

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER Living Center West		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 4th Avenue SE Cedar Rapids, IA 52403	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434</p> <p>Based on observation, clinical record review, policy review, and staff interviews, the facility failed to ensure privacy by leaving a resident exposed for several minutes during incontinence cares for 1 of 7 residents reviewed for dignity (Resident #6). The facility reported a census of 74 residents.</p> <p>Findings:</p> <p>Resident #6 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #6 required total assistance from staff for toileting hygiene. The MDS included diagnoses of anxiety disorder, depression, and weakness.</p> <p>The Care Plan Focus, dated 4/8/24, indicated Resident #6 experienced bladder incontinence related to impaired mobility, obesity, and overactive bladder. The Interventions directed the staff to use incontinence products to promote hygiene and dignity.</p> <p>On 7/23/24 at 1:25 PM, Staff E, Certified Nursing Assistant (CNA), and Staff F, CNA, transferred Resident #6 to the bed with a mechanical lift, as the Director of Nursing (DON) observed. Staff E and Staff F pulled down Resident #6's pants. Staff E unfastened her incontinent brief and pulled the brief down in front, exposing Resident #6's frontal perineal area (referring to the frontal genital area). Staff F stated she would go and find a large sized brief. Staff F and the DON left the room. Staff E waited for approximately 2 minutes and then proceeded to clean Resident #6's frontal perineal area. Approximately 2 minutes later, the DON returned to the room, and reported Staff F would be back with a few more items. Approximately 2 minutes later, Staff F returned with a pan of water on a rolling bedside table. Staff E utilized the pan of water and the cloths to complete Resident #6's perineal cleansing. Several minutes elapsed from the time Staff F and the DON left the room until Staff E completed the remainder of Resident #6's perineal cares. During this time, Resident #10 laid in bed without a drape with her frontal perineal area exposed.</p> <p>The facility policy Residents' [NAME] of Rights revised December 2023, stated residents had the right to personal privacy during personal care.</p> <p>On 7/29/24 at 1:14 PM Staff G, Licensed Practical Nurse (LPN), stated if staff stepped away from a resident for a few moments they should drape them for privacy.</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
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 1:30 PM the Director of Nursing (DON) stated if staff stepped away from an exposed resident, they should cover the resident up. She stated she thought the staff member waited to perform cares because the facility directed staff when the facility had State Surveyors in the building, the needed to wait for a member of administration to proceed with cares. She stated if the staff waited, they should cover the resident.		

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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>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** 35434</p> <p>Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to prevent sexual exploitation for 1 of 1 resident reviewed for abuse (Resident #10). After a staff member observed Staff A, Activities Director, and Resident #10 kissing in the activity room, they left the room leaving the two of them alone in the room. No one reported the witnessed event to members of administration until several weeks later and the facility didn't terminate Staff A until 6/17/24. In addition, the facility learned on 2/29/24 that Resident #10 stated he and Staff A kissed and she locked the door of the activity room so they could be alone. The facility failed to have documentation of an investigation into the situation, nor did they separate Staff A from Resident #10 or the other residents after 2/29/24. This deficient practice resulted in an Immediate Jeopardy to the health and safety of residents who resided at the facility. The facility reported a census of 74 residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/25/24 at 9:30 AM The IJ began on 2/29/24. The facility staff removed the immediacy on 6/14/24 through the following actions:</p> <ol style="list-style-type: none"> a. Previous Administrator employment at Living Center [NAME] ended 3/18/24. b. The facility suspended Staff A on 6/10/24. c. The facility terminated Staff A's employment on 6/17/24. b. The facility carried out abuse prevention education for all staff on 6/10/24. d. The facility sent the nurse home immediately on 6/10/24. e. The facility notified the agency the nurse couldn't return to the facility on [DATE] f. The facility retrained all of the staff on the Abuse Policy and Procedures (including reporting, prevention, etc.) specifically highlighting sexual exploitation completed by Administrator and Clinical Leadership on 6/10/24. g. Mental Health counseling offered to Resident #10. h. Weekly visits with Resident #10 and Social Worker initiated 6/14/24. i. Interviewed all cognitively intact residents to verify they facility didn't have other affected residents on 6/11/24. j. The facility notified Resident #10's provider and responsible party on 6/10/24. k. The facility reviewed and updated Resident #10's Care Plan <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>I. Monthly Staff In-services to occur to provide education and retraining as needed.</p> <p>m. Grievance procedures implemented 5/21/24 and continued education provided at June and July in services and resident council.</p> <p>The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures.</p> <p>Findings include:</p> <p>Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #10 required supervision or touching assistance with showering/bathing. The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, and depression.</p> <p>The Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, dated October 2022, stated all residents had the right to be free from abuse and defined abuse to include sexual exploitation. The policy stated sexual exploitation was consensual or nonconsensual sexual conduct with a dependent adult by a caretaker and stated it included but not limited to kissing.</p> <p>The Care Plan Focus dated 8/4/23 reflected Resident #10 required 24 hour care related to the inability to care for himself in the community.</p> <p>The Care Plan Focus dated 8/21/23 indicated Resident #10 had impaired cognitive function, dementia, or impaired thought processes related to his diagnoses of dementia, [NAME]'s encephalopathy (a disease of the brain which caused symptoms which included confusion), and psychotropic drug use. The Interventions directed the staff to keep Resident #10's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.