STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165428	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careage Hills Rehabilitation and Healthcare	725 North Second Street Cherokee, IA 51012

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** 41785 Based on observation, interview and record review the facility failed to ensure that residents were free from abuse for 1 of 4 residents. Resident #1 fell to the floor and sustained a hematoma on the back of his head after another resident pushed him down. The facility reported a census of 33 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive deficit). The resident required set up assistance with eating, and was independent with walking, transfers and toileting. His diagnosis included benign prostatic hyperplasia (BPH), Diabetes Mellitus, and non-Alzheimer's dementia. During observation on 11/4/24 at 12:40 PM, Resident #1 had just finished his lunch. He was pacing the hallway near his room and the door to the outside where the residents took their smoke breaks. He went back into the dining room and in and out of his room several times. At 12:58 PM he was sitting in chair near a large fish tank, when a staff member came and escorted the group out to the patio for their cigarette break. The Care Plan updated on 7/1/24, showed that Resident #1 was allowed to smoke during designated smoking times that were offered 4 times a day. He participated with psychiatric services for evaluation and response to psychotropic medications. Resident #1 had impaired cognitive function with short term memory loss and had periods of agitation. According to Incident Report dated 8/5/24 at 7:30 PM, the nurse on duty that evening heard a loud bang. When she went to investigate, she found Resident #1 was flat on his back on the floor in front of the fish tank. The resident said he pushed me and pointed at another resident (Resident #2). Staff called for the police and an ambulance. A Nursing Note dated 8/5/24 at 11:50 PM, showed that the two residents were immediately separated. Resident #1 was taken to the emergency room and returned soon after with diagnosis of post traumatic subdural hematoma. (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	An emergency room (ER) report dated 8/5/24 at 7:37 PM, showed that Resident #1 presented to the ER with a contusion to the back of the head and he complained of neck pain. The patient demonstrated the ability to move from the ambulance cot, stand, walk and transfer himself to the ER cot. A head scan showed the resident had sustained a small 4 millimeter (mm) subdural hematoma. The ER doctor consulted with the neurosurgeon at 8:35 PM, and they decided to send him back to the nursing home with increased monitoring. The MDS for Resident #2, dated 7/31/24, showed that he was admitted to the facility on [DATE] from the community. He had a BIMS score of 4 (severe cognitive deficit). He required set up assistance only for eating and dressing, and was totally independent with walking, transferring and toileting. His diagnosis included heart failure, peripheral vascular disease, diabetes mellitus and non-Alzheimer's dementia and adjustment disorder with mixed anxiety and depressed mood. An Incident Report dated 8/5/24 at 7:30 PM, showed that Resident #2 didn't say anything when Resident #1 accused him of pushing him down, but other residents saw the incident and said that Resident #2 did indeed push Resident #1. During interview on 11/4/24 at 3:00 PM Staff A, Certified Nurse Aide (CNA), said that she was working on 8/5/24 when Resident #1 fell . She said that it was after supper and she did not witness the event, but was in the area shortly after. Resident #2 was sitting in chair by the outside door and said I didn't do nothing. He then told her that Resident #1 threw water on him. Staff A said that most of the other resident's present said they didn't see anything but one said I'm not snitching. Staff A said that when it got close to 7:00 PM, Resident #1 tended to get more agitated as he waited for cigarette breaks. During interview on 11/4/24 at 2:09 PM Staff C, Certified Medication Aide (CMA) said that she did not know what was going on but saw Resident #1 on the ground. She said that Resident #1 tended to antagonize other residents and he gets naughty. She said that she knew of incidences where he had raised his hand to a CNA and threatened to hit her. During interview on 11/4/24 at 2:01 PM Staff D, CNA said that she was working the night of 8/5/24 but did not see the incident. She asked the other residents that were present but they said they hadn't seen anything. She said that Resident #1 told her that Resident #2 had pushed him, and that she had seen them get upset before and yell at each other. Staff D said that Resident #1 had threatened many people and if he didn't get out for a cigarette break, he would get especially agitated. She said that he had run toward her once with his hand in the air when another employee stepped in. On 11/5/24 at 4:15 PM, the Director of Nursing (DON) said that none of the staff witnessed the incident between Resident #1 and #2. She said that she had completed phone interviews with the staff that worked that night. She was not aware of any other altercations between the two residents. On 11/5/24 at 4:15 PM, the Administrator said that they did not know that Resident #2 had a history of aggressive behavior before he was admitted to the facility. She said that they gave the family a 30 day notice after the incident. She said that Resident #2 would antagonize other residents, for example, he would take a drink out of other resident's cups and that caused the increase in agitation the night of the fall. Apparently, he took a drink out of the cup that Resident #1 had, there were words back and forth, which led to the aggression. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a facility policy titled: Resident Rights, Abuse Prevention and Reporting last revised on 05/2007, residents must not be subjected to abuse by anyone, including .other residents. The Administration would maintain evidence that all alleged violations were thoroughly investigated.

