STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165401	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sibley Specialty Care	700 Ninth Avenue North Sibley, IA 51249

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 1 out of 3 residents (Resident #1) reviewed from physical abuse. The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of hypertension, non- Alzheimer's dementia and anxiety disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Review of the Progress Notes revealed: On 6/6/24 at 10:02 a.m., at approximately 5:45 a.m., nurse aid reports to nurse manager while resident was being assisted to the bathroom with 2-assist, per plan of care, nurse aid's partner struck resident in the upper left arm. Reporting nurse aid stated the resident was being very rude and physically and verbally aggressive towards the two nurse aids, and the other nurse aid appeared to become upset and hit the resident after she had hit him. Resident stated you can't hit me, and verbalized the nurse aid hit her in the upper left arm, and she wanted to report him. Nurse aid was immediately separated from resident and was kept away from all other residents. Administrator updated, and assessment completed on resident. Assessment completed on resident; no redness, bruising, discoloration, swelling noted to affected extremity. Vital signs within normal limits. No emotional distress noted to the resident; the resident was sitting calmly in a chair with eyes closed when nursing entered the room. Resident denied pain to the area during assessment, but statedit hurt when it happened, he got me good. Active range of motions within normal limits. Family, provider, and appropriate agencies also updated regarding the situation. Review of Facility Reported Incident Investigation revealed the following information: (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Statement by Staff D, Certified Nursing Assistant (CNA) dated 6/6/24 revealed: at approximately 5:45 a.m. , the nurse requested my partner and I to take Resident #1 to the bathroom so Staff E, CNA and I walked to Resident #1's room and opened the bathroom door and put her gait belt on. Resident was yelling at the staff seemingly unprovoked and when it was time to stand the resident up, Staff E seemed to forcefully stand her up by himself. Resident then yelled at Staff E and called him names and then hit him. At that time, Staff E then used a closed fist and hit her on her left upper arm and seemed to tighten the gait belt in his right hand by using a twisting motion. Resident #1 stated you don't hit me and Staff E responded to her with well you hit me first. Resident told Staff E not so tight and that she was going to report him. Staff E did not lessen the twisting motion on the gait belt until we got to the bathroom doorway. Staff D had a hold of her going towards the toilet and then Staff E went on the right side of her and held the gait belt while Staff D pulled her pants down to the toilet. Resident sat on the toilet and Staff D helped take off her soiled depends and clothing. Resident then started yelling at Staff D asking what I was doing, and Staff D told her that her pants were soiled and that I was just trying to help her. Resident responded with I know you are, but that bastard isn't and I am going to report him. Resident was then assisted with getting clean underwear on and wanted to sit on the toilet for a few minutes to finish. Staff D then went to the nurse manager that was on duty and told her what happened. b. Statement by Staff F, Registered Nurse (RN) dated 6/624 revealed: Resident #1 stated that Staff E better watch out. Staff F asked why. Resident #1 replied he hit me with his fist right here (points to left upper extremity). He's naughty. Staff F replied Thank you for letting me know. Resident responded you're welcome. c. Statement by Staff G, Social Worker and Administrator dated 6/6/24 at 2:00 p.m., revealed; Staff G joined Administrator to interview Resident #1. Resident #1's husband was present in the room. Administrator asked Resident #1 about an incident this morning, she could not recall anything. Administrator asked Resident #1's husband if she reported anything to him when he arrived this morning. He responded no. Resident #1 was then asked if she has had any trouble with any staff over the past couple of days, she identified Staff E. When asked what happened, Resident #1 revealed Staff E made a fist at her this morning. Staff G asked if Staff E hit her and she replied no. Staff G asked Resident #1 to lift her arm and if she has any pain. Resident #1 was able to move without pain. Staff G asked Resident #1 if she was afraid of Staff E and she said no but does not want him