</p> <p>The Care Plan Focus initiated 9/29/23 and revised 6/12/24 identified Resident #10 had signs and symptoms of mood distress as evidenced by verbalizing feeling down, depressed, or hopeless related to diagnoses for depression, anxiety, and dementia.</p> <p>In email correspondence, sent to Staff D, former Administrator, on 2/29/24 at 2:47 PM, Resident #10's Guardian (RR #10) stated Resident #10 declared his love for Staff A. RR #10 explained Resident #10 told him, they tried to figure out how to go out on dates together. Resident #10 told RR #10 they kissed each other and Staff A locked the activity room door so they could have privacy. Resident #10 said Staff A talked about her husband and reported problems in their relationship. Resident #10 stated he intended to protect Staff A and asked RR #10 for help facilitating the relationship so they could spend more time alone. Resident #10 stated they had to hide their relationship because of Staff A's employment. Resident #10 declared his love for Staff A. He never had this in his life before and he wanted to nurture it. He explained he would like to get married.</p> <p>In email correspondence, sent to RR #10 on 3/1/24 at 10:37 AM, Staff D responded they would address it immediately.</p> <p>The facility lacked documentation of an investigation into the concerns reported in the 2/29/24 email from RR #10 and lacked documentation they reported the concerns to the State Agency.</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 History and Physical, dated 5/1/24 reflected the hospital staff received limited history from Resident #10 due to his cognitive impairment. The report listed Resident #10 had [NAME] Korsakoff Syndrome (a condition which caused impaired memory).</p> <p>A statement dated 6/10/24, written by Staff B, Certified Medication Aide, (CMA), indicated on 5/7/24, when she looked for Resident #10 to give his medication, she noticed the activity room door slightly cracked. As Staff B looked in, she saw Resident #10 and Staff A kissing each other on the mouth. Staff B gave Resident #10 his medication and quickly left the room. Staff A found Staff B and asked her not to say anything, adding it would not happen again. Staff B reported the situation to Staff C, Registered Nurse (RN), after Staff A left the building.</p> <p>A statement dated 6/10/24, written by Staff C stated at the end of April or Early May (2024) Staff B told her she saw Resident #10 and Staff A making out. Staff C said she directed Staff B to report it to the Director of Nursing (DON). On or around 5/31/24, Staff C observed Resident #10 talking on the phone to Staff A around 7:00 PM.</p> <p>A statement dated 6/10/24, written by the DON, stated she notified RR #10 of the alleged incident. RR #10 explained while hospitalized in December 2023, the hospital staff saw text messages between Resident #10 and Staff A where he declared his love for her. RR #10 added Resident #10 told her about his relationship with Staff A. They would close the activity room door, kiss, and Staff A would tell him about her marital problems. RR #10 stated she emailed Staff D regarding the concerns on 3/1/24.</p> <p>In a written interview on 6/10/24, Resident #10 denied kissing Staff A.</p> <p>A statement dated 6/10/24, written by the DON, stated Resident #10 called her and said he lied about what they talked about earlier because he didn't want to get Staff A or himself in trouble. Resident #10 explained Staff A called him that evening and told him to be honest about things.</p> <p>A statement dated 6/10/24, written by Staff A, stated she had a relationship with Resident #10 for over 6 months now and it still continued. The note stated when Staff A left to go home, she gave Resident #10 a hug and just a smack on his cheek. The note stated no other staff or residents knew about the relationship. They started to become close around the end of November when he spent time with her in the activity room.</p> <p>The Health Status Note dated 6/10/24 at 7:05 PM indicated the facility had a report of someone witnessing Resident #10 and a staff member kissing in the activity room. Resident #10 denied any sexual contact or intimate relationship and stated they were just friends. Upon interview, the staff member admitted to the allegations and walked out of the facility.</p> <p>The Psychosocial Note dated 6/14/24 at 3:14 PM identified He was open to discussing his relationship with staff member Staff A and named them by name. He voiced frustration over the many questions over the matter and feeling that no one believed him that this incident is making a mountain out of a mole hill. He said he spent a lot of time with Staff A helping in the activity office. He said they became friends and that he liked them, even felt love for them but stated nothing sexually happened. He said he is okay with the questions, but worried about the impact of the situation on Staff A. Resident #10 said he is open to further visits to help with processing. Post-Traumatic Stress Disorder (PTSD) form completed with positive results for PTSD but related to a situation in his past.</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>Staff A's Personnel Record listed a termination date of 6/17/24.</p> <p>The Psychosocial Note dated 6/20/24 at 3:18 PM described Resident #10 as tearful about the facility firing Staff A. He stated if he didn't come to the facility, she would still have her job. He stated he didn't go to the activity room to color because of the sadness it brought him, so he colored in the lounge. He felt coloring helped him cope with the grief and guilt over the situation. He reported still having contact with Staff A via phone and text. He stated Staff A's spouse didn't care for her so he thought that led to his relationship with her. He stated he feared the facility would kick him out of the facility due to the situation.</p> <p>The Psychosocial Note dated 6/25/24 at 11:44 AM reflected Resident #10 had a meeting with staff for support, and reported he had a difficult morning. He still felt some blame but also anger over the situation. He said he had nightmares about the issue. He reported crying a lot, and trying to forget Staff A but he didn't really want. He has removed Staff A name and number from his phone. Resident #10 also shared that he is angry at Staff A spouse because he didn't care for Staff A and Staff A didn't love the spouse. Resident #10 said he didn't think the meeting helped him, but thought it gave him an opportunity to talk out some of his thoughts.</p> <p>On 7/22/24 at 2:35 PM watched Resident #10 propel himself down the hall in his wheelchair.</p> <p>On 7/23/24 at 2:48 PM, Resident #10 stated Staff A became pregnant and couldn't work at the facility anymore. He said they had a close relationship, but said they had no kissing involved. He stated they would text and call each other on the phone. He added they each had problems, so that was what friends did. He said they hugged as friends, kissed as friends, and had a light kiss on the cheek. He didn't think of that as an affair. He stated she closed the door to keep other people out, so they could work on projects.