

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2024
NAME OF PROVIDER OR SUPPLIER  Blackhawk Life Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  73 West 5th Street Lake View, IA 51450	

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 - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on observation, interviews, and record review the facility failed to treat residents with dignity and respect for 3 of 14 residents reviewed (Residents #11, #8, #10). On 3/20/24, observed Residents #11 and #8 sit at the breakfast table waiting for breakfast for over an hour after other residents finished their meals. When Resident #8 attempted to drink her chocolate drink, she spilled it on her blouse, and on the floor. Resident #10 reported during the evening meals, many of the residents who require assistance with transfers, wait until after 8:00 PM for the staff to assist them. In addition, Resident #10 also reported that a staff member was rude to her and embarrassed her while educating her about her medication.</p> <p>Findings include:</p> <p>1. Resident #11's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive deficits. He required maximum assistance with eating and dressing. He required total assistance with hygiene and transfers. The MDS included diagnoses of Down Syndrome, chronic kidney disease, obstructive and reflux uropathy (troubles with urination). Resident #11 required a mechanically altered diet while a resident.</p> <p>The Clinical Physician's Orders reviewed 3/21/24 listed an order dated 7/21/23 for a general diet with pureed texture.</p> <p>The Care Plan Focuses reflected the following:</p> <p>a. Revised 6/29/23: Resident #11 didn't have natural teeth and he choose to not wear dentures. The Interventions directed the staff to assist Resident #11 to eat with set-up assistance and verbal cues.</p> <p>b. Revised 12/12/23: Resident #11 had a risk for a weight change related to altered nutrition intake, needed for mechanically altered diet, and difficulty with communication.</p> <p>2. Resident #8's MDS assessment dated [DATE] identified a BIMS score of 1, indicating severely impaired cognition. She required supervision and assistance with eating. In addition, she required total assistance with hygiene and transfers. The MDS included diagnoses of anemia, renal insufficiency (poor kidney function), diabetes mellitus, and Alzheimer's Disease. Resident #8 required a mechanically altered diet while a resident at the facility.</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 - Some</p>	<p>The Care Plan Focuses indicated the following:</p> <p>a. Revised 9/12/23: Resident #8 needed assistance with activities of daily living (ADLs) related to weakness and impaired vision. She liked to eat food with fingers.</p> <p>b. Revised 11/13/23: Resident #8 had a risk for a weight change related to altered nutrition intake secondary to diabetes and anemia. The Interventions directed the staff to offer a pureed food diet, encourage good oral intake at meals, monitor for chewing and swallowing issues</p> <p>On 3/20/24 observed the following:</p> <p>a. At 8:10 AM #8 and #11 sat at the breakfast table waiting for food while other residents finished eating.</p> <p>b. At 8:34 AM Residents #8 and #11 still didn't have their food and waited for assistance to eat.</p> <p>c. At 9:00 AM Residents #8 and #11 still haven't ate and continued to sit waiting at the table.</p> <p>d. At 9:19 AM Residents #8 and #11 haven't ate and didn't have food in front of them yet, and the dining room didn't have other residents at the tables.</p> <p>e. At 9:26 AM when asked why Resident #8 and #11 didn't eat yet, Staff X, Dietary Aide, said they couldn't serve the residents with pureed food orders until they had an aide that could assist them with their meal.</p> <p>f. At 9:30 AM while Resident #8 drank a chocolate drink and it spilled down her blouse and onto the floor.</p> <p>g. At 9:31 AM witnessed the Director of Nursing (DON) sit with Resident #11 and assisted him with his meal.</p> <p>On 4/2/24 at 8:40 AM, the DON said she expected the kitchen staff to page an aide when they were ready for residents to eat.</p> <p>3. Resident #10's MDS assessment dated [DATE], identified a BIMS score of 15, indicating intact cognition. The MDS listed her as independent with eating, hygiene, dressing, and toilet use.</p> <p>On 3/20/24 at 10:56 AM, Resident #10 said she noticed some residents stayed in the dining room for hours after the end of the evening meal. She said one night, the residents had to wait until after 8:00 PM before the staff started transferring them back to their rooms. Resident #10 explained she felt so sorry for them. She added that she noticed the residents who needed help with eating, waited for a long time after everyone else had their meals to get help with their meals.</p> <p>In addition, Resident #10 reported she had one nurse embarrass her. When she questioned Staff Y, Registered Nurse (RN), about her medications, the nurse snapped at her in front of her roommate. She told her that she told about those medications that morning. She added she should have taken her to the emergency room when she hit her head, because she was getting goofy. Resident #10 said it embarrassed her and she felt degraded.</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 - Some</p>	<p>The Resident Rights policy revised November 2016 instructed the facility must treat each resident with respect and dignity. In addition, they should 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.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41785</p> <p>Based on interview, record, and policy review, the facility failed to notify the family and the doctor after a resident fell from the mechanical lift for 1 of 1 resident reviewed (Resident #12). While staff transferred Resident #12 with the mechanical lift, the machine tipped over, resulting in him falling into the recliner. Following the incident, the staff failed to call the family and doctor.</p> <p>Findings include:</p> <p>Resident #12's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #12 required extensive assistance from 2 persons for bed mobility, dressing, and toilet use. In addition, he required total assistance with transfers. The MDS included diagnoses of heart failure, renal insufficiency (poor functioning kidneys), diabetes, morbid (severe) obesity.</p> <p>The Care Plan updated 6/23/23 included the following:</p> <ol style="list-style-type: none"> <li>a. Resident #12 received hospice level of care.</li> <li>b. Resident #12 needed assistance with care due to his physical decline. The Interventions indicated the following: <ul style="list-style-type: none"> <li>- He used a bariatric bed with a foot extender</li> <li>- The staff lifted his recliner to accommodate his height.</li> <li>- He preferred to sleep in his recliner rather than the bed.</li> </ul> </li> <li>c. Resident #12 used high risk medication for heart failure, atrial fibrillation, chronic kidney disease and diabetes. He chose to stop his medications and go on hospice services.</li> <li>d. Resident #12 had chronic pain related to joint replacements, morbid obesity, arthritis and diabetic polyneuropathy (damage to multiple peripheral nerves by diabetes).</li> <li>e. Resident #12 had an ADL self-care deficit. The Intervention instructed he didn't walk and he required a full-body mechanical lift for transfers.