

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER Midlands Living Center L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 2452 North Broadway Council Bluffs, IA 51503	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on observations, record review, facility investigative file review, staff interviews and policy review the facility failed to ensure 1 of 3 residents (Resident #2) was treated with dignity. The facility reported a census of 72 residents.</p> <p>Findings include:</p> <p>According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 8/12/24 Resident #2 had a Brief Interview of Mental Status Score (BIMS) of 5. A BIMS score of 5 indicated mild cognitive impairment. The MDS indicated she did not display any physical, verbal or other symptoms during the review period. The MDS documented she had the following diagnoses: femur fracture, anemia, hyponatremia, thyroid disorder, hip fracture, and heart failure.</p> <p>The Care Plan focus area with an initiation date of 8/6/24 documented Resident #2 had Activities of Daily Living (ADLs) self-care performance deficit related to impaired mobility and pain.</p> <p>The facility investigation included the following summary and staff statement:</p> <p>-On 9/18/24 at approximately 4:00 PM the Director of Nursing (DON) was made aware of a Snapchat story that was sent from one of the facility's staff members to another facility staff member involving a resident by Staff B Assisted Living Facility DON. The Snapchat was captured on 9/17/24 in the evening and contained a video of Staff A Nurse Aide in Training (NAT) talking to a resident in the hallway. The resident's face was colored out so she could not be identified but we recognized her voice as Resident #2. Resident #2 was heard asking for help and Staff A replied I would be willing to help you, but you haven't listened to me once this entire night. I can't help you if you're not going to listen to me. The facility's Assistant Director of Nursing was in the building at the time of the incident and had overheard the interaction. She intervened and pulled Staff A into an office and provided education on appropriate interaction with residents. The ADON was unaware that Staff A was recording or snapchatting.</p> <p>-Review of the facility cameras at the approximate time of the incident, revealed Resident #2 along with other residents sitting across from the nurse's station with Staff A sitting next to one of the residents. Staff A could be heard telling Resident #2, I would be willing to help you, but you haven't listened to me once this entire night. I can't help you if you're not going to listen to me.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #2 was admitted to the facility on [DATE] and currently awaiting physician's diagnosis for dementia. She does ask repetitive questions, has short- and long-term care memory deficits.</p> <p>-The ADON emailed the following statement to the DON on 9/19/24 at 2:12 PM: On the evening of 9/17/24 she was walking past the nurse's desk at approximately 6:32 PM when she heard Staff A speaking to Resident #2 at the desk. She was speaking to Resident #2, who has dementia, in a condescending, and she felt disrespectful manner. The resident was at the desk and wanted to go back to her room. Staff A stated to Resident #2 you are not listening to me, so you have to stay here now, I have to sit with you now, I quit. Resident #2 was asking for help, Staff A responded no I caaaaaaan't do this for you, I would be willing to do this for you but you haven't listened to me once this entire night, so I can't help you if you are not going to listen to me. The ADON overheard the conversation and pulled Staff A into an office and discussed with her that Resident #2 has dementia, she cannot help that she cannot remember from one minute to the next. The ADON explained to Staff A that when we take care of dementia residents, we see if we can address their needs- food, water, do they need to use the toilet. If those needs are met then we try to distract them (as demonstrated to her). Resident #2 is an artist, ask her to tell you about her artwork, ask about her life, have her tell you about her family. But we don't ever treat or speak to them as if they are children that we are babysitting. She told Staff A she needs to be respectful and if having a difficulty, ask the floor nurse for assistance. Staff A responded to her, I have tried, I have tried all of that-she doesn't listen. The conversation was ended and Staff A agreed that she understood that she needs to approach and speak to the resident differently.</p> <p>On 9/27/24 at 10:54 AM the DON played the Snapchat video that was posted by Staff A. The resident's face and body were colored out with pink, no other residents visible in video. The video played the following audio conversation: Resident #2 said I need you to do this for me. Staff A stated I caaaaaaan't do this for you. Resident #2 I will come back. Resident #2 asked can you help me. Staff A stated I would be willing to help you but you haven't listened to me once this entire night. I can't help you if you're not going to listen to me. Resident #2 mumbled something that was not audible.</p> <p>On 9/27/24 at 10:40 AM the DON played the camera footage of where Resident #2 and Staff A was sitting at the time of the Snapchat recording. At 9/17/24 at 6:23 PM Staff A sat down next to a resident that was sitting in the commons area across from the nurse's station. Resident #2 was next to that resident. Three other residents were present, the television was on, other staff members walked by randomly as they went to the halls on either side of this area. Resident #2 asked what she should do and asked Staff A to call her daughter. Staff A stated she tired but her daughter was busy. Resident #2 stated I have to call her before bed, Staff A told her she was not able to do that for her. Then told her you are not listening you have to sit here with me. At 6:31 PM Staff A took her cell phone out of her pocket. Resident #2 said something that was not audible, then Staff A stated I can't. Resident #2 said I need you to (then unable to hear what was said). Staff A said I would be willing to help you but you have not listened to me once this entire night. At 6:32/6:33 PM the ADON walked up the hall from the main entrance area and removed Staff A from the area. At 6:34 PM Resident #2 left the area in the direction of her room. In the 10 minutes of watching the video the resident sat in her wheelchair, not attempting to leave the area, nor was she combative, disruptive or engaging with other residents. Resident sat in her wheelchair, repeating words, not yelling or shouting. Multiple staff members walked through that area throughout the 10 minutes of the video observed, including the ADON.