</p> <p>On 7/23/24 at 3:35 PM the Administrator stated Resident #10 struggled with the situation between him and Staff A. She described him as all over the map and his mood could go from a low to a high. She stated he had a time with her out of the picture. She indicated she had a hard time watching him as started to accept it and struggle. She described him as a lot quieter. She stated Staff B reported to Staff C that she saw Resident #10 and Staff A kissing on the lips in the activity room. Staff B stated Staff C told her not to worry about it. The Administrator stated she found out when Staff C told Staff F, CNA, about it a couple of weeks later. The Administrator stated when she met with Staff A, she told her she had a relationship with Resident #10 for 6 months, they loved each other, and had a kiss. She stated they had Staff A leave the building, then they talked to residents and staff. She stated initially Resident #10 denied it but then later that day he admitted to it. The Administrator stated RR #10 stated she reported it before and sent an email to Staff D. The Administrator said she couldn't find a follow up to the email.</p> <p>On 7/24/24 at 11:59 AM via phone, Staff B stated she tried to find Resident #10 to give him his medications and saw the activity room door cracked. When she looked in the room she saw Resident #10 in his wheelchair with Staff A sitting on his knee in the middle of a long kiss on the mouth. She said when Staff A looked up, she went in and gave Resident #10 his medications. She quickly left because she (Staff B) felt embarrassed. Staff B stated a few minutes later when Staff A found her, she asked her not to tell anyone, and added they wouldn't do that anymore. Staff B stated she waited for Staff A to leave the building, then told Staff C. Staff C told her not to tell anyone. She explained she didn't hear anything else about it until she got a call about a month later.</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 7/24/24 at 3:00 PM Resident #15, Resident #10's roommate, stated he told the Social Worker that morning he did a bad thing. He said he saw Staff A on Sunday at a picnic and she gave him some pictures to give to Resident #10. Resident #15 stated he gave the items to Resident #10. Resident #10 told him that he loved Staff A in a romantic way, he saw them hold hands but not kiss. Resident #15 said Resident #10 use to get up early and go to the activity room, but he no longer did that since Staff A left. He stated Resident #10 talked about her all of the time. During the conversation, Resident #15's phone rang and he said the call came from Staff A. Resident #10 said the number of the person calling, and it matched Staff A's phone number in her personnel record.</p> <p>On 7/24/24 at 4:44 PM, the Social Worker reported the situation with Staff A had a lot of impact on Resident #10. He stated he felt guilty and didn't feel like going to the activity room anymore. He talked to him about mental health counseling and he agreed to go. He stated Resident #10's cognition fluctuated and he didn't know if he could consent (for the kiss).</p> <p>On 7/24/24 at 4:53 PM, the Assistant Director of Nursing (ADON) said she noted a difference in Resident #10 since the situation with Staff A. She described him as more withdrawn, tearful, and didn't engage in activities as he did in the past.</p> <p>On 7/25/24 at 8:19 AM via phone, Staff D denied that someone reported to her that Resident #10 stated he kissed Staff A and she locked the door of the activity room for them to be alone. She didn't recall receiving an email on 2/29/24 about the situation and stated such allegations would be reportable. She stated the only thing that someone reported to her was that Resident #10 sent Staff A heart emojis and that isn't reportable.</p> <p>On 7/25/24 at 10:05 AM, the Administrator stated she suspended Staff A on 6/10/24 and she didn't return to the building. The facility terminated her on 6/17/24.</p> <p>On 7/25/24 at 10:18 AM, via phone, Staff C explained Staff B reported that she saw Staff A kissing a resident. Staff B told her Staff A took care of it, so Staff C thought that Staff A turned herself in.</p> <p>On 7/25/24 at 11:54 AM via phone, RR #10 stated when hospitalized last November, the hospital nursing staff saw him texting things like heart emojis to Staff A. RR #10 explained they reported it to Staff D. They told RR #10 the facility brought in Staff A, looked at her phone, and talked to her about boundaries. In February (2024), RR #10 went with Resident #10 when he had a procedure. He reported they gave him sedatives and described him as loopy. RR #10 stated Resident #10 told her that he had a romantic relationship with Staff A and they kissed. RR #10 reported this to the Administrator via email at the time, the Administrator told her she would address it. RR #10 didn't hear anything else about it. RR #10 said after the alleged witnessed kiss, Resident #10 became very anxious and upset that someone accused him of things. Resident #10 didn't understand what they accused him of. Resident #10 only had one other girlfriend in his life and he felt like he would never have a relationship. RR #10 stated she felt it was more meaningful for him than for Staff A.</p> <p>The facility lacked documentation of an investigation into the alleged text messages sent from Resident #10 to Staff A in November 2023.</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 7/29/24 at 1:30 PM, the DON stated Staff F reported the alleged kiss to the ADON. She said the incident happened weeks prior and the agency nurse didn't report it until later. She explained since the incident, staff have reported him as more depressed, not himself, and changed his routine. She said he didn't participate in activities as much and liked his solitude. She stated Resident #10 stayed in his room more.</p> <p>On 7/29/24 at 4:09 PM, the Administrator stated she expected residents to be free from abuse and staff should treat them like their own loved one. After an allegation of abuse, the facility would remove the alleged perpetrator from all residents and report it to the State Agency.