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurses Note dated 7/2/23 at 10:10 AM reflected Staff L, Registered Nurse (RN), Staff K, Licensed Practical Nurse (LPN), and Staff M, RN, had Resident #12 in the full-body mechanical lift to transfer him from the bed to his recliner. Staff M positioned herself behind recliner to help guide him into the chair and to assist with getting his hips pulled back. Staff K used the lift to get Resident #12 up in air so he could be moved. As Staff K pulled the lift back with the legs open, Staff L had Resident #12's feet and was turning him to align him with the lift, the legs on lift started to close. As this occurred the lift tipped over falling to the south. Staff M moved the recliner quickly so Resident #12 landed in recliner from the waist up, with his feet on the floor still hooked to the lift. The base of the lift came up to the north side hitting Staff L in both shins. While the upper lift landed on Staff K's left side of her back. Both filled out employee incident reports. They removed Resident #12 from the lift, so they could remove the lift off Staff K and assess their injuries. Staff M called additional staff to the room. The staff reconnected Resident #12 back up to the lift, while 1 staff member stood on each lift leg, they lifted Resident #12 in the air. With the legs to the life open and on each side of the recliner, the staff stepped off the lift and pushed the lift back further to get Resident #12 back in his recliner. The staff repositioned Resident #12 in his recliner in good position, and then the staff unhooked the lift. Resident #12 didn't have complaints of pain or discomfort. Staff M notified the DON immediately of the incident.</p> <p>On 3/21/24 at 10:25 AM, the Administrator said they didn't complete an incident report after Resident #12 fell from the lift because he didn't get hurt. The two staff who got hurt completed incident reports because they took the brunt of the machine. She said they didn't call Resident #12's family because he was his own person and made his own decisions. In addition, they didn't call the doctor since Resident #12 didn't get hurt.</p> <p>The Incident and Investigation Charting policy revised 8/22/17 directed a nurse should contact the physician and document means of contact. The nurse should contact the family and inform them of the events. If the fall occurred between 9 PM and 7 AM, without injury the call can happen at 7 AM the following morning.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41785</p> <p>Based on observation, interview, and employee file review the facility failed to protect residents from unnecessary punishment and abuse for 1 of 3 residents reviewed (Resident #2). On 1/26/24, Staff G, Certified Nurse Aide (CNA), reported that while she and Staff F, CNA, helped Resident #2 to the toilet, Resident #2 kicked, slapped, and spit at them. Staff G said that Staff F slapped Resident #2 on the face, stepped on her foot, and manhandled her into the wheelchair.</p> <p>Findings include:</p> <p>Resident #2's Minimum Data Set (MDS) assessment dated [DATE], listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive deficits. Resident #2 required total staff assistance for toilet use, showering and dressing. She required partial assistance with toilet transfers. The MDS described Resident #2 as frequently incontinent of urine and bowel. The MDS included diagnoses of Alzheimer's disease, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), malnutrition (inadequate intake of nutrients) and anxiety disorder.</p> <p>The Care Plan included the following Focuses:</p> <p>a. Revised 3/3/24: Resident #2 needed assistance with activities of daily living (ADLs) and had a history of falls. The Interventions indicated the following.</p> <ul style="list-style-type: none"> <li>- Resident #2 had anti roll back brakes on her wheelchair</li> <li>- She could pivot transfer with the assistance of one.</li> <li>- The staff used a pull alarm attached to the wheelchair and to her clothing to alert them when she tried to self transfer.</li> </ul> <p>b. Revised 1/31/24: Resident #2 cognitive decline made it difficult at times for the staff to manage her behaviors or health condition. The Interventions indicated the staff would assist her family to find a specialized memory unit for placement.</p> <p>c. Revised 2/3/24: Resident #2 had a behavioral problem related to her Alzheimer's dementia, mood disturbance, and agitation. The Interventions reflected</p> <ul style="list-style-type: none"> <li>- Resident #2 had a Wander Guard alarm for safety due to history of exit seeking.</li> <li>- Monitor Resident #2's behavior episodes and attempt to determine the underlying causes such as location, time of day, persons involved and situations.</li> </ul> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/19/24 at 1:51 PM, observed Resident #2 in her wheelchair in the dining room area. She appeared calm but did occasionally attempt to get out of her chair. The observation revealed an alarm clipped to her shirt and hanging from her wheelchair. At 3:36 PM witnessed her sleeping in her wheelchair and at 4:00 she still appeared calm while sitting in her wheelchair in dining area.</p> <p>The Facility Investigation dated 1/26/24 reflected Staff G, CNA, voiced concerns to Staff T, RN DON, regarding the occurrences during the overnight shift. Staff G talked further with administration regarding her concerns. During discussion Staff G stated Resident #2 sat in the living area in the front of the facility. Staff G and Staff F tried different interventions to help Resident #2 calm down. Staff G expressed Resident #2 stated she would go to the bathroom, so they assisted her to the bathhouse. While in the bathhouse Staff G expressed Resident #2 went to spit on her and Staff F. Staff G stepped back. Resident #2 continued to hit and kick at them. At this time Staff F bent down to Resident #2's level and sternly asked her not to spit. Staff F then raised his hand and tapped Resident #2 on her left cheek. When asked to further explain, Staff G expressed, she wasn't sure if she should call it a tap or a smack or what. She was sure that his hand contacted Resident #2's face. Staff G felt like Staff F may have stepped on Resident #2's foot, but with her hitting and kicking, it was hard to explain everything that happened. The nursing staff completed a skin assessment on 1/26/24, that revealed no new skin areas on Resident #2's left cheek/and or face with no indication of injury to Resident #2's left cheek. When Resident #2 visited with the Administration the morning of 1/26/24, she explained she had a good night and described all the helpers as so nice. Resident #2 worked on a puzzle during that time but couldn't record any specific details of the night when asked. When interviewing Staff F, CNA, he validated he worked the night before. Staff F verbalized that Resident #2, spit, hit, and screamed at the staff. He expressed they had tried the interventions from her activity book, bathroom, snack, 1 on 1s, but Resident #2 wouldn't calm down. Staff F stated he attempted to hold Resident #2's hands, when she expressed she would kick him. Staff F stated when asked, Yes, I tapped her (Resident #2) on the face and said to her, can you please stop? Staff F described the tap as very soft with no power behind it. Discussion throughout the conversation included utilizing his walkie for the charge nurse at the time, and Staff F verbalized understanding. At the end of the conversation Staff F stated, I'm sorry - I wasn't trying to hurt her. Staff U, RN DON, and Staff T expressed they didn't have any specific resident concerns with Staff F. Staff U expressed that Staff F continued to need education regarding skills at times.