STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165381	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Place Senior Living Campus	900 South Stone Street Sigourney, IA 52591

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. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to treat residents with dignity and respect by failing to assist a resident with positioning in a dignified manner (Resident #1), failing to avoid roughness during incontinence cares (Resident #5), failing to speak to residents in a dignified manner and ensure confidentiality (Resident #5), and failing to engage with residents during the provision of cares (Resident #9) for 3 of 11 residents reviewed for dignity. The facility reported a census of 23 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment tool, dated 4/18/24, listed diagnoses for Resident #1 which included severe intellectual disabilities, conduct disorder, and disruptive mood dysregulation disorder (a condition characterized by ongoing irritability, anger, and frequent, intense temper outbursts). The MDS documented the resident exhibited physical behavioral symptoms directed toward others such as hitting, kicking, pushing, and grabbing which occurred on 4-6 days during the 7 day review period and listed her cognition as severely impaired. A 3/28/23 Care Plan entry stated the resident was comforted by being on the floor and may position herself on the floor for comfort. An untitled facility investigation, dated 5/15/24, written by the Director of Nursing (DON) stated staff reported Staff A Certified Nursing Assistant (CNA) yanked the resident back by her hood and was choking her. Staff A stated the resident started to go forward in her chair and he grabbed the back of her pants and sweatshirt with one hand and grabbed the upper part of the sweatshirt with the other hand. The facility carried out education that he should grab the shoulder rather than the neck of the shirt. The facility investigation lacked documentation of other resident interviews conducted. On 5/19/24 at 10:41 a.m., Resident #2 reported Resident #1 tried to get out of her chair and Staff A grabbed her by the hood of her shirt and pulled on it and it choked her. He stated the resident became angry and swung at Staff A. He stated Staff A still worked at the facility. The MDS for Resident #2 dated 2/29/24 documented a BIMS score of 15 which indicated intact cognition. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/24 at 12:50 p.m., via phone, Staff C CNA stated Staff A was trying to scoot Resident #1 back in her chair but he grabbed her by the hood (of her shirt). The resident became upset and swung to hit Staff A and she (Staff C) told him to let her go. She stated Staff A did not know how to do things. On 5/19/24 at 1:06 p.m. via phone., Staff D CNA was queried with regard to the incident with Staff A and Resident #1. She stated Staff A was new on the floor and no one in the facility received any training with regard to Resident #1. Staff D stated she was not a typical nursing home resident and was a lot more challenging. She stated no one received any training and they just went with their first instincts and this had a lot to do with the scenario. Resident #1 required 1:1 supervision and she (Staff D) was charting on the couch and another resident stated that Resident #1 was about to fall out of her chair. Staff A had her chair laid all the way back and she was on the edge and he had her by her pants and the hood of her shirt. Staff D jumped up and grabbed her pants and the resident tried to get Staff A off her and she swung and hit Staff D in the nose. Staff D noticed in the midst of this that the resident was wet and thought this was why she tried to get out of her chair. Staff D stated she did not feel like Staff A was trying to harm the resident, he just lacked training and knowledge. Staff D stated the resident had red marks on her neck from the shirt's zipper. Staff D stated Staff A continued to work the rest of the shift and also the following Friday. On 5/19/24 at 3:12 p.m., the Administrator stated with regard to the situation with Staff A, she received a phone call that there was a possible abuse. She stated they came in and completed a thorough investigation. She stated she was at the facility within 2 minutes and the resident did not have any red marks or visible sights of abuse. She stated they educated staff on how to properly prevent a fall and stated they did not remove Staff A from the facility. She stated Staff A returned to work Friday night and was as needed (prn) so he could potentially return to work. The Administrator stated they provided the survey team with the entire investigation. She stated she would not report an allegation if there were no physical signs of abuse and she did not think there was a concern. On 5/19/24 at 3:26 p.m., the DON stated after she heard of the abuse allegation she immediately assessed the resident and she acted and appeared fine. She stated the resident was scooting out of her chair and Staff A grabbed the back of her shirt so she would not fall face forward. She immediately completed education and called the person who was mentoring the Administrator and he stated there was no harm so put it in a soft file. She stated the resident did not have any marks. She stated Staff A was prn and could return to the facility any time. She stated she did not talk to any other residents and did not ask the staff members if there were any resident witnesses. She stated she did not ask other residents if they had had concerns with Staff A. The DON stated they would report anything with harm or intent. On 5/19/24 at 3:54 p.m. via phone., Staff F Licensed Practical Nurse (LPN) stated after the incident with Staff A, Resident #1 had red marks on the front of her neck from her sweatshirt which went away in less than an hour. Observation on 5/19/24 at 4:10 p.m. revealed Resident #1 sat on the very edge of her wheelchair seat and propelled herself with her feet. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 8:18 a.m. via phone Staff A stated he was doing 1:1 with Resident #1 and she was about to fall out of the chair and he tried to prevent it by pulling her back from her pants and shirt. He stated after the incident the Administrator and DON explained to him not to hold residents that way. 2. The Quarterly 4/11/24 MDS listed diagnoses for Resident #5 which included anxiety, depression, and obesity. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, which indicated intact cognition. On 5/19/24 at 11:00 a.m., Resident #5 stated Staff A was aggressive and rough when wiping her after she had a bowel movement. On 5/19/24 at 11:00 a.m., Resident #5 stated the DON told her in front of other residents and staff that she had to move out of her private room into a shared room and said she already owed the facility money. She stated the DON saying this in front of others made her feel terrible. On 5/21/24 at 1:03 p.m., Staff I CNA stated Resident #5 was in a common area getting ready to go to her doctor's appointment and the DON told her that she would need to be paired with a roommate soon and stated that the resident owed money. The facility policy, Resident Rights, revised October 2022, stated employees shall treat all resident with kindness, respect, and dignity. Resident rights included the right to a dignified existence and the right to privacy and confidentiality. 3. The Quarterly MDS assessment tool, dated 3/14/24, listed diagnoses for Resident #9 which included heart failure, cerebrovascular accident (stroke), and anxiety and listed her BIMS score as 15 out of 15, indicating intact cognition. On 5/19/24 at approximately 3:00 p.m., Resident #9 stated when staff came into her room, they were talking to each other about other things. She stated they paid no attention to her and she felt like a number and insignificant. On 5/22/24 at 2:14 p.m., the Administrator stated after an allegation of abuse, they should assess the situation and carry out immediate protection of the 2 parties. She stated staff should treat residents with dignity and respect and should speak and engage with the residents. She stated with regard to the comment made to Resident #5 regarding her finances that that should not have happened and was a Health Insurance Portability and Accountability Act (HIPAA) violation.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to protect a resident (Resident #4) from being pinched by another resident (Resident #1) on 4/17/24 with a history of physical aggression for 1 of 1 residents reviewed for abuse. The facility reported a census of 23 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment tool, dated 4/18/24, listed diagnoses for Resident #1 which included severe intellectual disabilities, conduct disorder, and disruptive mood dysregulation disorder (a condition characterized by ongoing irritability, anger, and frequent, intense temper outbursts). The MDS stated the resident exhibited physical behavioral symptoms directed toward others such as hitting, kicking, pushing, and grabbing which occurred on 4-6 days during the 7 day review period and listed her cognition as severely impaired. A 3/22/23 Incident Audit Report stated another resident (Resident #15) yelled ow stop and the resident (#1) swatted toward the resident. The staff member did not witness contact but the other resident had a small skin tear to the top of her left hand. Her mother stated it was a good idea to keep her away from other people because with her autism if she feels like they're invading her space, she would strike out. A 3/28/23 Care Plan entry stated the resident had the potential to be physically aggressive to herself and others at times related to poor impulse control. The resident was easily upset and had mood swings, worry, and anxiety, and was easily overwhelmed and over stimulated. The resident was comforted by being on the floor and may position herself on the floor for comfort. The 3/28/23 Care Plan interventions revealed the following: Staff directed to analyze time of day, places, circumstances, triggers and what de-escalated her behavior. Music calmed the resident and she enjoyed cartoons, soft objects, and colorful things. Staff directed to assess and anticipate her needs: food thirst, toileting needs, comfort level, bed positioning, pain level. Staff directed that when she became agitated, intervene before agitation escalated, guide away from the source of distress, engage calmly in conversation ,if response is aggressive, staff to walk calmly away and approach later. A 12/25/23 Incident Audit Report stated a staff member observed Resident #1 grabbing and pulling at the back of a male resident's (Resident #2) wheelchair. The male resident called out and reported she grabbed his shoulder resulting in a pinch. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 1/1/24 Nurses Note stated Resident #1 grabbed another resident's arm (Resident #14), would not let go, and required the assistance of 3 staff members to get the resident to let go. A 1/14/24 Nurses Note stated Resident #1 bit Resident # 5. The note stated staff provided 1:1 supervision and kept her away from other resident to keep this from happening again. A 1/14/24 Incident Audit Report stated the resident bit another resident in the dining room. A 2/15/24 Care Plan entry stated the resident had been known to bite. A 2/26/24 Care Plan entry directed staff to carry out 30 minute checks around the clock. A 4/17/24 Incident Audit Report stated staff heard another resident (Resident #4) yelling ouch and the resident stated Resident #1 pinched her on the leg. The note stated the resident should be 1:1 while out of her room. A 4/23/24 Nurses Note stated Resident #1 pinched another resident (Resident #4) on 4/17/24 and remained on 1:1 supervision. On 5/19/24 at 9:25 a.m., Resident #1 sat at a table in close proximity to Staff E Certified Nursing Assistant (CNA). 2. The Admission MDS assessment tool, listed diagnoses for Resident #4 which included depression, diabetes, and chronic obstructive pulmonary disease. The MDS listed her BIMS score as 6 out of 15, indicating severely impaired cognition. On 5/20/24 at 4:25 p.m., Resident #4 stated for no reason Resident #1 came up to her and pinched her. She stated at the moment no staff were present. On 5/20/24 at 2:43 p.m., Staff G LPN stated there were many times where Resident #1 reached out to other residents. They tried to adjust her medications but it did not work and her behavior has gotten worse. Staff G stated when she first came , she did not pinch and bite. She stated the residents were told to staff away from Resident #1. She stated after Resident #1 bit Resident 5 she could see bite marks. On 5/20/24 at 3:06 p.m. Staff D CNA stated two months ago Resident #1 was not a 1:1 but after she grabbed another resident, they started 1:1's. On 5/20/24 at 3:18 p.m. Staff C CNA stated with regard to the incident between Resident #1 and Resident #4, she (Staff C) and the other aide had to go and assist 2 other residents and while they were gone Resident #1 pinched Resident #4. On 5/20/24 at 3:45 p.m., the Director of Nursing (DON) stated at the time of the incident with Resident #4, Resident #1 was not on 1:1 supervision. She stated she had not had any behaviors so they put her on 30 minute checks and after the situation with Resident #4, they placed her back on 1:1 supervision. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 8:36 a.m., the DON stated after the Resident #1 bit Resident #5 they placed her on 1:1 supervision. When her behavior was better, they changed it to 30 minute checks. She stated the resident was a roller coaster and unpredictable. She stated she did not trust her so that is why she is on 1:1 supervision. She stated she felt they could not serve her needs and reached out to other facilities that could better serve her. On 5/21/23 at 10:22 a.m. the DON stated the former Administrator removed 1:1 supervision for Resident #1 after a period of time lapsed in which she had no behaviors. The undated facility policy Abuse stated residents had the right to be free from abuse including physical abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to report an allegation of abuse to the State Agency when a staff member failed to treat a resident with dignity and respect during positioning (Resident #1) for 1 of 2 residents reviewed for an allegation of abuse. The facility reported a census of 23 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 4/18/24, listed diagnoses for Resident #1 which included severe intellectual disabilities, conduct disorder, and disruptive mood dysregulation disorder (a condition characterized by ongoing irritability, anger, and frequent, intense temper outbursts). The MDS stated the resident exhibited physical behavioral symptoms directed toward others such as hitting, kicking, pushing, and grabbing which occurred on 4-6 days during the 7-day review period and listed her cognition as severely impaired. A 3/28/23 Care Plan entry stated the resident was comforted by being on the floor and may position herself on the floor for comfort. An untitled facility investigation, dated 5/15/24, written by the Director of Nursing (DON) stated staff reported Staff A Certified Nursing Assistant (CNA) yanked the resident back by her hood and was choking her. Staff A stated the resident started to go forward in her chair and he grabbed the back of her pants and sweatshirt with one hand and grabbed the upper part of the sweatshirt with the other hand. The facility carried out education that he should grab the shoulder rather than the neck of the shirt. The facility investigation lacked documentation of other resident interviews conducted. The facility lacked documentation they reported the incident to the State Agency. On 5/19/24 at 10:41 a.m., Resident #2 stated Resident #1 tried to get out of her chair and Staff A grabbed her by the hood of her shirt and pulled on it and it choked her. He stated the resident became angry and swung at him. He stated Staff A still worked at the facility. On 5/19/24 at 12:50 p.m., via phone, Staff C (CNA) stated Staff A was trying to scoot Resident #1 back in her chair but he grabbed her by the hood (of her shirt). The resident became upset and swung to hit Staff A and she (Staff C) told him to let her go. She stated Staff A did not know how to do things. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/24 at 1:06 p.m. via phone, Staff D CNA was queried with regard to the incident with Staff A and Resident #1. She stated Staff A was new on the floor and no one in the facility received any training with regard to Resident #1. Staff D stated she was not a typical nursing home resident and was a lot more challenging. She stated no one received any training and they just went with their first instincts and this had a lot to do with the scenario. Resident #1 required 1:1 supervision and she (Staff D) was charting on the couch and another resident stated that Resident #1 was about to fall out of her chair. Staff A had her chair laid all the way back and she was on the edge and he had her by her pants and the hood of her shirt. Staff D jumped up and grabbed her pants and the resident tried to get Staff A off her and she swung and hit Staff D in the nose. Staff D noticed in the midst of this that the resident was wet and thought this was why she tried to get out of her chair. Staff D stated she did not feel like Staff A was trying to harm the resident, he just lacked training and knowledge. Staff D stated the resident had red marks on her neck from the shirt's zipper. Staff D stated Staff A continued to work the rest of the shift and also the following Friday. On 5/19/24 at 3:12 p.m., the Administrator stated with regard to the situation with Staff A, she received a phone call that there was a possible abuse. She stated they came in and completed a thorough investigation. She stated she was at the facility within 2 minutes and the resident did not have any red marks or visible sights of abuse. She stated they educated staff on how to properly prevent a fall and stated they did not remove Staff A from the facility. She stated Staff A returned to work Friday night and was as needed (prn) so he could potentially return to work. The Administrator stated they provided the survey team with the entire investigation. She stated she would not report an allegation if there were no physical signs of abuse and she did not think there was a concern. On 5/19/24 at 3:26 p.m., the DON stated after she heard of the abuse allegation she immediately assessed the resident and she acted and appeared fine. She stated the resident was scooting out of her chair and Staff A grabbed the back of her shirt so she would not fall face forward. She immediately completed education and called the person who was mentoring the Administrator and he stated there was no harm so put it in a soft file. She stated the resident did not have any marks. She stated Staff A was prn and could return to the facility any time. She stated she did not talk to any other residents and did not ask the staff members if there were any resident witnesses. She stated she did not ask other residents if they had had concerns with Staff A. The DON stated they would report anything with harm or intent. On 5/19/24 at 3:54 p.m. via phone., Staff D Licensed Practical Nurse (LPN) stated after the incident with Staff A, Resident #1 had red marks on the front of her neck from her sweatshirt which went away in less than an hour. Observation on 5/19/24 at 4:10 p.m. revealed Resident #1 sat on the very edge of her wheelchair seat and propelled herself with her feet. On 5/20/24 at 8:18 a.m. via phone Staff A stated he was doing 1:1 with Resident #1 and she was about to fall out of the chair and he tried to prevent it by pulling her back from her pants and shirt. He stated after the incident the Administrator and DON explained to him not to hold residents that way. The facility policy, Resident Rights, revised October 2022, stated employees shall treat all resident with kindness, respect, and dignity. Resident rights included the right to a dignified existence and the right to privacy and confidentiality. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 2:14 p.m., the Administrator stated after an allegation of abuse, they should assess the situation and carry out immediate protection of the 2 parties. She stated staff should treat residents with dignity and respect and should speak and engage with the residents. The undated facility policy Abuse stated all report of resident abuse would be promptly reported to State Agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews the facility failed to complete a thorough investigation and ensure immediate protection for 2 of 2 residents reviewed for an allegation of abuse (Resident #1) from a staff member and for an allegation of abuse from a fell ow resident (Resident #3). The facility reported a census of 23 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 4/18/24, listed diagnoses for Resident #1 which included severe intellectual disabilities, conduct disorder, and disruptive mood dysregulation disorder (a condition characterized by ongoing irritability, anger, and frequent, intense temper outbursts). The MDS stated the resident exhibited physical behavioral symptoms directed toward others such as hitting, kicking, pushing, and grabbing which occurred on 4-6 days during the 7-day review period and listed her cognition as severely impaired. a. A 3/28/23 Care Plan entry stated the resident was comforted by being on the floor and may position herself on the floor for comfort. An untitled facility investigation, dated 5/15/24, written by the Director of Nursing (DON) stated staff reported Staff A Certified Nursing Assistant (CNA) yanked the resident back by her hood and was choking her. Staff A stated the resident started to go forward in her chair and he grabbed the back of her pants and sweatshirt with one hand and grabbed the upper part of the sweatshirt with the other hand. The facility carried out education that he should grab the shoulder rather than the neck of the shirt. The facility investigation lacked documentation of other resident interviews conducted. On 5/19/24 at 9:25 a.m., Resident #1 sat at a table in close proximity to Staff E CNA. On 5/19/24 at 10:41 a.m., Resident #2 stated Resident #1 tried to get out of her chair and Staff A grabbed her by the hood of her shirt and pulled on it and it choked her. He stated the resident became angry and swung at him. He stated Staff A stilled worked at the facility. On 5/19/24 at 12:50 p.m., via phone, Staff C Certified Nursing Assistant (CNA) stated Staff A was trying to scoot Resident #1 back in her chair but he grabbed her by the hood (of her shirt). The resident became upset and swung to hit Staff A and she (Staff C) told him to let her go. She stated Staff A did not know how to do things. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/24 at 1:06 p.m. via phone., Staff D CNA was queried with regard to the incident with Staff A and Resident #1. She stated Staff A was new on the floor and no one in the facility received any training with regard to Resident #1. Staff D stated she was not a typical nursing home resident and was a lot more challenging. She stated no one received any training and they just went with their first instincts and this had a lot to do with the scenario. Resident #1 required 1:1 supervision and she (Staff D) was charting on the couch and another resident stated that Resident #1 was about to fall out of her chair. Staff A had her chair laid all the way back and she was on the edge and he had her by her pants and the hood of her shirt. Staff D jumped up and grabbed her pants and the resident tried to get Staff A off her and she swung and hit Staff D in the nose. Staff D noticed in the midst of this that the resident was wet and thought this was why she tried to get out of her chair. Staff D stated she did not feel like Staff A was trying to harm the resident, he just lacked training and knowledge. Staff D stated the resident had red marks on her neck from the shirts zipper. Staff D stated Staff A continued to work the rest of the shift and also the following Friday. On 5/19/24 at 3:12 p.m., the Administrator stated with regard to the situation with Staff A, she received a phone call that there was a possible abuse. She stated they came in and completed a thorough investigation. She stated she was at the facility within 2 minutes and the resident did not have any red marks or visible sights of abuse. She stated they educated staff on how to properly prevent a fall and stated they did not remove Staff A from the facility. She stated Staff A returned to work Friday night and was as needed(prn) so he could potentially return to work. The Administrator stated they provided the survey team with the entire investigation. She stated she would not report an allegation if there were no physical signs of abuse and she did not think there was a concern. On 5/19/24 at 3:26 p.m., the DON stated after she heard of the abuse allegation she immediately assessed the resident and she acted and appeared fine. She stated the resident was scooting out of her chair and Staff A grabbed the back of her shirt so she would not fall face forward. She immediately completed education and called the person who was mentoring the Administrator and he stated there was no harm so put it in a soft file. She stated the resident did not have any marks. She stated Staff A was prn and could return to the facility any time. She stated she did not talk to any other residents and did not ask the staff members if there were any resident witnesses. She stated she did not ask other residents if they had had concerns with Staff A. The DON stated they would report anything with harm or intent. On 5/19/24 at 3:54 p.m. via phone., Staff D Licensed Practical Nurse (LPN) stated after the incident with Staff A, Resident #1 had red marks on the front of her neck from her sweatshirt which went away in less than an hour. Observation on 5/19/24 at 4:10 p.m. revealed Resident #1 sat on the very edge of her wheelchair seat and propelled herself with her feet. On 5/20/24 at 8:18 a.m. via phone Staff A stated he was doing 1:1 with Resident #1 and she was about to fall out of the chair and he tried to prevent it by pulling her back from her pants and shirt. He stated after the incident the Administrator and DON explained to him not to hold residents that way. The facility policy, Resident Rights, revised October 2022, stated employees shall treat all resident with kindness, respect, and dignity. Resident rights included the right to a dignified existence and the right to privacy and confidentiality. (continued on next page)