</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** 35434</p> <p>Based on observation, clinical record review, policy review, staff, and resident interviews, the facility failed to report an allegation of sexual exploitation for 1 of 1 resident reviewed for abuse (Resident #10). On 5/7/24 a staff member observed Staff A, Activities Director, and Resident #10 kissing in the activity room. No one reported the witnessed event to members of administration until 6/10/24. The facility suspended Staff A on 6/10/24 and terminated her on 6/17/24. The deficient practice resulted in an Immediate Jeopardy to the health and safety of residents who resided at the facility. The facility reported a census of 74 residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/25/24 at 9:30 AM The IJ began on 2/29/24. The facility staff removed the immediacy on 6/10/24 through the following actions:</p> <ul style="list-style-type: none"> a. Previous Administrator employment at Living Center [NAME] ended 3/18/24. b. The facility suspended Staff A on 6/10/24. c. The facility terminated Staff A's employment on 6/17/24. b. The facility carried out abuse prevention education for all staff on 6/10/24. d. The facility sent the nurse home immediately on 6/10/24. e. The facility notified the agency the nurse couldn't return to the facility on [DATE]. f. The facility retrained all of the staff on the Abuse Policy and Procedures (including reporting, prevention, etc.)specifically highlighting sexual exploitation completed by Administrator and Clinical Leadership on 6/10/24. <p>The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures.</p> <p>Findings include:</p> <p>Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #10 required supervision or touching assistance with showering/bathing. The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, and depression.</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>The Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, dated October 2022, stated all residents had the right to be free from abuse and defined abuse to include sexual exploitation. The policy stated sexual exploitation was consensual or nonconsensual sexual conduct with a dependent adult by a caretaker and stated it included but not limited to kissing. The policy stated the facility would report all allegations of abuse immediately to the State Agency not later than 2 hours after receiving the report of the allegation.</p> <p>The Care Plan Focus dated 8/4/23 reflected Resident #10 required 24 hour care related to the inability to care for himself in the community.</p> <p>The Care Plan Focus dated 8/21/23 indicated Resident #10 had impaired cognitive function, dementia, or impaired thought processes related to his diagnoses of dementia, Wernicke's encephalopathy (a disease of the brain which caused symptoms which included confusion), and psychotropic drug use. The Interventions directed the staff to keep Resident #10's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.</p> <p>The Care Plan Focus initiated 9/29/23 and revised 6/12/24 identified Resident #10 had signs and symptoms of mood distress as evidenced by verbalizing feeling down, depressed, or hopeless related to diagnoses for depression, anxiety, and dementia.</p> <p>In email correspondence, sent to Staff D, former Administrator, on 2/29/24 at 2:47 PM, Resident #10's Guardian (RR #10) stated Resident #10 declared his love for Staff A. RR #10 explained Resident #10 told him, they tried to figure out how to go out on dates together. Resident #10 told RR #10 they kissed each other and Staff A locked the activity room door so they could have privacy. Resident #10 said Staff A talked about her husband and reported problems in their relationship. Resident #10 stated he intended to protect Staff A and asked RR #10 for help facilitating the relationship so they could spend more time alone. Resident #10 stated they had to hide their relationship because of Staff A's employment. Resident #10 declared his love for Staff A. He never had this in his life before and he wanted to nurture it. He explained he would like to get married.</p> <p>In email correspondence, sent to RR #10 on 3/1/24 at 10:37 AM, Staff D responded they would address it immediately.</p> <p>The facility lacked documentation into the concerns reported in the 2/29/24 email from RR #10 indicating they reported the concerns to the State Agency.</p> <p>A statement dated 6/10/24, written by Staff B, Certified Medication Aide, (CMA), indicated on 5/7/24, when she looked for Resident #10 to give his medication, she noticed the activity room door slightly cracked. As Staff B looked in, she saw Resident #10 and Staff A kissing each other on the mouth. Staff B gave Resident #10 his medication and quickly left the room. Staff A found Staff B and asked her not to say anything, adding it would not happen again. Staff B reported the situation to Staff C, Registered Nurse (RN), after Staff A left the building.</p> <p>A statement dated 6/10/24, written by Staff C stated at the end of April or Early May (2024) Staff B told her she saw Resident #10 and Staff A making out. Staff C said she directed Staff B to report it to the Director of Nursing (DON). On or around 5/31/24, Staff C observed Resident #10 talking on the phone to Staff A around 7:00 PM.</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 statement dated 6/10/24, written by the DON, stated she notified RR #10 of the alleged incident. RR #10 explained while hospitalized in December 2023, the hospital staff saw text messages between Resident #10 and Staff A where he declared his love for her. RR #10 added Resident #10 told her about his relationship with Staff A. They would close the activity room door, kiss, and Staff A would tell him about her marital problems. RR #10 stated she emailed Staff D regarding the concerns on 3/1/24.</p> <p>In a written interview on 6/10/24, Resident #10 denied kissing Staff A.</p> <p>A statement dated 6/10/24, written by the DON, stated Resident #10 called her and said he lied about what they talked about earlier because he didn't want to get Staff A or himself in trouble. Resident #10 explained Staff A called him that evening and told him to be honest about things.</p> <p>A statement dated 6/10/24, written by Staff A, stated she had a relationship with Resident #10 for over 6 months now and it still continued. The note stated when Staff A left to go home, she gave Resident #10 a hug and just a smack on his cheek. The note stated no other staff or residents knew about the relationship. They started to become close around the end of November when he spent time with her in the activity room.</p> <p>The Health Status Note dated 6/10/24 at 7:05 PM indicated the facility had a report of someone witnessing Resident #10 and a staff member kissing in the activity room. Resident #10 denied any sexual contact or intimate relationship and stated they were just friends. Upon interview, the staff member admitted to the allegations and walked out of the facility.</p> <p>The Psychosocial Note dated 6/14/24 at 3:14 PM identified He was open to discussing his relationship with staff member Staff A and named them by name. He voiced frustration over the many questions over the matter and feeling that no one believed him that this incident is making a mountain out of a mole hill. He said he spent a lot of time with Staff A helping in the activity office. He said they became friends and that he liked them, even felt love for them but stated nothing sexually happened. He said he is okay with the questions, but worried about the impact of the situation on Staff A. Resident #10 said he is open to further visits to help with processing. Post-Traumatic Stress Disorder (PTSD) form completed with positive results for PTSD but related to a situation in his past.