</p> <p>The Police Report interview conducted on 1/31/24 between Staff F and the police officer, Staff F reported Resident #2 had dementia and often caused problems for the workers. The night of the incident, Resident #2 yelled and screamed, he knew that she would get better when people were around her and could bring her back to reality He told the officer that he saw Staff G having trouble with Resident #2. As Resident #2 hit and screamed at Staff G, so he decided to go in and help Staff G. While Resident #2 sat on the toilet, he got down to her eye level and tapped on her cheek to bring her back to reality. Resident #2 got more upset and threatened to kick him in the genital area. At that time, Staff F took his foot and placed it on top of Resident #2's foot to prevent her from kicking him.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/21 at 3:52 PM. Staff G said the incident with Staff F and Resident #2 happened so fast. Resident #2 was being difficult, hitting, and spitting which was not unusual for her. Staff G took her to the bathhouse to toilet her and she asked Staff F to assist. As Resident #2 sat on the toilet, she went to spit on Staff F. He got down to eye level with her and said we do not spit. The resident told him to go to hell. He went back to eye level with the resident again, said fuck it, and slapped her on the check. When Resident #2 tried to kick him in the genitals, Staff F stepped on one of her feet to keep her from kicking him. Staff G got between the two of them and Resident #2 said I'd rather deal with you, because I don't want to be black and blue. Staff G got Resident #2 up from the toilet, pulled her pants up, Staff F then grabbed the back of Resident #2's pants, whipped her around, and swung her into the wheelchair. The chair tipped back and if it hadn't had the anti tip bar on the back, she could have fell backwards in her chair. Staff G said she got Resident #2 to the dining room and tended to her the rest of the night. About an hour after the incident, Resident #2 went to sleep in her room. Staff G said that hours went by before she saw the nurse. Staff F followed Staff G around throughout the rest of their shift and asked; are you going to tell on me? Staff G said she didn't get a chance to say anything to the nurse with Staff F always behind her. Staff G said the slap was not hard enough to leave a bruise, but it did leave a red mark on Resident #2's check that disappeared by morning. Staff G said she witnessed Staff F lose his temper at residents, as he would yell at them. She being afraid of Staff F that she could be retaliated against for reporting the incident.</p> <p>On 3/20/24 at 12:40 PM, Staff F said that Resident #2 was agitated the majority of the time. He said that on the overnight shift from 1/25/24 1/26/24, he asked the nurse if she could give her some medication to help her calm down and the nurse responded she already gave her an Ativan (antianxiety medication) earlier in the evening and couldn't give her any more. Staff F said he went to help Staff G because she let Resident #2 hit and kick her. He told her to get out of the way and let him take over. Resident #2 spit in his face, clawed at him, and flailed her arms. While Resident #2 sat on the toilet, she threatened to kick him between the legs, so he put his foot on top of her foot and placed it down. She started to claw more and spit in his face so he tried to talk to her because she can understand. Staff F said he tapped her on the face real soft, but it didn't work, so he told Staff G to take over. He said they put Resident #2 back into her wheelchair and wheeled her out to the nurse's station in front of the nurse. Staff F remembered being upset with the nurse because she didn't help them with Resident #2. He said the nurse saw them both scratched up pretty good, but the scratches happened when they cared for a different agitated resident earlier that evening. Staff F described Staff G as quiet and withdrawn, she just let Resident #2 beat her up and that's why he decided to take over, he said they shouldn't just stand there letting residents hit and kick them. Staff F said he grabbed Resident #2's hands and held them down to get her to stop hitting but she didn't care. Staff F said the nurse took Resident #2 back to her room until she went to sleep while he and Staff G answered call lights the rest of the night.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on observation, interviews, record, and policy review, the facility failed to immediately report allegations of abuse to the proper authorities for 2 of 5 residents reviewed (Residents #2 and #15). On 1/26/24, Staff G, Certified Nurse Aide (CNA), reported on the overnight shift of 1/25/24 1/26/24, Resident #2 hit, kicked, and spit at the staff. Staff F, CNA, took over for Staff G, and proceeded to slap Resident #2 on the face, step on her foot, and manhandled her into the wheelchair, sometime around 12:30 1:15 AM on 1/26/24. Staff G failed to report the alleged abuse to the Administration until later in the morning of 1/26/24. While investigating the situation between Staff F and Resident #2, Staff P, Registered Nurse (RN), reported approximately 3 months before, she had a similar situation with Staff F. Staff F told Staff P as Resident #15 became combative, he tapped her a little hard when he tried to get her dressed for bed. Staff P denied reporting the incident to the Administration or to the state authorities. The failure to report or intervene to ensure the residents' safety resulted in an Immediate Jeopardy (IJ) to the health, safety and security of the residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy that began as of 1/26/24 on 3/28/24 at 5:22 PM. The facility staff removed the IJ on 3/28/24 through the following actions:</p> <ol style="list-style-type: none"> <li>The facility administration separated the alleged perpetrator immediately upon notification from the staff of the incident on 1/26/24. The alleged perpetrator was immediately suspended, and furthermore terminated upon the outcome of investigation on 1/31/24.</li> <li>The facility added a Report Abuse Fact Sheet to the inside cover of the staff communication book as a permanent reference for all staff. In addition, they placed the Report Abuse Fact Sheets in the employee clock area, breakroom, as well as added to the new hire onboarding packets.</li> <li>The facility educated the staff on 3/28/24 (and will continue to educate) on the process of reporting allegations of abuse. The facility staff will complete the IHCA (Iowa HealthCare Association) training: Understanding and Responding to Dementia Related Behaviors within the next thirty days.</li> <li>The facility would reviewed the Abuse policy monthly at in services, and department meetings. In addition, they will review the policy with new employee onboarding. The facility will randomly audit staff on the facility process of reporting allegations of abuse weekly for 3 months. The facility will report the outcome of the audits to the QAPI (Quality Assurance Performance Improvement) interdisciplinary team. The QAPI team will establish any further direction on auditing this area for 3 months, based on outcomes.</li> </ol> <p>The facility lowered the scope from a L to a F at the time of the survey after ensuring the facility implemented education with their policy and procedures.</p> <p>Findings include:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE], listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive deficits. Resident #2 required total staff assistance for toilet use, showering and dressing. She required partial assistance with toilet transfers. The MDS described Resident #2 as frequently incontinent of urine and bowel. The MDS included diagnoses of Alzheimer's disease, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), malnutrition (inadequate intake of nutrients) and anxiety disorder.