it happened. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/24 at 5:35 PM, Staff K, RN (Registered Nurse) stated Staff H and Resident #50 didn't get along. Staff K stated the last incident with Staff H and Resident #50, she was called into the room and Staff H came out and Resident #50 stated she didn't want Staff H in her room anymore. Staff K stated immediately Staff H and Staff J traded residents and Staff K thought the issue solved. Staff K thought the incident happened a few weeks prior to the DON (Director of Nursing) questioning her. During an interview on 6/19/24 at 5:57 PM, Staff G, CNA stated she reported to her nurse Staff H aggressive with a resident in Hall 4. She stated the resident had an accident in his pants and she yelled at him. Staff G stated Staff H called the resident a butt hole and refused to lay him down so she told the nurse. Staff G stated she didn't know the nurse's name and they worked for agency staffing. During an interview on 6/20/24 at 9:29 AM, Staff J, CNA stated she had resident tell her staff were rough with them. Staff J stated the residents named Staff H. Staff J stated one weekend she worked with Staff H and Staff H asked her to switch residents with her because Staff H thought Resident #50 a b word. Staff J stated that her and Staff H went to the ADON (Assistant Director of Nursing) after the incident and told her they switched residents and the ADON thought it an appropriate alternative to keep the staff member and resident apart. Staff J stated the situation got worse because Staff H refused to take care of Resident #50 and would turn off her call light while Resident #50 on the bed pan so she reported it to the DON. During an interview on 6/20/24 at 11:47 AM, Staff D, CNA stated Resident #50 told her that Staff H didn't speak to her very politely and refused to do cares on her. Staff D stated she witnessed Staff H refuse cares for Resident #50 when they worked Hall 4 together and Staff D would go and help Resident #50. During an interview on 6/20/24 at 12:24 PM, Staff I, CNA stated she worked with Staff H she witnessed an incident when Staff H found out about Resident #50 talking with another resident and Staff H went into Resident #50 room and in a loud voice told Resident #50 she should be ashamed of herself and should be grieving for her husband. Staff I stated she witnessed another incident when Staff H performed incontinent cares on Resident #50 and asked the resident why she didn't use the bed pan and Staff H told the resident if they could work a phone, they could use a bed pan. Staff I stated after the comment, Resident #50 told Staff H to shut up and get out of her room and from then on Staff H refused to do cares on Resident #50. Staff I stated she helped Staff H with a mechanical lift with a resident and Staff H called the resident lazy because he needed to stand up and needed their help. Staff I stated Staff H knew what she did because she made comments not to say anything to anyone because Staff H didn't want moved from her hall. Staff I stated she never told anyone until she was pulled into the office because she thought it couldn't have been the first time Staff H spoke to the resident that way. Staff I stated this was her first CNA job and didn't know what to say and maybe she was wrong. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/20/24 at 4:06 PM, the DON stated Staff H exhibited behaviors were not appropriate for the facility and she wished the staff would of came to her sooner. The DON confirmed she would of liked the staff to come to her soon and they completed education on abuse and even if the staff unsure if abuse to still report it. She stated the staff knew how to report and to report as soon as possible. The Facility Abuse Policy dated 7/19 revealed the following information: a. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.