</p> <p>Staff A's Personnel Record listed a termination date of 6/17/24.</p> <p>The Psychosocial Note dated 6/20/24 at 3:18 PM described Resident #10 as tearful about the facility firing Staff A. He stated if he didn't come to the facility, she would still have her job. He stated he didn't go to the activity room to color because of the sadness it brought him, so he colored in the lounge. He felt coloring helped him cope with the grief and guilt over the situation. He reported still having contact with Staff A via phone and text. He stated Staff A's spouse didn't care for her so he thought that led to his relationship with her. He stated he feared the facility would kick him out of the facility due to the situation.</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>The Psychosocial Note dated 6/25/24 at 11:44 AM reflected Resident #10 had a meeting with staff for support, and reported he had a difficult morning. He still felt some blame but also anger over the situation. He said he had nightmares about the issue. He reported crying a lot, and trying to forget Staff A but he didn't really want. He has removed Staff A name and number from his phone. Resident #10 also shared that he is angry at Staff A spouse because he didn't care for Staff A and Staff A didn't love the spouse. Resident #10 said he didn't think the meeting helped him, but thought it gave him an opportunity to talk out some of his thoughts.</p> <p>On 7/22/24 at 2:35 PM watched Resident #10 propel himself down the hall in his wheelchair.</p> <p>On 7/23/24 at 2:48 PM, Resident #10 stated Staff A became pregnant and couldn't work at the facility anymore. He said they had a close relationship, but said they had no kissing involved. He stated they would text and call each other on the phone. He added they each had problems, so that was what friends did. He said they hugged as friends, kissed as friends, and had a light kiss on the cheek. He didn't think of that as an affair. He stated she closed the door to keep other people out, so they could work on projects.</p> <p>On 7/23/24 at 3:35 PM the Administrator stated Resident #10 struggled with the situation between him and Staff A. She described him as all over the map and his mood could go from a low to a high. She stated he had a time with her out of the picture. She indicated she had a hard time watching him as started to accept it and struggle. She described him as a lot quieter. She stated Staff B reported to Staff C that she saw Resident #10 and Staff A kissing on the lips in the activity room. Staff B stated Staff C told her not to worry about it. The Administrator stated she found out when Staff C told Staff F, CNA, about it a couple of weeks later. The Administrator stated when she met with Staff A, she told her she had a relationship with Resident #10 for 6 months, they loved each other, and had a kiss. She stated they had Staff A leave the building, then they talked to residents and staff. She stated initially Resident #10 denied it but then later that day he admitted to it. The Administrator stated RR #10 stated she reported it before and sent an email to Staff D. The Administrator said she couldn't find a follow up to the email.</p> <p>On 7/24/24 at 11:59 AM via phone, Staff B stated she tried to find Resident #10 to give him his medications and saw the activity room door cracked. When she looked in the room she saw Resident #10 in his wheelchair with Staff A sitting on his knee in the middle of a long kiss on the mouth. She said when Staff A looked up, she went in and gave Resident #10 his medications. She quickly left because she (Staff B) felt embarrassed. Staff B stated a few minutes later when Staff A found her, she asked her not to tell anyone, and added they wouldn't do that anymore. Staff B stated she waited for Staff A to leave the building, then told Staff C. Staff C told her not to tell anyone. She explained she didn't hear anything else about it until she got a call about a month later.</p> <p>On 7/24/24 at 3:00 PM Resident #15, Resident #10's roommate, stated he told the Social Worker that morning he did a bad thing. He said he saw Staff A on Sunday at a picnic and she gave him some pictures to give to Resident #10. Resident #15 stated he gave the items to Resident #10. Resident #10 told him that he loved Staff A in a romantic way, he saw them hold hands but not kiss. Resident #15 said Resident #10 use to get up early and go to the activity room, but he no longer did that since Staff A left. He stated Resident #10 talked about her all of the time. During the conversation, Resident #15's phone rang and he said the call came from Staff A. Resident #10 said the number of the person calling, and it matched Staff A's phone number in her personnel record.</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 7/24/24 at 4:44 PM, the Social Worker reported the situation with Staff A had a lot of impact on Resident #10. He stated he felt guilty and didn't feel like going to the activity room anymore. He talked to him about mental health counseling and he agreed to go. He stated Resident #10's cognition fluctuated and he didn't know if he could consent (for the kiss).</p> <p>On 7/24/24 at 4:53 PM, the Assistant Director of Nursing (ADON) said she noted a difference in Resident #10 since the situation with Staff A. She described him as more withdrawn, tearful, and didn't engage in activities as he did in the past.</p> <p>On 7/25/24 at 8:19 AM via phone, Staff D denied that someone reported to her that Resident #10 stated he kissed Staff A and she locked the door of the activity room for them to be alone. She didn't recall receiving an email on 2/29/24 about the situation and stated such allegations would be reportable. She stated the only thing that someone reported to her was that Resident #10 sent Staff A heart emojis and that isn't reportable.</p> <p>On 7/25/24 at 10:05 AM, the Administrator stated she suspended Staff A on 6/10/24 and she didn't return to the building. The facility terminated her on 6/17/24.</p> <p>On 7/25/24 at 10:18 AM, via phone, Staff C explained Staff B reported that she saw Staff A kissing a resident. Staff B told her Staff A took care of it, so Staff C thought that Staff A turned herself in.