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	165381	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Place Senior Living Campus	900 South Stone Street Sigourney, IA 52591

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 2:14 p.m., the Administrator stated after an allegation of abuse, they should assess the situation and carry out immediate protection of the 2 parties. She stated staff should treat residents with dignity and respect and should speak and engage with the residents. b. A 12/5/23 Nurses Note stated the resident refused to keep clothes on. A 12/19/23 Nurses Notes stated the resident refused staff assistance to put on a brief and pants. A 12/27/23 Behavior Note stated the resident periodically took her clothes off and staff covered her with a blanket. A 1/1/24 Nurses Note stated the resident would not leave her pants on. A 3/13/24 Nurses Note stated a Certified Medication Assistant (CMA) reported she heard the curtain to the resident's (#1) room pulled and she observed a male resident exiting the resident's room. The CMA walked into the resident's room and the resident was naked from the waist up. A 3/13/24 Incident Audit Report stated a CMA reported she heard the curtains pulled in Resident #1's room and observed a male resident exiting the room. Resident #1 was naked from the waist up. The CMA did not realize this needed reported right away and the nurse carried out education regarding this. 2. The Quarterly MDS assessment tool, dated 2/1/24, listed diagnoses for Resident #3 which included anxiety, depression, and chronic obstructive pulmonary disease. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. A 6/20/23 Nurses Note stated the resident was observed looking into another resident's room when she was resting in her bed. A Certified Nursing Assistant (CNA) stated she informed the resident that this was not acceptable behavior and to please respect another residents' privacy. An 11/1/23 Nurses Note stated the resident gave a female resident a drink and the nurse educated him to not feed or provide drinks to other residents. The note stated the resident seemed to have taken a liking to this particular resident. An 11/21/23 Nurses Note stated the resident was in a fell ow female resident's room and the nurse encouraged the resident to leave the room as he was not invited into her room and was kindly asked to leave. This resident was also noted to be giving the female resident a glass of juice and staff reminded the resident that he had already been educated on not feeding or giving drinks to other residents. The resident screamed no one ever told me that garbage. An 11/29/23 Nurses Note stated staff observed the resident feeding a fell ow female resident and the nurse educated him it was unsafe for him to feed other residents. A 12/17/23 Nurses Note stated the resident walked behind a female resident at lunch and asked staff if the resident had a bra on and ran his hand over her shoulder. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/5/24 Behavior Note stated the resident kept entering a resident's room and opened the door and pulled the curtain back. The family requested that he not go in her room or open her door. The nurse explained this to the resident and he used an expletive and stormed away. A 3/10/24 Nurses Note stated the resident attempted to take another resident to her room and staff informed him this was not allowed and a CNA would take the resident to her room to dress her. The resident's Care Plan lacked documentation the resident had a history of entering other resident's rooms and lacked direction to staff regarding guidance related to his supervision. On 5/21/24 at 8:36 a.m. the Director of Nursing (DON) stated Staff J heard the curtain closed and Resident #3 walked out of Resident #1's room and Resident #1 was naked which wasn't super unusual for the resident. She stated she didn't know if he was peeking at her but they had to protect Resident #1. They turned the situation in as abuse and called the police. The DON stated it was upsetting because Resident #1 had the mental capacity of a small child. She stated the sheriff's office came and said they would issue him a ticket for trespassing but when they input his name, they found he had a warrant in another county so he was arrested. She stated they issued him an emergency 3-day discharge while he was in jail. On 5/21/24 at 11:04 a.m., Staff J stated she heard Resident #1's room curtain shut and saw Resident #3 walk out of her room. When she went into Resident #1's room, she was sleeping but had her clothes off. She stated she did not report it right away but thought she did within the hour. She stated she assumed another staff member reported it but wasn't sure which staff member that was. She stated after she (Staff J) informed the DON, the residents were kept apart. On 5/21/24 at 12:24 p.m. Staff H Licensed Practical Nurse (LPN) stated there were a couple female residents Resident #3 was friendly to and on one instance he took Resident #13 and said he was going to assist her into her pajamas. She stated this resident was not cognitively intact and she had to intervene. On 5/21/24 at 12:42 p.m., the DON stated she was not aware he tried to assist a resident in getting ready for bed. She stated she would want staff to notify her right away if he was exiting Resident #1's room. She stated she did not locate a timeline for the day in question but would continue looking. She stated she was not aware that he rubbed another resident's shoulders and stated she could not care plan for issues she did not know about. On 5/22/24 at 2:14 p.m., the Administrator stated after an allegation of abuse, they should assess the situation and carry out immediate protection of the 2 parties. On 5/22/24 at 2:50 p.m., the DON stated if she had known about Resident #3 being in other resident rooms, she would have care planned and directed staff to know what he was doing on a regular basis. The facility policy, Resident Rights, revised October 2022, stated residents had the right to privacy. The undated policy Abuse, stated the facility would carry out timely and thorough investigations of all reports and allegations of abuse and stated the alleged perpetrator would immediately be removed and the resident protected.