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/29/24 at 1:15 PM an attempt was made to contact Staff B. There was no answer on the cell phone number provided by the facility. A voicemail was left and a text message was sent to return the call at her convenience. At the conclusion of the investigation, a return call was not received.</p> <p>On 9/29/24 at 1:28 PM Staff A stated her mom is on the call too because she is a minor. Staff A stated while her trainer was in the bathroom the ADON came and told her what to do with Resident #2 such as helping her with something. Staff A stated she did not know how to deal with dementia residents and she was stressing out. The ADON told her not to talk with residents the way she was talking with Resident #2. The ADON educated her to ask questions of the resident but Resident #2 kept saying stuff over and over and she did not know how to talk with residents like that. Staff A indicated she did not feel like she was talking to Resident #2 in a disrespectful or rude way. She was just telling the resident she could not help her and that she did not know what to do for her. When asked what Resident #2 was saying and doing she stated she kept moving from her chair, trying to leave the building, just moving around. Resident #2 was saying she needed to go to this, I need to go do this. Staff A told her you can't do that, I can't help you. When asked why she told Resident #2 she could not help her if she was not going to listen to her, Staff A stated because she did not know what to say, no one had taught her what to say to dementia residents. She was not, not trying to help, she was upset and confused at that time. Staff A indicated she wanted to help Resident #2 but did not have someone there with her to help. She wanted Staff A to call her daughter but her daughter was already there that day, obviously she did not remember that. Staff A indicated she did not refuse to call her daughter, but she did not have access to certain things like phone numbers. Staff A indicated other staff members had walked by during this time but could not remember while they were. When asked why Staff A recorded a Snapchat video of Resident #2, she stated the resident was trying to move away, kept saying things and moving. So, she pulled out her phone to show her mom. She was stressed out from the ADON telling her what to do, she wanted to record what was going on to show her boss and mom. Staff A stated the Snapchat was sent to a small group of friends. She acknowledged it was wrong and should not have done that. At the time she did not know it was wrong but now she see's that it is wrong.</p> <p>On 9/30/24 at 10:46 AM the ADON stated she was here late that day. She was walking to the nurse's station area where Resident #2 and Staff A were sitting. She heard Staff A speaking with Resident #2, not sure what was said but she was kind of talking down to her, like she was babysitting a kid. She was speaking in a demeaning manner, not respectful. So, she asked her to come with her so she could speak with her. She pulled her in to the DON's office and let her know we don't speak to residents like that. If you are not able to redirect the resident, get a nurse to help with that. Told her to talk with Resident #2 about art, she was an artist before. When her and Staff B were done, the ADON went to see if Resident #2 needed anything and to ask about her art work. She pleasantly spoke of her art. During the remaining time at the facility that evening she did not hear any further interaction that was questionable.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/30/24 at 2:24 PM Staff C CNA stated she trained Staff A on the day the Snapchat story was posted. It was her first night working with her. Other CNA's had reported to her that Staff A liked to be on her phone a lot. She had it out in the dining room while Staff C was assisting a resident with their meal. She asked her to put it away then sat next to Staff C. Staff C then assisted a resident with her meal by asking the resident to open their mouth, then made an airplane noise and said the food is coming in. Staff C told her to stop that it was disrespectful and that the resident was not a baby. Staff C stated it was just a joke and did not make any further comments to that resident during that time. Staff C went to the restroom and when she returned she had noticed the ADON was on the first floor talking with Staff A. Staff C noticed Staff A was worked up and asked what was going on. She indicated the ADON told her she needed to stay with Resident #2 but Staff C indicated that resident's aide was right there and they needed to continue to assist their residents down the hall. Staff C stated 3-4 days later she had heard Staff A posted the Snapchat video on the day she was training her. Staff C denied having to educate Staff A any further that evening.</p> <p>On 9/30/24 at 2:56 PM the DON stated Staff B notified her, via text message, that a staff member of DON's recorded something on Snapchat and posted it. The video was sent to the Administrator, reported the incident to the State Agency, and suspended Staff A because of how she was speaking to Resident #2 and because she had recorded the interaction. Based on the surveillance video and Snapchat video they decided to terminate Staff A's employment. When asked to describe how Staff A was speaking to Resident #2 the DON stated she was not sure if she was intentionally being abusive but really thinks it was because she was young, frustrated and did not know how to interact with a demented resident. She was unsure if she understood dementia even though she had training or this profession is not her cup of tea. When asked how Staff A's tone was with Resident #2 in the video, the DON stated borderline demeaning.</p> <p>The Administrator provided a document titled Residents' [NAME] of Right that their staff are to follow. The document contained the following information:</p> <p>1. Residents' Rights</p> <p>1) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified below:</p> <p>a) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>5. Respect and Dignity</p> <p>1) The resident has a right to be treated with respect and dignity.</p>		