</p> <p>On 7/25/24 at 11:54 AM via phone, RR #10 stated when hospitalized last November, the hospital nursing staff saw him texting things like heart emojis to Staff A. RR #10 explained they reported it to Staff D. They told RR #10 the facility brought in Staff A, looked at her phone, and talked to her about boundaries. In February (2024), RR #10 went with Resident #10 when he had a procedure. He reported they gave him sedatives and described him as loopy. RR #10 stated Resident #10 told her that he had a romantic relationship with Staff A and they kissed. RR #10 reported this to the Administrator via email at the time, the Administrator told her she would address it. RR #10 didn't hear anything else about it. RR #10 said after the alleged witnessed kiss, Resident #10 became very anxious and upset that someone accused him of things. Resident #10 didn't understand what they accused him of. Resident #10 only had one other girlfriend in his life and he felt like he would never have a relationship. RR #10 stated she felt it was more meaningful for him than for Staff A.</p> <p>The facility lacked documentation of an investigation into the alleged text messages sent from Resident #10 to Staff A in November 2023.</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 7/29/24 at 9:05 AM Staff A stated they became close because as Activity Director, she made sure the residents came to activities and participated. When she first met him, he expressed confusion about being in the facility and they didn't have activities for him to do. She stated he began activities and spent most of those days in the activity room. She stated they became close probably around November of 2023. They shared information with each other about their family and they became close. They ended up being close friends and gave each other advice. She stated their relationship became too close. She stated she worked at the facility for [AGE] years and never abused anyone. She stated a kiss happened once. It was 4:45 PM, as she left for the day, she gave everyone a hug. When she told Resident #10 about her leaving, she gave him a hug, he held onto her a little longer, pulled her in, and kissed her. She stated Resident #10 kissed her on the mouth and pulled her back again. She described it as just one kiss, a couple of quick smacks on the mouth. She reported standing during the kiss and as he sat in his wheelchair. She stated the CMA walked in and saw this. After, Staff A stated she found the CMA and apologized to her for having seen that. The CMA said not to worry about it and she wouldn't say anything. Staff A denied asking the CMA not to say anything. She stated she held hands with Resident #10 before this, as a friend, but stated she held hands with other residents too. She stated Resident #10 told her he loved her a while ago. He knew about her about her being married. He told her he wanted to be with her. She told him that nothing was going to happen (between them). She said when she first met Resident #10, he thought they met prior to him being at the facility. Staff A stated that she never met him before though. She stated when he didn't sleep, he became very confused. Sometimes he thought he was her husband. She stated she sometimes sent him heart emojis and he sent her heart emojis but in friendship and not romantically. She texted him hearts when she thought he was down. She told him she loved him as a friend, her best friend. When he told her, he needed more than that, she tried to block him from her phone a couple of times. She stated he left voicemails and would become crying mad, asking why she hid from him. She stated this occurred prior to when someone observed them kiss. She denied shutting the door to the activity room. She denied having contact with Resident #10 or calling Resident #15 the previous week. She did meet Resident #15 at a picnic last week and gave him books on anxiety to give to Resident #10. She felt Resident #10 had more depression. She stated she didn't want Resident #10 to feel she turned her back on him. She stated she hadn't communicated with him for a couple of months since they suspended her. When she told him that she wasn't coming back, he got very mad, apologized, and blamed himself.</p> <p>On 7/29/24 at 1:14 PM Staff G, Licensed Practical Nurse (LPN), reported Resident #10 expressed he missed Staff A.</p> <p>On 7/29/24 at 1:30 PM, the DON stated Staff F reported the alleged kiss to the ADON. She said the incident happened weeks prior and the agency nurse didn't report it until later. She explained since the incident, staff have reported him as more depressed, not himself, and changed his routine. She said he didn't participate in activities as much and liked his solitude. She stated Resident #10 stayed in his room more.</p> <p>On 7/29/24 at 4:09 PM, the Administrator stated she expected residents to be free from abuse and staff should treat them like their own loved one. After an allegation of abuse, the facility would remove the alleged perpetrator from all residents and report it to the State Agency.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434</p> <p>Based on observation, clinical record review, policy review, staff, and resident interviews, the facility failed to investigate an allegation of sexual exploitation and separate an alleged perpetrator of sexual exploitation from other residents for 1 of 1 resident reviewed for abuse (Resident #10). When a staff member observed Staff A, Activities Director, and Resident #10 kissing in the activity room. No one reported the witnessed event to members of administration until several weeks later. At that time, the facility suspended Staff A and then terminated her employment on 6/17/24. In addition, the facility learned Resident #10 reported on 2/29/24 he and Staff A kissed and she locked the door of the activity room so they could be alone. In addition, the facility learned on 2/29/24 that Resident #10 stated he and Staff A kissed and she locked the door of the activity room so they could be alone. After learning of either incident, the facility failed to report the incident to the Department of Inspections, Appeals, and Licensing (DIAL or State Agency) until 6/10/24. In addition, the facility failed to separate Staff A from Resident #10 or other residents after 2/29/24. This deficient practice resulted in an Immediate Jeopardy to the health and safety of residents who resided at the facility. The facility reported a census of 74 residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/25/24 at 9:30 AM The IJ began on 2/29/24. Facility staff removed the Immediate Jeopardy on 6/14/24 through the following actions:</p> <ul style="list-style-type: none"> a. Previous Administrator employment at Living Center [NAME] ended 3/18/24. b. The facility suspended Staff A on 6/10/24. c. The facility terminated Staff A's employment on 6/17/24. b. The facility carried out abuse prevention education for all staff on 6/10/24. d. The facility sent the nurse home immediately on 6/10/24. e. The facility notified the agency the nurse couldn't return to the facility on [DATE] f. The facility retrained all of the staff on the Abuse Policy and Procedures (including reporting, prevention, etc.) specifically highlighting sexual exploitation completed by Administrator and Clinical Leadership on 6/10/24. g. Interviewed all cognitively intact residents to verify they facility didn't have other affected residents on 6/11/24. h. The facility notified Resident #10's provider and responsible party on 6/10/24. i. Grievance procedures implemented 5/21/24 and continued education provided at June and July in services and resident council. <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures.</p> <p>Findings include:</p> <p>Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #10 required supervision or touching assistance with showering/bathing. The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, and depression.</p> <p>The Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, dated October 2022, stated all residents had the right to be free from abuse and defined abuse to include sexual exploitation. The policy stated sexual exploitation was consensual or nonconsensual sexual conduct with a dependent adult by a caretaker and stated it included but not limited to kissing. The facility would investigate the alleged incident and implement measures to prevent further potential abuse of residents during the investigation by suspending the employee, removing the employee from a resident contact area, or in rare instances, separating the employee from Resident #10 alleged to have been abused, but allowing the employee to care for and have contact with other residents if there was a second employee who remained with and accompanied the employee accused of abuse at all times.</p> <p>The Care Plan Focus dated 8/4/23 reflected Resident #10 required 24 hour care related to the inability to care for himself in the community.</p> <p>The Care Plan Focus dated 8/21/23 indicated Resident #10 had impaired cognitive function, dementia, or impaired thought processes related to his diagnoses of dementia, Wernicke's encephalopathy (a disease of the brain which caused symptoms which included confusion), and psychotropic drug use. The Interventions directed the staff to keep Resident #10's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.</p> <p>In email correspondence, sent to Staff D, former Administrator, on 2/29/24 at 2:47 PM, Resident #10's Guardian (RR #10) stated Resident #10 declared his love for Staff A. RR #10 explained Resident #10 told him, they tried to figure out how to go out on dates together. Resident #10 told RR #10 they kissed each other and Staff A locked the activity room door so they could have privacy. Resident #10 said Staff A talked about her husband and reported problems in their relationship. Resident #10 stated he intended to protect Staff A and asked RR #10 for help facilitating the relationship so they could spend more time alone. Resident #10 stated they had to hide their relationship because of Staff A's employment. Resident #10 declared his love for Staff A. He never had this in his life before and he wanted to nurture it. He explained he would like to get married.</p> <p>In email correspondence, sent to RR #10 on 3/1/24 at 10:37 AM, Staff D responded they would address it immediately.</p> <p>The facility lacked documentation of an investigation into the concerns reported in the 2/29/24 email from RR #10.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/23/24 at 2:48 PM, Resident #10 stated Staff A became pregnant and couldn't work at the facility anymore. He said they had a close relationship, but said they had no kissing involved. He stated they would text and call each other on the phone. He added they each had problems, so that was what friends did. He said they hugged as friends, kissed as friends, and had a light kiss on the cheek. He didn't think of that as an affair. He stated she closed the door to keep other people out, so they could work on projects.</p> <p>On 7/23/24 at 3:35 PM the Administrator stated Staff B reported to Staff C that she saw Resident #10 and Staff A kissing on the lips in the activity room. Staff B stated Staff C told her not to worry about it. The Administrator stated she found out when Staff C told Staff F, CNA, about it a couple of weeks later. The Administrator stated when she met with Staff A, she told her she had a relationship with Resident #10 for 6 months, they loved each other, and had a kiss. She stated they had Staff A leave the building, then they talked to residents and staff. She stated initially Resident #10 denied it but then later that day he admitted to it. The Administrator stated RR #10 stated she reported it before and sent an email to Staff D. The Administrator said she couldn't find a follow up to the email.</p> <p>On 7/24/24 at 11:59 AM via phone, Staff B stated she tried to find Resident #10 to give him his medications and saw the activity room door cracked. When she looked in the room she saw Resident #10 in his wheelchair with Staff A sitting on his knee in the middle of a long kiss on the mouth. She said when Staff A looked up, she went in and gave Resident #10 his medications. She quickly left because she (Staff B) felt embarrassed. Staff B stated a few minutes later when Staff A found her, she asked her not to tell anyone, and added they wouldn't do that anymore. Staff B stated she waited for Staff A to leave the building, then told Staff C. Staff C told her not to tell anyone. She explained she didn't hear anything else about it until she got a call about a month later.</p> <p>On 7/25/24 at 8:19 AM via phone, Staff D denied that someone reported to her that Resident #10 stated he kissed Staff A and she locked the door of the activity room for them to be alone. She didn't recall receiving an email on 2/29/24 about the situation and stated such allegations would be reportable. She stated the only thing that someone reported to her was that Resident #10 sent Staff A heart emojis and that isn't reportable.</p> <p>On 7/25/24 at 10:05 AM, the Administrator stated she suspended Staff A on 6/10/24 and she didn't return to the building. The facility terminated her on 6/17/24.</p> <p>On 7/25/24 at 10:18 AM, via phone, Staff C explained Staff B reported that she saw Staff A kissing a resident. Staff B told her Staff A took care of it, so Staff C thought that Staff A turned herself in.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Living Center West		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 4th Avenue SE Cedar Rapids, IA 52403	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/25/24 at 11:54 AM via phone, RR #10 stated when hospitalized last November, the hospital nursing staff saw him texting things like heart emojis to Staff A. RR #10 explained they reported it to Staff D. They told RR #10 the facility brought in Staff A, looked at her phone, and talked to her about boundaries. In February (2024), RR #10 went with Resident #10 when he had a procedure. He reported they gave him sedatives and described him as loopy. RR #10 stated Resident #10 told her that he had a romantic relationship with Staff A and they kissed. RR #10 reported this to the Administrator via email at the time, the Administrator told her she would address it. RR #10 didn't hear anything else about it. RR #10 said after the alleged witnessed kiss, Resident #10 became very anxious and upset that someone accused him of things. Resident #10 didn't understand what they accused him of. Resident #10 only had one other girlfriend in his life and he felt like he would never have a relationship. RR #10 stated she felt it was more meaningful for him than for Staff A.