</p> <p>The Care Plan included the following Focuses:</p> <p>a. Revised 3/3/24: Resident #2 needed assistance with activities of daily living (ADLs) and had a history of falls. The Interventions indicated the following.</p> <ul style="list-style-type: none"> <li>- Resident #2 had anti roll back brakes on her wheelchair</li> <li>- She could pivot transfer with the assistance of one.</li> <li>- The staff used a pull alarm attached to the wheelchair and to her clothing to alert them when she tried to self transfer.</li> </ul> <p>b. Revised 1/31/24: Resident #2 cognitive decline made it difficult at times for the staff to manage her behaviors or health condition. The Interventions indicated the staff would assist her family to find a specialized memory unit for placement.</p> <p>c. Revised 2/3/24: Resident #2 had a behavioral problem related to her Alzheimer's dementia, mood disturbance, and agitation. The Interventions reflected</p> <ul style="list-style-type: none"> <li>- Resident #2 had a Wander Guard alarm for safety due to history of exit seeking.</li> <li>- Monitor Resident #2's behavior episodes and attempt to determine the underlying causes such as location, time of day, persons involved and situations.</li> </ul> <p>On 3/19/24 at 1:51 PM, observed Resident #2 in her wheelchair in the dining room area. She appeared calm but did occasionally attempt to get out of her chair. The observation revealed an alarm clipped to her shirt and hanging from her wheelchair. At 3:36 PM witnessed her sleeping in her wheelchair and at 4:00 she still appeared calm while sitting in her wheelchair in dining area.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The Facility Investigation dated 1/26/24 reflected Staff G, CNA, voiced concerns to Staff T, RN DON, regarding the occurrences during the overnight shift. Staff G talked further with administration regarding her concerns. During discussion Staff G stated Resident #2 sat in the living area in the front of the facility. Staff G and Staff F tried different interventions to help Resident #2 calm down. Staff G expressed Resident #2 stated she would go to the bathroom, so they assisted her to the bathhouse. While in the bathhouse Staff G expressed Resident #2 went to spit on her and Staff F. Staff G stepped back. Resident #2 continued to hit and kick at them. At this time Staff F bent down to Resident #2's level and sternly asked her not to spit. Staff F then raised his hand and tapped Resident #2 on her left cheek. When asked to further explain, Staff G expressed, she wasn't sure if she should call it a tap or a smack or what. She was sure that his hand contacted Resident #2's face. Staff G felt like Staff F may have stepped on Resident #2's foot, but with her hitting and kicking, it was hard to explain everything that happened. The nursing staff completed a skin assessment on 1/26/24, that revealed no new skin areas on Resident #2's left cheek/and or face with no indication of injury to Resident #2's left cheek. When Resident #2 visited with the Administration the morning of 1/26/24, she explained she had a good night and described all the helpers as so nice. Resident #2 worked on a puzzle during that time but couldn't record any specific details of the night when asked. When interviewing Staff F, CNA, he validated he worked the night before. Staff F verbalized that Resident #2, spit, hit, and screamed at the staff. He expressed they had tried the interventions from her activity book, bathroom, snack, 1 on 1s, but Resident #2 wouldn't calm down. Staff F stated he attempted to hold Resident #2's hands, when she expressed she would kick him. Staff F stated when asked, Yes, I tapped her (Resident #2) on the face and said to her, can you please stop? Staff F described the tap as very soft with no power behind it. Discussion throughout the conversation included utilizing his walkie for the charge nurse at the time, and Staff F verbalized understanding. At the end of the conversation Staff F stated, I'm sorry - I wasn't trying to hurt her. Staff U, RN DON, and Staff T expressed they didn't have any specific resident concerns with Staff F. Staff U expressed that Staff F continued to need education regarding skills at times.</p> <p>On 3/21 at 3:52 PM. Staff G said the incident with Staff F and Resident #2 happened so fast. Resident #2 was being difficult, hitting, and spitting which was not unusual for her. Staff G took her to the bathhouse to toilet her and she asked Staff F to assist. As Resident #2 sat on the toilet, she went to spit on Staff F. He got down to eye level with her and said we do not spit. The resident told him to go to hell. He went back to eye level with the resident again, said fuck it, and slapped her on the cheek. When Resident #2 tried to kick him in the genitals, Staff F stepped on one of her feet to keep her from kicking him. Staff G got between the two of them and Resident #2 said I'd rather deal with you, because I don't want to be black and blue. Staff G got Resident #2 up from the toilet, pulled her pants up, Staff F then grabbed the back of Resident #2's pants, whipped her around, and swung her into the wheelchair. The chair tipped back and if it hadn't had the anti tip bar on the back, she could have fell backwards in her chair. Staff G said she got Resident #2 to the dining room and tended to her the rest of the night. About an hour after the incident, Resident #2 went to sleep in her room. Staff G said that hours went by before she saw the nurse. Staff F followed Staff G around throughout the rest of their shift and asked; are you going to tell on me? Staff G said she didn't get a chance to say anything to the nurse with Staff F always behind her. Staff G said the slap was not hard enough to leave a bruise, but it did leave a red mark on Resident #2's cheek that disappeared by morning. Staff G said she witnessed Staff F lose his temper at residents, as he would yell at them. She being afraid of Staff F that she could be retaliated against for reporting the incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 3/20/24 at 12:40 PM, Staff F said that Resident #2 was agitated the majority of the time. He said that on the overnight shift from 1/25/24 1/26/24, he asked the nurse if she could give her some medication to help her calm down and the nurse responded she already gave her an Ativan (antianxiety medication) earlier in the evening and couldn't give her any more. Staff F said he went to help Staff G because she let Resident #2 hit and kick her. He told her to get out of the way and let him take over. Resident #2 spit in his face, clawed at him, and flailed her arms. While Resident #2 sat on the toilet, she threatened to kick him between the legs, so he put his foot on top of her foot and placed it down. She started to claw more and spit in his face so he tried to talk to her because she can understand. Staff F said he tapped her on the face real soft, but it didn't work, so he told Staff G to take over. He said they put Resident #2 back into her wheelchair and wheeled her out to the nurse's station in front of the nurse. Staff F remembered being upset with the nurse because she didn't help them with Resident #2. He said the nurse saw them both scratched up pretty good, but the scratches happened when they cared for a different agitated resident earlier that evening. Staff F described Staff G as quiet and withdrawn, she just let Resident #2 beat her up and that's why he decided to take over, he said they shouldn't just stand there letting residents hit and kick them. Staff F said he grabbed Resident #2's hands and held them down to get her to stop hitting but she didn't care. Staff F said the nurse took Resident #2 back to her room until she went to sleep while he and Staff G answered call lights the rest of the night.