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to adequately supervise a resident (Resident #3) in order to protect another resident's personal privacy (Resident #1) for 2 of 5 residents reviewed for supervision. The facility reported a census of 23 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 4/18/24, listed diagnoses for Resident #1 which included severe intellectual disabilities, conduct disorder, and disruptive mood dysregulation disorder (a condition characterized by ongoing irritability, anger, and frequent, intense temper outbursts). The MDS listed her cognition as severely impaired. The facility policy, Resident Rights, revised October 2022, stated residents had the right to privacy. A 12/5/23 Nurses Note stated the resident refused to keep clothes on. The Care Plan intervention dated 12/6/23 documented Resident #1 often disrobes and to allow her privacy to do so. A 12/19/23 Nurses Notes stated the resident refused staff assistance to put on a brief and pants. A 12/27/23 Behavior Note stated the resident periodically took her clothes off and staff covered her with a blanket. A 1/1/24 Nurses Note stated the resident would not leave her pants on. A 3/13/24 Nurses Note stated a Certified Medication Assistant (CMA) reported she heard the curtain to the resident's (#1) room pulled and she observed a male resident exiting the resident's room. The CMA walked into the resident's room and the resident was naked from the waist up. A 3/13/24 Incident Audit Report stated a CMA reported she heard the curtains pulled in Resident #1's room and observed a male resident exiting the room. Resident #1 was naked from the waist up. The CMA did not realize this needed reported right away and the nurse carried out education regarding this. 2. The Quarterly MDS assessment tool, dated 2/1/24, listed diagnoses for Resident #3 which included anxiety, depression, and chronic obstructive pulmonary disease. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, which indicated intact cognition. A 6/20/23 Nurses Note stated the resident was observed looking into another resident's room when she was resting in her bed. A Certified Nursing Assistant(CNA) stated she informed the resident that this was not acceptable behavior and to please respect other residents privacy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An 11/1/23 Nurses Note stated the resident gave a female resident a drink and the nurse educated him to not feed or provide drinks to other residents. The note stated the resident seemed to have taken a liking to this particular resident. An 11/21/23 Nurses Note stated the resident was in a fell ow female resident's room and the nurse encouraged the resident to leave the room as he was not invited into her room and was kindly asked to leave. This resident was also noted to be giving the female resident a glass of juice and staff reminded the resident that he had already been educated on not feeding or giving drinks to other residents. The resident screamed no one ever told me that garbage. An 11/29/23 Nurses Note stated staff observed the resident feeding a fell ow female resident and the nurse educated him it was unsafe for him to feed other residents. A 12/17/23 Nurses Note stated the resident walked behind a female resident at lunch and asked staff if the resident had a bra on and ran his hand over her shoulder. A 3/5/24 Behavior Note stated the resident kept entering a resident's room and opened the door and pulled the curtain back. The family requested that he not go in her room or open her door. The nurse explained this to the resident and he used an expletive and stormed away. A 3/10/24 Nurses Note stated the resident attempted to take another resident to her room and staff informed him this was not allowed and a CNA would take the resident to her room to dress her. The resident's Care Plan lacked documentation the resident had a history of entering other resident's rooms and lacked direction to staff regarding guidance related to his supervision. On 5/21/24 at 8:36 a.m. the Director of Nursing (DON) stated Staff J heard the curtain closed and Resident #3 walked out of Resident #1's room and Resident #1 was naked which wasn't super unusual for the resident. She stated she didn't know if he was peeking at her but they had to protect Resident #1. They turned the situation in as abuse and called the police. The DON stated it was upsetting because Resident #1 had the mental capacity of a small child. She stated the sheriff's office came and said they would issue him a ticket for trespassing but when they input his name, they found he had a warrant in another county so he was arrested. She stated they issued him an emergency 3 day discharge while he was in jail. On 5/21/24 at 11:04 a.m., Staff J stated she heard Resident #1's room curtain shut and saw Resident #3 walk out of her room. When she went into Resident #1's room, she was sleeping but had her clothes off. She stated she did not report it right away but thought she did within the hour. She stated she assumed another staff member reported it but wasn't sure which staff member that was. She stated after she (Staff J) informed the DON, the residents were kept apart. On 5/21/24 at 12:24 p.m. Staff H Licensed Practical Nurse (LPN) stated there were a couple female residents Resident #3 was friendly to and on one instance he took Resident #13 and said he was going to assist her into her pajamas. She stated this resident was not cognitively intact and she had to intervene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 12:42 p.m., the DON stated she was not aware he tried to assist a resident in getting ready for bed. She stated she would want staff to notify her right away if he was exiting Resident #1's room. She stated she did not locate a timeline for the day in question but would continue looking. She stated she was not aware that he rubbed another resident's shoulders and stated she could not care plan for issues she did not know about. On 5/22/24 at 2:50 p.m., the DON stated if she had known about Resident #3 being in other resident rooms, she would have care planned and directed staff to know what he was doing on a regular basis.