</p> <p>The facility lacked documentation of an investigation into the alleged text messages sent from Resident #10 to Staff A in November 2023.</p> <p>On 7/29/24 at 1:30 PM, the DON stated Staff F reported the alleged kiss to the ADON. She said the incident happened weeks before and the agency nurse didn't report it until later.</p> <p>On 7/29/24 at 4:09 PM, the Administrator stated she expected residents to be free from abuse and staff should treat them like their own loved one. After an allegation of abuse, the facility would remove the alleged perpetrator from all residents and report it to the State Agency.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434</p> <p>Based on observation, clinical record review, and staff interview, the facility failed to follow the care plan to provide a pressure reducing cushion for 1 of 3 residents reviewed with a pressure ulcer (Resident #11). The facility reported a census of 74 residents.</p> <p>Findings:</p> <p>1. Resident #11 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of arthritis, non Alzheimer's dementia, and weakness. The MDS stated Resident #10 required partial to moderate assistance for rolling right to left, substantial to maximum assistance for showering and transfers, and was dependent of staff for toileting hygiene. The MDS listed a Brief Interview for Mental Status (BIMS) score as 5 out of 15, indicating severely impaired cognition.</p> <p>The Care Plan Focus dated 6/27/23, reflected Resident #11 had a risk for skin breakdown related to impaired mobility, incontinence, and weakness.</p> <p>The Care Plan Focus, dated 6/12/24, indicated Resident #11 had a pressure reducing cushion to the chair.</p> <p>The Braden Scale for Predicting Pressure Sore Risk, dated 7/18/24, identified Resident #11 at risk for the development of pressure sores.</p> <p>The Wound/Skin Healing Records revealed Resident #11 had a Stage 2 (partial thickness loss of skin) pressure ulcer on the coccyx (tailbone) with an onset date of 6/11/24 which measured 0.5 centimeters (cm) x 0.2 cm x 0.1 cm. (length x width x depth).</p> <p>The Subsequent Wound/Skin Health Record measurements included:</p> <ul style="list-style-type: none"> a. 6/17/24 0.8 cm x 0.5 cm x 0.1 cm b. 6/24/24 0.5 cm x 0.4 cm x 0.1 cm c. 7/1/24 0.8 cm x 0.4 cm x 0.2 cm d. 7/8/24 0.6 cm x 0.3 cm x 0.2 cm e. 7/15/24 0.5 cm x 0.3 cm x 0.1 cm f. 7/22/24 0.5 cm x 0.2 cm x 0.1 cm <p>Observations on the following dates/times revealed Resident #11 in her wheelchair with no cushion under her: 7/23/24 at 8:44 AM, 12:16 PM and 12:41 PM 7/24/24 at 8:10 AM</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/24/24 at 2:38 PM, Staff G, Licensed Practical Nurse (LPN), measured a wound on Resident #11's coccyx as 0.5 cm x 0.3 cm x 0.2 cm. The wound had a yellow center and red edges.</p> <p>On 7/29/24 at 1:14 PM Staff G stated Resident #11 should always have a cushion in her chair, she had an incontinent episode and they had to switch it out. She stated the staff should replace the cushion in the chair in a timely manner.</p> <p>On 7/29/24 at 1:30 PM the Director of Nursing (DON) stated Resident #11 had a cushion in her wheelchair but stated she didn't know why she didn't have it the week before. She stated they could be cleaning it or the staff could have failed to place it in the chair. She stated they had extra cushions (if one became soiled).</p> <p>The facility policy Pressure Ulcer Prevention Program, effective 6/7/17, directed the facility would provide care to promote the prevention and healing of pressure ulcers. The policy indicated the most effective means of preventing skin breakdown included relief of pressure on the skin and directed staff to utilize pressure redistribution devices.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>35434</p> <p>Based on review of Quality Assurance and Performance Improvement (QAPI) meeting documentation, policy review, and staff interview, the facility failed to carry out Quality Assurance (QA) activities to obtain feedback, use data, and act to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting facility wide processes that impact quality of care, quality of life, and resident safety. The facility reported a census of 74 residents.</p> <p>Findings:</p> <p>The Centers for Medicare and Medicaid Services (CMS) 2567, dated 1/18/24, listed, in part, the following concerns: F550, F600</p> <p>The CMS 2567, dated 6/6/24, listed, in part, the following concerns: F550</p> <p>The current survey, conducted 7/22/24 7/29/24, also identified the above concerns.</p> <p>A 1/17/24 Performance Improvement Project (PIP) Inventory document stated all staff would complete abuse prevention training and the current phase of the PIP was monitoring. The document listed the indicators and measures tracked to show improvement to include better treatment noted to residents by family, staff, and residents.</p> <p>The facility In Service Agenda for 5/21/24 included the topics of resident rights and the abuse policy/procedures.</p> <p>The QA Committee Meeting Sign in, dated 6/19/24, listed a PIP Team Report for Abuse.</p> <p>The facility lacked further documentation of QAPI/QA program activities related to resident treatment or abuse prevention. The facility lacked evidence of an ongoing QAPI program related to the above areas including a process of addressing how the committee would conduct the activities necessary to identify and correct quality deficiencies. The facility lacked do documentation of monitoring or evaluating the effectiveness of corrective action/ performance improvement activities and revision as needed.</p> <p>On 7/29/24 at 4:09 PM, when queried about QA activities from January to June 2024 which addressed dignity or abuse prevention, the Administrator stated they all had staff abuse training which had a completion deadline of 2/1/24. In February 2024, they educated all staff regarding de escalation techniques and resident rights. She stated in May, they talked to staff regarding resident rights, grievances, and conducted abuse education on 6/10/24. The Administrator stated she would email all QA activities related to dignity and abuse prevention to the survey team.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's QAPI Plan, updated 7/19/18, indicated the plan provided guidance for the overall quality improvement program . The plan reflected the facility utilized a systematic approach to determine when they needed an in depth analysis to fully understand identified problems, causes of the problems, and implications of a change. The facility would implement the plan, evaluate the results, and analyze the outcome.</p>		