STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165444	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Bend Health and Rehabilitation	203 Fourth Street NW West Bend, IA 50597

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to treat each resident in a manner that promoted dignity and respect for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 43 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #4 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had diagnoses including non-Alzheimer's dementia. The Care Plan dated 9/16/24 identified Resident #4 at risk for depression related to wanting to return back to the community, with the goal to remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood. Interventions included monitoring/documenting/reporting signs/symptoms of depression to the nurse/doctor including hopelessness, anxiety, sadness, and negative statements. A facility report by the Administrator and Interim Director of Nursing (DON) documented receipt of a reported incident on 12/9/24 at approximately 12:30 p.m. Staff B Certified Nursing Assistant (CNA) notified them during walking rounds (at 6 a.m.) on 12/7/24 she heard Staff G CNA say Resident #4 had been on the call light non-stop for the last 4 hours to go to the bathroom. Later, Staff B went to get the resident up for lunch. Resident #4 said she heard that guy complaining about taking her to the bathroom so she figured she would just stay in bed and pee the bed rather than have someone complain about her. In a statement signed 12/9/24, Staff A CNA said during walking rounds on Saturday (12/7/24) Staff G was cussing about every resident for example, for 1 resident he said he was full of f***ing s**t when referring to a bowel movement. As walking rounds continued they approached Resident #4's room. Staff G CNA said Resident #4 was f***ing annoying because she was up every hour for the last 4 hours asking to go to the bathroom and not doing anything. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 9:29 a.m. Staff B CNA stated Saturday 12/7/24 she did not feel good and heard something about how Resident #4 had been on her light a lot to go to the bathroom. Staff B was training a new girl Staff H CNA on her first day down north hallway. She went to get people up for lunch and Resident #4 still laid in bed in her white pajamas. Staff B said let's get up and go to the bathroom and Resident #4 said no. Staff B asked why and the resident said she heard Staff G complaining about her that morning and she wasn't going to pull her light, and she didn't want to go to the bathroom. Staff B said she was there to get her dressed and get cleaned up. When Staff B pulled back the blankets, Resident #4 was soaked. They walked her to the bathroom and then changed her clothes and cleaned her up so that she didn't feel sticky, and got her ready for the day. Staff B told Staff F Registered Nurse (RN) about it on Saturday. She didn't know if it got addressed so she talked to the DON on Monday. She just wanted to make sure they took care of, that something was said. On 12/12/24 at 12:49 p.m. Staff E CNA stated she went on walking rounds Saturday morning. Staff G swore and talked about the resident and call light use. Staff E said Staff G said Resident #4's name and that she was annoying. On 12/16/24 at 8:50 a.m. Staff H CNA stated it was her 1st day working at the facility. She went on walking rounds that morning. Staff G said Resident #4 was annoying on the call light and swore when he said it loudly, and they were right outside her room. Staff G said negative things about other residents also. She was working with Staff B and they went to get Resident #4 for lunch. She was still in bed and soaked. Resident #4 said she heard the staff saying she was annoying and didn't want to be a burden, so she just wet herself. Staff B said she was not a burden and they were there to help her. She then let them help her to the bathroom and help her get cleaned up. On 12/16/24 at 8:58 a.m. Staff I CNA stated on walking rounds she had to get a drink of water and when resumed rounds they were by room [ROOM NUMBER] and Staff G said Resident #4 had been f***ing annoying all night on the call light. Staff I said Staff G always used profanity. On 12/13/24 at 12:52 p.m. G CNA denied using profanity during walking rounds or saying that Resident #4 was annoying. He said they had a chaotic night with a lot of call lights and residents awake. He commented that was annoying. He didn't say any specific person was annoying. On 12/16/24 at 2:07 p.m. the Administrator stated they changed the way they do report. They did a verbal report in the break room, then a walk through to check the residents. They terminated Staff G. The Resident's [NAME] of Rights dated 2/07 included the right to considerate and respectful care and to be treated with honesty, dignity, respect and with reasonable accommodation of individual needs except where the health, safety or rights of the resident or other individuals in the facility would be endangered. It was recognized that every resident was an individual with feelings, preferences, personal needs and requirements.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to ensure staff followed professional standards for administering medication for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 43 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #4 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had diagnoses including non-Alzheimer's dementia. On 12/12/24 at 9:29 a.m. Staff B Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) stated she worked the day shift Saturday (12/7/24). When they went to get Resident #4 for lunch there were pills on Resident #4's table, so Staff B asked the nurse and they were from that morning. She said Staff F Registered Nurse (RN) left them in her room. He usually didn't do that but he was an agency worker. Staff B had the resident take the medications. The December 2024 Medication Administration Record (MAR) showed Staff F signed off giving Resident #4, 9 medications on the 12/7/24 MAR for the a.m. On 12/12/24 at 1:38 p.m. Staff F stated he did leave