to work with her anymore. d. Review of text message screen shot from Staff E's phone number a message dated 6/6/24 at 6:34 a.m., stated sorry you had to see me lose my temper with Resident #1. Interview on 6/27/24 at 10:34 a.m., with Staff F revealed it was the beginning of her shift and she was working on doing vital signs and assessments. She needed to get Resident #1's vitals. When she entered Resident #1's room she was awake so she started talking to her and explained she was going to get her vital signs. Resident #1 told Staff F that Staff E better watch out. Staff F asked her why. Resident #1 revealed Staff E hit me right here (pointed to her left upper arm) with his fist. Staff E told Resident #1 ok thank you for letting me know. Staff E assessed the area and revealed no redness, swelling, bruising noted to the area. Resident #1 had no restrictions on her range of motion (ROM). After Staff F exited the room she told Staff C about the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/27/24 at 11:58 a.m., with Staff C, RN, Assistant Director of Nursing (ADON) revealed she had come in that morning and around 5:30 a.m., Staff D came into her office and looked upset so she asked her what was going on. Staff D reported when her and Staff E were assisting Resident #1 to the bathroom, Resident #1 had smacked Staff E and he hit her back. Resident #1 stated you can't hit me, Staff D reported she froze in the room for a minute and finished assisting Resident #1 to the toilet and exited the room. Staff C watched Staff E leave the facility and then called the Director of Nursing (DON) and the Administrator. Approximately an hour later Staff C went into Resident #1's room and she was sitting in a recliner with her eyes closed. Staff C asked Resident #1 how her arm was feeling. Resident #1 stated Staff E got me good. He hit me. Staff C assessed the area at that time and there was no redness, swelling or pain noted. Resident #1 stated it hurt then he got me good. Interview on 6/26/24 at 12:14 p.m., with Staff H, RN revealed she had come in after the incident had occurred. She was asked by Staff C to do an assessment of Resident #1 as there was an allegation of Staff E striking her. Staff H assessed Resident #1 and seemed to be in good spirits, denied pain, had good ROM and no hematoma present. Resident #1 told Staff H that Staff E had struck her in her arm. Resident #1 was upset when she was talking about it and was upset that a situation like this could occur. Staff H did reassess the area throughout the day and if indication of bruising, inflammation or hematoma was present. Interview on 6/27/24 at 5:38 p.m., with Staff D revealed Staff F asked Staff D and Staff E to assist Resident #1 to the bathroom. Staff D explained Staff E applied the gait belt and when Resident #1 was ready to stand up. Staff E took the gait belt and picked her up aggressively by himself. Staff D did not assist in the transfer to stand. Staff E further revealed when they were walking Resident #1 to the bathroom Resident #1 appeared to be mad at Staff E and Resident #1 hit Staff E. Staff E with a closed fist hit Resident #1 in her left upper arm. Resident #1 told Staff E you don't hit me, I am going to report you. Staff E replied in an aggressive tone you hit me first, Staff D explained she said to Resident #1 let's continue to the bathroom. Staff D explained Staff E was getting impatient with Resident #1 and started twisting the gait belt and it was getting tighter. Staff D explained once Resident #1 was on the toilet and she assisted her with care. Staff D revealed Resident #1 told her she knew she was trying to help her but that bastard isn't. Staff D and Staff E finished assisting Resident #1 and left her in the restroom to finish. Staff D went and reported to Staff C about the incident when she left the room. Staff D stated she received a text message from Staff E saying sorry you had to see me lose my temper with Resident #1. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revision date of April 2021 revealed residents have the right to be free from abuse. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems. Provide staff orientation and training or orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. Review of the facility policy titled Identifying Types of Abuse with a revision date of April 2021 revealed abuse of any kind against residents is strictly prohibited. Physical abuse includes but is not limited to hitting. Interview on 6/28/24 at 9:54 a.m., with The Administrator revealed during his investigation he knows something happened but does not know exactly what happened. The Administrator further revealed the facility takes all allegations of abuse seriously.