</p> <p>2. Resident #15's MDS assessment dated [DATE] identified a BIMS score of 1, indicating severely impaired cognition. Resident #15 required total assistance from staff for lower body dressing, toilet hygiene, and putting on footwear. She displayed verbal behavioral symptoms directed toward others such as screaming and cursing 1 3 days a week. She did not exhibit physical behavioral symptoms such as hitting, kicking and scratching during the week-long look back period. The MDS included diagnoses of Alzheimer's Disease, muscle wasting (loss of muscle mass and strength), and chronic obstructive pulmonary disease (long-term lung issues).</p> <p>The Care Plan Focus revised 1/23/24, indicated Resident #15 would at times refuse or resist care. At times, she cussed at the staff or said unpleasant words or statements to the staff. The Interventions directed the staff to monitor and record occurrence of target symptoms.</p> <p>On 3/27/24 at 5:50 PM, Staff P, RN, said that she worked the 6p 6a shift and she worked with Staff F several times. She didn't personally hear Staff F raise his voice or get angry at residents, but heard from other staff that he would get in their face. She said one night, Staff F came to her and told her that he may have tapped a little hard on a resident's shoulder. He told her as he tried to get a resident changed for the night, she swung at him. He said he tried to distract her to get her attention and tapped her shoulder. Staff P immediately assessed the resident's shoulder and didn't see any marks. She said he got frustrated sometimes and she would separate him from the residents. She didn't remember a date but thought it happened within the past 3 months and with Resident #15. Staff P did not remember if she had reported this incident to the administration.</p> <p>On 4/1/24 at 4:30 PM, Staff G said she worked with Staff F one night when he came out Resident #15's room and told the nurse that he tapped Resident #15 while getting her ready for bed. She didn't know if the nurse assessed Resident #15 or what happened afterwards.</p> <p>According to the Daily Assignment Sheets on the 10 PM 6 AM shift on 12/19/23, Staff P, Staff G, and Staff F all worked that shift together.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The Nurses Note dated 12/20/23 at 2:32 AM, Staff P documented about Resident #15 being combative with care, hitting, and scratching staff that evening.</p> <p>On 4/1/24 at 10:04 AM the Administrator said she expected Staff G to report the alleged abuse immediately. She added she addressed that concern as soon as she learned about it on the morning of 1/26/24. She educated all the staff that day that they must report alleged abuse immediately so the alleged abuser could be separated from the residents. She said that she had no knowledge of anger issues with Staff F towards residents before this incident. She denied knowing about any incident between Resident #15 and Staff F.</p> <p>On 3/27/24 at 12:33 PM, Staff T, Registered Nurse (RN) and Director of Nursing (DON), said Staff G went home after she finished her shift at 6:00 AM on 1/26/24 and then later that morning, she sent Staff T a text. The note said she needed to talk to her about the incident. She asked Staff G to come back in to the facility and write up a statement. She said she didn't know what time of night the incident happened but it was early enough in the shift that Staff G should have let them know right away so they could have separated Staff F from the residents.</p> <p>During a confidential interview, Staff Z said they went to the DON and the Administrator with concerns about Staff F's anger issues and how he would yell at the residents. Staff Z said that they didn't take the concerns seriously and didn't investigate.</p> <p>The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy revised October 2023, All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. In addition, all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and/or misappropriation of property should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator or designated representative. All allegations of resident abuse would be reported to the Iowa Department of Inspections and Appeals no later than two (2) hours after the allegation was made.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on observation, interviews, record and policy review, the facility failed to immediately separate an alleged abuser from residents for 2 of 5 residents reviewed (Residents #2 and #15). On 1/26/24, when Staff G, Certified Nurse Aide (CNA), reported Staff F, CNA (alleged abuser), slapped Resident #2 because she hit, kicked, and spit at the staff. Staff G failed to intervene at the time of incident to prevent further emotional or physical damage to Resident #2. In addition, Staff G failed to report the incident until a few hours after Staff F and her shift. This allowed Staff F to work with other [NAME] residents until the end of their shift at 6:00 AM. During the investigation of the incident with Resident #2 and Staff F, Staff P reported a similar situation with Staff F. One night approximately 3 months before, Staff F reported he may have tapped Resident #15 a little hard when he tried to get her dressed for bed, when she was combative. When Staff P failed to notify the Administration or separate Staff F from the residents, this allowed him to tap another resident. Staff P reported she didn't remember reporting the incident to the Administration. With the failure to report, this resulted in a failure to investigate and prevent additional incidents from occurring resulting in an immediate jeopardy situation to the health, safety and security of the residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy that began as of 1/26/24 on 3/28/24 at 2:15 PM. The facility staff removed the IJ on 3/28/24 through the following actions:</p> <ol style="list-style-type: none"> <li>The facility administration separated the alleged perpetrator immediately upon notification from the staff of the incident on 1/26/24. The alleged perpetrator was immediately suspended, and furthermore terminated upon the outcome of investigation on 1/31/24.</li> <li>The facility added a Report Abuse Fact Sheet to the inside cover of the staff communication book as a permanent reference for all staff. In addition, they placed the Report Abuse Fact Sheets in the employee clock area, breakroom, as well as added to the new hire onboarding packets.</li> <li>The facility educated the staff on 3/28/24 (and will continue to educate) on the process of reporting allegations of abuse. The facility staff will complete the IHCA (Iowa HealthCare Association) training: Understanding and Responding to Dementia Related Behaviors within the next thirty days.</li> <li>The facility would reviewed the Abuse policy monthly at in services, and department meetings. In addition, they will review the policy with new employee onboarding. The facility will randomly audit staff on the facility process of reporting allegations of abuse weekly for 3 months. The facility will report the outcome of the audits to the QAPI (Quality Assurance Performance Improvement) interdisciplinary team. The QAPI team will establish any further direction on auditing this area for 3 months, based on outcomes.</li> </ol> <p>The facility lowered the scope from a L to a F at the time of the survey after ensuring the facility implemented education with their policy and procedures.</p> <p>Findings include:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE], listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive deficits. Resident #2 required total staff assistance for toilet use, showering and dressing. She required partial assistance with toilet transfers. The MDS described Resident #2 as frequently incontinent of urine and bowel. The MDS included diagnoses of Alzheimer's disease, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), malnutrition (inadequate intake of nutrients) and anxiety disorder.