Resident #4's medications in her room that day, and the CNA/CMA found them and gave them to her. On 12/12/24 at 3:30 p.m. Resident #4 stated they would at times leave her medications in her room for her to take when she was ready. On 12/16/24 at 2:07 p.m. the interim Director of Nursing (DON) stated Resident #4 had not been assessed for self administration of medications. The facility policy Administration of Medications dated 7/2017 documented directions included: Only licensed and medical and nursing personnel may prepare, administer and record medication administration. Medications must be given in accordance with the resident's service plan. The nurse or medication technician administering the medication must record such information on the resident's MAR before administering the next resident's medication. Should a drug be withheld, refused, or given other than the time scheduled time, the staff administering must indicate the reason on the MAR.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 3 residents reviewed (Resident #1) and failed to ensure linens and clothing soiled by incontinence were changed promptly.The facility reported a census of 43 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident depended on staff for toilet hygiene, bathing, personal hygiene, and transfers. The MDS documented the resident was always incontinent of bowel and bladder. The resident had diagnoses including traumatic spinal cord dysfunctiob, diabetes, and hemiplegia/hemiparesis (weakness/paralysis of 1 side of the body. The Care Plan initiated 6/28/23 identified Resident #1 had hemiplegia/hemiparesis related to trauma to C7 (vertebrae of the neck) as a result of a fall. The hemiplegia included the right dominant side. The Care Plan identified the resident: a. At risk for diarrhea. b. Had a urinary tract infection dated 10/31/24. c. Had an ADL self care deficit related to Parkinson's, and history of trauma to C7. Interventions included the resident required 2 staff assist for toileting needs, hoyer lift for transfers or bedpan to be utilized. The resident required substantial/maximal assist of 2 staff participation to reposition and turn in bed. d. The resident had bladder incontinence related to a diagnosis of overactive bladder and use of diuretics. Interventions included the resident wore a disposable brief, to check as required for incontinence, wash rinse and dry perineum. The Clinical-MDS page dated 12/11/24 at 11:03 a.m. documented the resident resided in room E (East) 11-B. On 12/11/24 at 12:45 p.m. Resident #1 laid in bed, gave little response, and kept her eyes closed. At 4 p.m. staff checked, changed and repositioned Resident #1. Staff gave her a drink of water and asked if she felt comfortable. The resident had her eyes open, but did not respond. The nursing schedule for 11/22/24 showed Staff J Certified Nursing Assistant (CNA) assigned to the East hall on the 2-10 shift from 4-9 p.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The POC Response History for urinary incontinence showed Resident #1 documented continent only 1 time between 11/12/24 and 11/22/24. On 11/22/24 the resident had documentation of incontinence at 1:53 p.m. and 9:59 p.m. The resident had nothing documented between the 2 times. On 12/12/24 at 11:04 a.m. Staff C CNA stated on 11/22/24 Staff J CNA was assigned Resident #1 and did not change her. They found her saturated in urine. On 12/12/24 at 1:38 p.m. Staff F Registered Nurse (RN) stated one day he had instructed Staff J CNA to change Resident #1, and about 1/2 hour later she said she had. But the way they found her, Staff J couldn't have. He did talk to her about it. On 12/12/24 at 11:21 a.m. Staff D Licensed Practical Nurse (LPN) stated Resident #1 was declining and Staff F RN told CNA Staff J to change her. But the 6 p.m. to 6 a.m. shift CNA found her in a soaked bed. When she asked Staff J about it, she said she checked her and she was dry. When asked how she checked her, she said she checked her pad in the front. Staff D asked if Staff J rolled her and checked the back side and she said no. Staff D told her she had to check in the back to make sure residents were not incontinent. On 12/16/24 at 12:56 p.m. Staff J stated she worked 11/22/24 from 4 p.m. to 9 p.m. She said Staff F was the day shift nurse and he did ask her to check Resident #1. She remembered she did, and Resident #1 was dry. She said on the evening shift, they didn't have as many staff, so they all went where they were needed. Staff J was sure she would have gone down to the resident's room again, but didn't specifically recall it. Staff J stated Resident #1 needed repositioning every 2 hours so they would have checked her in the back. When asked who they were, she could not recall. She said Staff F worked until 6 p.m. so they would have checked her between 4 and 6 p.m A statement received 12/9/24 at 3:36 p.m. from Staff A CNA included throughout the weekend it was a trend for a resident to have a wet soaker, but their brief would be dry. A wet sheet but a dry soaker. Or they would be absolutely drenched when they went to their room at 7-8 a.m. None of the scenarios were acceptable. When they approached the night shift about it, they blamed the 2-10 shift, stating they were like that when they got there. They left it at that, because they had conflict with them all weekend. Staff A reported it to the interim Director of Nursing (DON) that day. She also reported to nurses all weekend. In one specific case a resident had been put to bed in her day clothes. This specific resident did not refuse cares. The night shift said 2-10 put her to bed that way. On 12/16/24 at 8:58 a.m. Staff I CNA stated they had found residents with a dry brief but wet bed pad and/or sheet. If they asked about it, night shift blamed the 2-10 shift. She said last week a resident was wet from her hair down. She said another resident had a dry incontinent pad, but the under pad and sheet were wet. On 12/16/24 at 2:07 p.m. the Administrator stated they should change all wet linens, but they may not be able to tell if the bed pad or sheet were wet with the lights down low and wearing gloves.