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to provide sufficient staff with skill sets to care for a cognitively impaired resident who required 1:1 supervision (Resident #1) and a resident with behaviors affecting others (Resident #3). The facility reported a census of 23 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 4/18/24, listed diagnoses for Resident #1 which included severe intellectual disabilities, conduct disorder, and disruptive mood dysregulation disorder. The MDS stated the resident exhibited physical behavioral symptoms directed toward others such as hitting, kicking, pushing, and grabbing which occurred on 4-6 days during the 7 day review period and listed her cognition as severely impaired. A 3/28/23 Care Plan entry stated the resident was comforted by being on the floor and may position herself on the floor for comfort. An untitled documented, referred to by the Director of Nursing (DON) as a Walking Care Plan and updated 2/14/24, directed staff to provide the resident with objects to hold and keep her away from other residents. The document lacked further direction for staff regarding how to handle her behaviors and lacked documentation on how to assist the resident out of her wheelchair if she tried to exit the chair. An untitled facility investigation, dated 5/15/24, written by the DON stated staff reported Staff A Certified Nursing Assistant (CNA) yanked the resident back by her hood and was choking her. Staff A stated the resident started to go forward in her chair and he grabbed the back of her pants and sweatshirt with one hand and grabbed the upper part of the sweatshirt with the other hand. The facility carried out education that he should grab the shoulder rather than the neck of the shirt. The facility investigation lacked documentation of other resident interviews conducted. On 5/19/24 at 9:25 a.m., Resident #1 sat at a table in close proximity to Staff E CNA. Observation on 5/19/24 at 4:10 p.m. revealed Resident #1 sat on the very edge of her wheelchair seat and propelled herself with her feet. On 5/19/24 at 10:41 a.m., Resident #2 stated Resident #1 tried to get out of her chair and Staff A grabbed her by the hood of her shirt and pulled on it and it choked her. He stated the resident became angry and swung at him. He stated Staff A still worked at the facility. On 5/19/24 at 12:50 a.m., Staff C CNA stated Staff A was trying to scoot Resident #1 back in her chair but he grabbed her by the hood of her shirt. The resident became upset and swung to hit Staff A and she (Staff C) told him to let her go. She stated Staff A did not know how to do things. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/24 at 1:06 p.m. via phone., Staff D CNA was queried with regard to the incident with Staff A and Resident #1. She stated Staff A was new on the floor and no one in the facility received any training with regard to Resident #1. Staff D stated she was not a typical nursing home resident and was a lot more challenging. She stated no one received any training and they just went with their first instincts and this had a lot to do with the scenario. Resident #1 required 1:1 supervision and she (Staff D) was charting on the couch and another resident stated that Resident #1 was about to fall out of her chair. Staff A had her chair laid all the way back and she was on the edge and he had her by her pants and the hood of her shirt. Staff D jumped up and grabbed her pants and the resident tried to get Staff A off her and she swung and hit Staff D in the nose. Staff D noticed in the midst of this that the resident was wet and thought this was why she tried to get out of her chair. Staff D stated she did not feel like Staff A was trying to harm the resident, he just lacked training and knowledge. Staff D stated the resident had red marks on her neck from the shirts zipper. Staff D stated Staff A continued to work the rest of the shift and also the following Friday. On 5/19/24 at 3:12 p.m., the Administrator stated with regard to the situation with Staff A, she received a phone call that there was a possible abuse. She stated they came in and completed a thorough investigation. She stated she was at the facility within 2 minutes and the resident did not have any red marks or visible sights of abuse. She stated they educated staff on how to properly prevent a fall and stated they did not remove Staff A from the facility. She stated Staff A returned to work Friday night and was as needed (prn) so he could potentially return to work. The Administrator stated they provided the survey team with the entire investigation. She stated she would not report an allegation if there were no physical signs of abuse and she did not think there was a concern. On 5/19/24 at 3:26 p.m., the DON stated after she heard of the abuse allegation she immediately assessed the resident and she acted and appeared fine. She stated the resident was scooting out of her chair and Staff A grabbed the back of her shirt so she would not fall face forward. She immediately completed education and called the person who was mentoring the Administrator and he stated there was no harm so put it in a soft file. She stated the resident did not have any marks. She stated Staff A was prn and could return to the facility any time. She stated she did not talk to any other residents and did not ask the staff members if there were any resident witnesses. She stated she did not ask other residents. if they had had concerns with Staff A. The DON stated they would report anything with harm or intent. On 5/19/24 at 3:54 p.m. via phone., Staff D Licensed Practical Nurse (LPN) stated after the incident with Staff A, Resident #1 had red marks on the front of her neck from her sweatshirt which went away in less than an hour. On 5/20/24 at 8:18 a.m. via phone Staff A stated he was doing 1:1 with Resident #1 and she was about to fall out of the chair and he tried to prevent it by pulling her back from her pants and shirt. He stated after the incident the Administrator and DON explained to him not to hold residents that way. 2. The MDS assessment tool, dated 2/1/24, listed diagnoses for Resident #3 which included anxiety, depression, and chronic obstructive pulmonary disease. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 6/20/23 Nurses Note stated the resident was observed looking into another resident's room when she was resting in her bed. A CNA stated she informed the resident that this was not acceptable behavior and to please respect other residents privacy. An 11/1/23 Nurses Note stated the resident gave a female resident a drink and the nurse educated him to not feed or provide drinks to other residents. The note stated the resident seemed to have taken a liking to this particular resident. A 11/21/23 Nurses Note stated the resident was in a fell ow female resident's room and the nurse encouraged the resident to leave the room as he was not invited into her room and was kindly asked to leave. This resident was also noted to be giving the female resident a glass of juice and staff reminded the resident that he had already been educated on not feeding or giving drinks to other residents. The resident screamed no one ever told me that garbage. A 11/29/23 Nurses Note stated staff observed the resident feeding a fell ow female resident and the nurse educated him it was unsafe for him to feed other residents. A 12/17/23 Nurses Note stated the resident walked behind a female resident at lunch and asked staff if the resident had a bra on and ran his hand over her shoulder. A 3/5/24 Behavior Note stated the resident kept entering a resident's room and opened the door and pulled the curtain