</p> <p>The Care Plan included the following Focuses:</p> <p>a. Revised 3/3/24: Resident #2 needed assistance with activities of daily living (ADLs) and had a history of falls. The Interventions indicated the following.</p> <ul style="list-style-type: none"> <li>- Resident #2 had anti roll back brakes on her wheelchair</li> <li>- She could pivot transfer with the assistance of one.</li> <li>- The staff used a pull alarm attached to the wheelchair and to her clothing to alert them when she tried to self transfer.</li> </ul> <p>b. Revised 1/31/24: Resident #2 cognitive decline made it difficult at times for the staff to manage her behaviors or health condition. The Interventions indicated the staff would assist her family to find a specialized memory unit for placement.</p> <p>c. Revised 2/3/24: Resident #2 had a behavioral problem related to her Alzheimer's dementia, mood disturbance, and agitation. The Interventions reflected</p> <ul style="list-style-type: none"> <li>- Resident #2 had a Wander Guard alarm for safety due to history of exit seeking.</li> <li>- Monitor Resident #2's behavior episodes and attempt to determine the underlying causes such as location, time of day, persons involved and situations.</li> </ul> <p>On 3/19/24 at 1:51 PM, observed Resident #2 in her wheelchair in the dining room area. She appeared calm but did occasionally attempt to get out of her chair. The observation revealed an alarm clipped to her shirt and hanging from her wheelchair. At 3:36 PM witnessed her sleeping in her wheelchair and at 4:00 she still appeared calm while sitting in her wheelchair in dining area.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The Facility Investigation dated 1/26/24 reflected Staff G, CNA, voiced concerns to Staff T, Registered Nurse (RN) Director of Nursing (DON), regarding the occurrences during the overnight shift. Staff G talked further with administration regarding her concerns. During discussion Staff G stated Resident #2 sat in the living area in the front of the facility. Staff G and Staff F tried different interventions to help Resident #2 calm down. Staff G expressed Resident #2 stated she would go to the bathroom, so they assisted her to the bathhouse. While in the bathhouse Staff G expressed Resident #2 went to spit on her and Staff F. Staff G stepped back. Resident #2 continued to hit and kick at them. At this time Staff F bent down to Resident #2's level and sternly asked her not to spit. Staff F then raised his hand and tapped Resident #2 on her left cheek. When asked to further explain, Staff G expressed, she wasn't sure if she should call it a tap or a smack or what. She was sure that his hand contacted Resident #2's face. Staff G felt like Staff F may have stepped on Resident #2's foot, but with her hitting and kicking, it was hard to explain everything that happened. The nursing staff completed a skin assessment on 1/26/24, that revealed no new skin areas on Resident #2's left cheek/and or face with no indication of injury to Resident #2's left cheek. When interviewing Staff F, CNA, he validated he worked the night before. Staff F verbalized that Resident #2, spit, hit, and screamed at the staff. He expressed they had tried the interventions from her activity book, bathroom, snack, 1 on 1s, but Resident #2 wouldn't calm down. Staff F stated he attempted to hold Resident #2's hands, when she expressed she would kick him. Staff F stated when asked, Yes, I tapped her (Resident #2) on the face and said to her, can you please stop? Staff F described the tap as very soft with no power behind it.</p> <p>On 3/21 at 3:52 PM. Staff G said the incident with Staff F and Resident #2 happened so fast. Resident #2 was being difficult, hitting, and spitting which was not unusual for her. Staff G took her to the bathhouse to toilet her and she asked Staff F to assist. As Resident #2 sat on the toilet, she went to spit on Staff F. He got down to eye level with her and said we do not spit. The resident told him to go to hell. He went back to eye level with the resident again, said fuck it, and slapped her on the cheek. When Resident #2 tried to kick him in the genitals, Staff F stepped on one of her feet to keep her from kicking him. Staff G got between the two of them and Resident #2 said I'd rather deal with you, because I don't want to be black and blue. Staff G got Resident #2 up from the toilet and pulled her pants up. Then Staff F grabbed the back of Resident #2's pants, whipped her around, and swung her into the wheelchair. The chair tipped back and if it hadn't had the anti tip bar on the back, she could have fell backwards in her chair. Staff G said she got Resident #2 to the dining room and tended to her the rest of the night. About an hour after the incident, Resident #2 went to sleep in her room. Staff G said that hours went by before she saw the nurse. Staff F followed Staff G around throughout the rest of their shift and asked; are you going to tell on me? Staff G said she didn't get a chance to say anything to the nurse with Staff F always behind her. Staff G said the slap was not hard enough to leave a bruise, but it did leave a red mark on Resident #2's face but it disappeared by morning. Staff G said she witnessed Staff F lose his temper at residents, as he would yell at them. She being afraid of Staff F that she could be retaliated against for reporting the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 3/20/24 at 12:40 PM, Staff F described Resident #2 as agitated the majority of the time. He said that on the overnight shift from 1/25/24 1/26/24, he asked the nurse if she could give her some medication to help her calm down and the nurse responded she already gave her an Ativan (antianxiety medication) earlier in the evening and couldn't give her any more. Staff F said he went to help Staff G because she let Resident #2 hit and kick her. He told her to get out of the way and let him take over. Resident #2 spit in his face, clawed at him, and flailed her arms. While Resident #2 sat on the toilet, she threatened to kick him between the legs, so he put his foot on top of her foot and placed it down. She started to claw more and spit in his face so he tried to talk to her because she can understand. Staff F said he tapped her on the face real soft, but it didn't work, so he told Staff G to take over. He said they put Resident #2 back into her wheelchair and wheeled her out to the nurse's station in front of the nurse. Staff F remembered being upset with the nurse because she didn't help them with Resident #2. He said the nurse saw them both scratched up pretty good, but the scratches happened when they cared for a different agitated resident earlier that evening. Staff F described Staff G as quiet and withdrawn, she just let Resident #2 beat her up and that's why he decided to take over, he said they shouldn't just stand there letting residents hit and kick them. Staff F said he grabbed Resident #2's hands and held them down to get her to stop hitting but she didn't care. Staff F said the nurse took Resident #2 back to her room until she went to sleep while he and Staff G answered call lights the rest of the night.