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NAME OF PROVIDER OR SUPPLIER: Careage Hills Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 725 North Second Street Cherokee, IA 51012	

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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	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to thoroughly investigate alleged abuse for 1 of 3 residents, and failed to investigate an injury of unknown origin for 1 of 1 resident reviewed. The facility reported a census of 33 residents Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive deficit). The resident required set up assistance with eating, and was independent with walking, transfers and toileting. His diagnosis included benign prostatic hyperplasia (BPH), Diabetes Mellitus, and non-Alzheimer's dementia. The Care Plan updated on 7/1/24, showed that Resident #1 was allowed to smoke during designated smoking times that were offered 4 times a day. He participated with psychiatric services for evaluation and response to psychotropic medications. Resident #1 had impaired cognitive function with short term memory loss and had periods of agitation. According to an Incident Report dated 8/5/24 at 7:30 PM, the nurse on duty heard a loud bang down the hallway and found that Resident #1 was flat on his back on the floor in front of the fish tank. The resident said he pushed me and pointed at another resident (Resident #2). Staff called for the police and an ambulance. On 11/4/24 at 1:32 PM the Director of Nursing said that she did not have documentation of witness statements. She said that she called the staff, but none of them saw what happened. During interview on 11/4/24 at 3:00 PM Staff A, Certified Nurse Aide (CNA) said that she worked the evening of 8/5/24. It was after supper when another CNA told her that Resident #1 was on the floor. She said that Resident #2 was sitting in chair near the outside door and told her I didn't do nothing. Resident #2 told her that Resident #1 threw water on him and all the other residents sitting around said that they hadn't see anything. Staff A did not remember having been interviewed by the DON or having submitted a signed statement During interview on 11/4/24 at 2:17 PM Staff B, CNA, said that she was present the night of the incident but hadn't seen anything. Later that evening another resident that had been present told her; you should've seen that guy getting laid out. During interview on 11/4/24 at 2:01 PM Staff D, CNA, said that she worked the evening of 8/5/24. She did not see it happen but Resident #1 told her that Resident #2 pushed him down. She said that they would get upset with each other and say mean things to each other. She said that she hadn't completed a signed statement. 2) According to the MDS dated [DATE], Resident #4 was admitted to the facility on [DATE]. She had moderate difficulty with hearing and a BIMS score of 5 (severe cognitive deficit). Resident #4 was independent with dressing, hygiene, sit to stand, transfers and walking. Her diagnosis included non-Alzheimer's dementia, cerebrovascular accident (CVA), chronic pain and osteoporosis. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan updated on 4/3/24, showed Resident #4 had the potential for injury related to smoking. She had the potential for impairment to skin integrity and was at risk for falls. Staff were to use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Resident #4 was on anti-platelet mediation, staff were directed to monitor for signs and symptoms of bleeding and to notify the doctor. A Nursing Note dated 6/28/24 at 10:33 PM, showed that Resident #4 had scattered dark bruising to the bilateral lower extremities and was reporting extreme pain to her lower back. A fax was sent to the doctor. Follow up Nursing Notes dated; 6/29/24 at 1:50 PM, 6/29 at 11:05 PM, 6/30 at 3:41 PM, and 6/30 at 11:46 PM, indicated that the resident had been up as usual and ambulated around the facility. Scattered bruising was present but no complaints of pain. The chart lacked description or measurements of the bruising. A Skin Evaluation /Weekly Evaluation (SEWE), dated 6/23/24 at 12:56 PM showed no new skin issues. A SEWE dated 6/30 at 1:38 PM, showed that the resident had scattered bruising of different sizes and stages of healing to the Bilateral Lower Extremities (BLE). The documentation lacked measurements. On 11/5/24 at 2:07 PM, Staff E, Licensed Practical Nurse (LPN), said that when she saw the bruising on the legs of Resident #4, on 6/28/24, she was surprised to find that there hadn't been any documentation of it. She said that when there was an unexplained, new skin issue the nurse would complete a risk management incident report. She tried to remember but thought that the resident denied pain, and the bruising was scattered, mostly on the front of the legs above the knees and near the hip. Staff E said that she would have passed it onto the next shift. On 11/5/24 at 10:25 AM, Staff F, Registered Nurse (RN) acknowledged that she had completed a skin evaluation for Resident #4 and saw that she had tiny bruises at various stages of healing. She said I probably should have measured and charted that. When asked what the process was for investigating unknown causes she said I've always been able to explain them and added that the resident must have bumped her leg on something. She did not know if there was an investigation on the cause of the bruising. On 11/5/24 at 2:12 PM when asked if there were any incident reports for Resident #4, the Administrator said that they did not have any. On 11/5/24 at 3:50 PM, Staff G, CNA brought Resident #4 into the whirlpool room for a bath. She asked the resident if we could look at her legs. The resident agreed and removed her pants on her own. She had a dark purple bruise on the inside of left thigh, a couple smaller bruises further down her left leg and one on the top of her right leg. The resident was unable to state how she got the bruising. On 11/5/24 at 4:15 PM, the DON said that she was not aware of new skin concerns for Resident #4. She said that she expected the nurses to initiate a risk assessment form with any change in skin condition, including bruises. She said that Resident #4 often put her hands in her pockets and pinched herself in those areas where there's bruising but she would have wanted to know so she could do an investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a facility policy titled: Resident Rights, Abuse Prevention and Reporting last revised 05/2007, residents must not be subjected to abuse by anyone, including .other residents. The Administration would maintain evidence that all alleged violations were thoroughly investigated. Any staff member who had reasonable cause to believe or reason to suspect any situation may be considered abuse or neglect along with injuries of unknown origin, including any bruises, skin tears or other injures would immediately report to the charge nurse. The charge nurse would complete an initial investigation to attempt to determine the cause of the injury through interviews of staff, resident and witnesses. Statements should include all details. Witnesses were encouraged to give a signed statement. The Administrator, Director of Nursing Services, Staff Development Coordinator and Social Service Director would review the incident. Any incident would be investigated by interviewing resident, staff and or other witnesses.