back. The family requested that he not go in her room or open her door. The nurse explained this to the resident and he used an expletive and stormed away. A 3/10/24 Nurses Note stated the resident attempted to take another resident to her room and staff informed him this was not allowed and a CNA would take the resident to her room to dress her. The resident's Care Plan lacked documentation the resident had a history of entering other resident's rooms and lacked direction to staff regarding guidance related to his supervision. On 5/21/24 at 8:36 a.m. the DON stated Staff J heard the curtain closed and Resident #3 walked out of Resident #1's room and Resident #1 was naked which wasn't super unusual for the resident. She stated she didn't know if he was peeking at her but they had to protect Resident #1. They turned the situation in as abuse and called the police. The DON stated it was upsetting because Resident #1 had the mental capacity of a small child. She stated the sheriff's office came and said they would issue him a ticket for trespassing but when they input his name, they found he had a warrant in another county so he was arrested. She stated they issued him an emergency 3 day discharge while he was in jail. On 5/21/24 at 11:04 a.m., Staff J stated she heard Resident #1's room curtain shut and saw Resident #3 walk out of her room. When she went into Resident #1's room, she was sleeping but had her clothes off. She stated she did not report it right away but thought she did within the hour. She stated she assumed another staff member reported it but wasn't sure which staff member that was. She stated after she (Staff J) informed the DON, the residents were kept apart. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 12:24 p.m. Staff H Licensed Practical Nurse (LPN) stated there were a couple female residents Resident #3 was friendly to and on one instance he took Resident #13 and said he was going to assist her into her pajamas. She stated this resident was not cognitively intact and she had to intervene. On 5/21/24 at 12:42 p.m., the DON stated she was not aware he tried to assist a resident in getting ready for bed. She stated she would want staff to notify her right away if he was exiting Resident #1's room. She stated she did not locate a timeline for the day in question but would continue looking. She stated she was not aware that he rubbed another resident's shoulders and stated she could not care plan for issues she did not know about. On 5/22/24 at 2:50 p.m., the DON stated if she had known about Resident #3 being in other resident rooms, she would have care planned and directed staff to know what he was doing on a regular basis. 3. Review of staff training/education for the time period of 5/21/23 to 5/22/24 revealed the training files of Staff A CNA, Staff B CNA, Staff C CNA, Staff D CNA, and Staff E CNA lacked documentation of education completed related to resident behavioral health needs. The facility policy Required Training, Certification and Continuing Education of Nurse Aides, dated 12/1/23, stated the facility would provide 12 hours of in-service training annually and would included dementia management and care of the cognitively impaired and behavioral health training. The facility policy Behavioral Assessment, Intervention, and Monitoring, revised September 2022, stated each resident shall receive and the facility would provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The policy stated the facility would evaluate whether the staffing needs had changed based on the acuity of the residents and their plans of care and stated additional staff and/or staff training would be provided if it was determined that the needs of the residents could not be met with the current level of staff of staff training. The untitled Facility Assessment, updated 5/15/24, stated the facility cared for an average of 8 residents with behavioral health needs and listed staff competencies to include caring for residents with mental and psychosocial disorders. The assessment stated the facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to attain or maintain the highest practicable mental and psychosocial well-being. The assessment stated the facility must provide behavioral health training consistent with the requirements at 483.40. On 5/22/24 at 2:50 p.m., the DON stated staff referred to the walking care plan and had 5 days of orientation regarding the residents. She stated with regard to Resident #1 and Resident #3, it may have helped for them to go through behavioral health training. She stated with regard to Resident #1, staff are told in orientation that it is ok for her to be on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165381	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Place Senior Living Campus	900 South Stone Street Sigourney, IA 52591

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35434 Based on record review, policy review, and staff interview, the facility failed to carry out quality assurance (QA) activities in order to address problem-prone areas and create a plan for improvement. The facility reported a census of 23 residents. Findings: The Centers for Medicare and Medicaid Services (CMS) 2567, dated 6/29/23, listed the following concerns: F550, F609, F610. The CMS 2567, dated 11/30/23, listed the following concerns: F550, F609. The CMS 2567, dated 1/25/24, listed the following concerns: F689. Review of facility QA activities for the period of 1/1/24-5/19/24 revealed a 2/28/24 QA Committee sheet with the topic of all Plan of Correction (POC) tags. The QA documentation lacked further documentation related to the above concern areas including data collection, monitoring, audits, input from staff, and performance indicators. The facility lacked documentation the QA committee systematically identified, reported, tracked, investigated, analyzed and or utilized data to develop activities to prevent future adverse events. The current survey, conducted from 5/19/24-5/22/24 also identified the above concerns. The undated policy Quality Assurance and Performance Improvement (QAPI) stated the facility would maintain documentation to demonstrate evidence of it's ongoing QAPI program which may included but was not limited to: -systems and reports demonstrating systematic identification , reporting, investigation, analysis, and prevention of adverse events; and -documentation demonstrating the development , implementation , and evaluation of corrective actions or performance improvement activities. On 5/22/24 at 2:14 p.m., the Administrator stated they should be carrying out QA activities related to former survey concerns. She stated they should cover abuse prevention every month.