</p> <p>2. Resident #15's MDS assessment dated [DATE] identified a BIMS score of 1, indicating severely impaired cognition. Resident #15 required total assistance from staff for lower body dressing, toilet hygiene, and putting on footwear. She displayed verbal behavioral symptoms directed toward others such as screaming and cursing 1 3 days a week. She did not exhibit physical behavioral symptoms such as hitting, kicking and scratching during the week-long look back period. The MDS included diagnoses of Alzheimer's Disease, muscle wasting (loss of muscle mass and strength), and chronic obstructive pulmonary disease (long-term lung issues).</p> <p>The Care Plan Focus revised 1/23/24, indicated Resident #15 would at times refuse or resist care. At times, she cussed at the staff or said unpleasant words or statements to the staff. The Interventions directed the staff to monitor and record occurrence of target symptoms.</p> <p>On 3/27/24 at 5:50 PM, Staff P, RN, said she worked the 6 PM - 6 AM shift and she worked with Staff F several times. She didn't personally hear Staff F raise his voice or get angry at residents, but heard from other staff that he would get in their face. She said one night, Staff F came to her and told her that he may have tapped a little hard on a resident's shoulder. He told her as he tried to get a resident changed for the night, she swung at him. He said he tried to distract her to get her attention and tapped her shoulder. Staff P immediately assessed the resident's shoulder and didn't see any marks. She said he got frustrated sometimes and she would separate him from the residents. She didn't remember a date but thought it happened within the past 3 months and with Resident #15. Staff P did not remember if she had reported this incident to the administration.</p> <p>On 4/1/24 at 4:30 PM, Staff G said she worked with Staff F one night when he came out Resident #15's room and told the nurse that he tapped Resident #15 while getting her ready for bed. She didn't know if the nurse assessed Resident #15 or what happened afterwards.</p> <p>According to the Daily Assignment Sheets on the 10 PM 6 AM shift on 12/19/23, Staff P, Staff G, and Staff F all worked that shift together.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The Nurses Note dated 12/20/23 at 2:32 AM, Staff P documented about Resident #15 being combative with care, hitting, and scratching staff that evening.</p> <p>On 4/1/24 at 10:04 AM the Administrator said she expected Staff G to report the alleged abuse immediately. She added she addressed that concern as soon as she learned about it on the morning of 1/26/24. She educated all the staff that day that they must report alleged abuse immediately so the alleged abuser could be separated from the residents. She said that she had no knowledge of anger issues with Staff F towards residents before this incident. She denied knowing about any incident between Resident #15 and Staff F.</p> <p>On 3/27/24 at 12:33 PM, Staff T said Staff G went home after she finished her shift at 6:00 AM on 1/26/24 and then later that morning, she sent Staff T a text. The note said she needed to talk to her about the incident. She asked Staff G to come back in to the facility and write up a statement. She said she didn't know what time of night the incident happened but it was early enough in the shift that Staff G should have let them know right away so they could have separated Staff F from the residents.</p> <p>During a confidential interview, Staff Z said they went to the DON and the Administrator with concerns about Staff F's anger issues and how he yelled at the residents. Staff Z said that they didn't take the concerns seriously and didn't investigate.</p> <p>The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy revised October 2023, All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. In addition, all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and/or misappropriation of property should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator or designated representative. All allegations of resident abuse would be reported to the Iowa Department of Inspections and Appeals no later than two (2) hours after the allegation was made.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on observation, interviews, record, and policy review the facility failed to update a Care Plan with resident specific goals and interventions. In addition, the facility failed to follow the interventions established in the Care Plan for 1 of 3 residents reviewed (Resident #17). The staff reported Resident #17 often hit and scratched them during care. In addition, the staff failed to monitor episodes to determine underlying causes as the plan of care directed.</p> <p>Findings include:</p> <p>Resident #17's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS indicated Resident #17 didn't have physical behavioral symptoms directed toward others, such as hitting, kicking, pushing, scratching. In addition, she didn't exhibit rejection of care behavior. She required partial to moderate assistance with showers and upper body dressing. In addition, she required total assistance for toileting hygiene and putting on footwear. The MDS included diagnoses of unspecified dementia, without behavioral/psychiatric mood, anemia (low blood iron) and depression.</p> <p>The Care Plan included the following Focuses:</p> <p>a. 11/3/23: Resident #17 had impaired cognitive function and impaired thought processes related to dementia, but could verbalize her needs.</p> <p>b. 9/8/23: Resident #17 had a risk for behaviors related to dementia and would have daily incidents of refusing cares, not cooperating with staff, yelling or hitting at staff. The Interventions last updated 6/14/23, directed the staff to monitor behavior episodes and attempt to determine underlying causes, considering location, time of day, persons involved, and situations, then document behavior and potential causes.</p> <p>In a confidential interview, Staff F, Certified Nurse Aide (CNA), said Resident #17 often hit and scratched staff. They didn't feel the nurses and Administration did much to find solutions to these behaviors.</p> <p>In a confidential interview, Staff S, CNA, displayed fresh marks and scratches on the inside and outside of her lower arms. She said that she sustained these injuries from Resident #17 while providing care. She said that the resident would become agitated, and along with other CNA's, Staff S felt that they needed to come up with some better plans for assisting the resident with her agitation while protecting staff.</p> <p>A review of the nursing notes showed that since 1/1/24, the following progress notes contained incidents where Residents #17 became combative and scratched staff:</p> <p>a. 1/2/24 at 2:00 AM</p> <p>b. 1/4/24 at 9:23 PM</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. 1/10/24 at 1:43 PM</p> <p>d. 1/15/24 at 9:48 PM</p> <p>e. 1/29/24 at 4:48 PM</p> <p>f. 1/31/24 at 1:02 AM</p> <p>g. 2/6/24 at 8:33 PM</p> <p>h. 2/20/24 at 2:03 PM</p> <p>i. 2/25/24 at 2:17 PM</p> <p>j. 2/26/24 at 5:10 PM</p> <p>k. 3/9/24 at 2:54 PM</p> <p>l. 3/13/24 at 9:58 PM</p> <p>m. 3/24/24 at 8:57 PM</p> <p>On 4/1/24 at 11:00 AM, Staff U, Registered Nurse (RN, Director of Nursing, DON), said when they had an incident with Resident #17 and the staff, they talked about it at the time of the event to determine the cause. If staff got scratched or hurt, they directed them to fill out an incident report and Administration would investigate the details. She acknowledged that they didn't use resident incident reporting to track and monitor the events. She said that they did not have any staff reports of getting scratched for a long time.</p> <p>On 4/1/24 at 11:40 AM, the Administrator said she thought Resident #17's behaviors got better because the staff didn't say anything to her about getting hit or scratched for sometime. When asked about team meetings to discuss, plan interventions and monitor progress, she said that they didn't use incident reports to track the episode, but they use different care pathways that triggered Care Plan goals.</p> <p>On 4/2/24 at 8:40 AM, Staff T, (RN, DON) said they would look back a week before to determine the MDS areas of concern. She acknowledged Resident #17's MDS dated ,d+[DATE], should include the incidents of behavioral concerns the prior week. When asked about the Care Plan intervention to monitor episodes and attempt to determine underlying cause, document behavior and potential causes. She replied they usually had those conversations and planning at the Care Conferences, then document it in the meeting notes.</p> <p>The Care Conference Notes dated 1/18/24 at 10:15 AM, listed the attendance as only Staff T and the Social Worker. The Problems/Needs area of the report showed a concern that the resident gets irritated with staff at times. The Resident/family concerns section showed no concerns at this time other than the resident scratching the staff at times. The document didn't include solutions or ideas for interventions that worked and/or didn't work.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan Development policy dated March 2017, directed the facility to develop a comprehensive plan of care. The plan of care would be reviewed periodically for the need for updating, modifying or additions.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on observation, interview and record review the facility failed to provide timely assessments and interventions to 2 of 5 residents reviewed (Resident #12 and #17). Resident #12 fell when the mechanical lift tipped over, the nurses failed to provide follow up assessments. Resident #17 had a pattern of aggressive/combatative behaviors and the staff failed to monitor for effective and ineffective interventions, in order to determine the best responses to keep her and the staff safe.</p> <p>Finding include:</p> <p>1. Resident #12's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #12 required extensive assistance from 2 persons for bed mobility, dressing, and toilet use. In addition, he required total assistance with transfers. The MDS included diagnoses of heart failure, renal insufficiency (poor functioning kidneys), diabetes, morbid (severe) obesity.</p> <p>The Care Plan updated 6/23/23 included the following:</p> <p>a. Resident #12 received hospice level of care.</p> <p>b. Resident #12 needed assistance with care due to his physical decline. The Interventions indicated the following:</p> <ul style="list-style-type: none"> <li>- He used a bariatric bed with a foot extender</li> <li>- The staff lifted his recliner to accommodate his height.</li> <li>- He preferred to sleep in his recliner rather than the bed.</li> </ul> <p>c. Resident #12 used high risk medication for heart failure, atrial fibrillation, chronic kidney disease and diabetes. He chose to stop his medications and go on hospice services.</p> <p>d. Resident #12 had chronic pain related to joint replacements, morbid obesity, arthritis and diabetic polyneuropathy (damage to multiple peripheral nerves by diabetes).</p> <p>e. Resident #12 had an ADL self-care deficit. The Intervention instructed he didn't walk and he required a full-body mechanical lift for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurses Note dated 7/2/23 at 10:10 AM reflected Staff L, Registered Nurse (RN), Staff K, Licensed Practical Nurse (LPN), and Staff M, RN, had Resident #12 in the full-body mechanical lift to transfer him from the bed to his recliner. Staff M positioned herself behind recliner to help guide him into the chair and to assist with getting his hips pulled back. Staff K used the lift to get Resident #12 up in air so he could be moved. As Staff K pulled the lift back with the legs open, Staff L had Resident #12's feet and was turning him to align him with the lift, the legs on lift started to close. As this occurred the lift tipped over falling to the south. Staff M moved the recliner quickly so Resident #12 landed in recliner from the waist up, with his feet on the floor still hooked to the lift. The base of the lift came up to the north side hitting Staff L in both shins. While the upper lift landed on Staff K's left side of her back. Both filled out employee incident reports. They removed Resident #12 from the lift, so they could remove the lift off Staff K and assess their injuries. Staff M called additional staff to the room. The staff reconnected Resident #12 back up to the lift, while 1 staff member stood on each lift leg, they lifted Resident #12 in the air. With the legs to the life open and on each side of the recliner, the staff stepped off the lift and pushed the lift back further to get Resident #12 back in his recliner. The staff repositioned Resident #12 in his recliner in good position, and then the staff unhooked the lift. Resident #12 didn't have complaints of pain or discomfort. Staff M notified the DON immediately of the incident.</p> <p>On 3/21/24 at 10:58 AM Staff M said she helped two other nurses transfer Resident #12 in the lift when it tipped over. She said Resident #12 landed in the recliner with his feet on the floor. She said that didn't complain of any pain and she didn't see any scratches. She didn't know if anyone completed a full nursing assessment.</p> <p>On 3/26/24 at 10:00 AM, when asked if the nurses completed a full assessment on Resident #12 after the fall, the Administrator said she didn't know for sure, and added Resident #12 would let them know if he had any pain or concerns.</p> <p>2. Resident #17's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS indicated Resident #17 didn't have physical behavioral symptoms directed toward others, such as hitting, kicking, pushing, scratching. In addition, she didn't exhibit rejection of care behavior. She required partial to moderate assistance with showers and upper body dressing. In addition, she required total assistance for toileting hygiene and putting on footwear. The MDS included diagnoses of unspecified dementia, without behavioral/psychiatric mood, anemia (low blood iron) and depression.</p> <p>The Care Plan included the following Focuses:</p> <p>a. 11/3/23: Resident #17 had impaired cognitive function and impaired thought processes related to dementia, but could verbalize her needs.</p> <p>c. 9/8/23: Resident #17 had a risk for behaviors related to dementia and would have daily incidents of refusing cares, not cooperating with staff, yelling or hitting at staff. The Interventions last updated 6/14/23, directed the staff to monitor behavior episodes and attempt to determine underlying causes, considering location, time of day, persons involved, and situations, then document behavior and potential causes.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a confidential interview, Staff F, Certified Nurse Aide (CNA), said Resident #17 often hit and scratched staff. They didn't feel the nurses and Administration did much to find solutions to these behaviors.</p> <p>In a confidential interview, Staff S, CNA, displayed fresh marks and scratches on the inside and outside of her lower arms. She said that she sustained these injuries from Resident #17 while providing care. She said that the resident would become agitated, and along with other CNA's, Staff S felt that they needed to come up with some better plans for assisting the resident with her agitation while protecting staff.</p> <p>On 4/1/24 at 11:00 AM, Staff U, Registered Nurse (RN, Director of Nursing, DON), said that when they have an incident with Resident #17 being combative, they talk about it at the time of the event to determine cause. She reported they didn't have a formal Interdisciplinary Team Meeting (IDT) to talk about root causes or possible solutions.</p> <p>On 4/1/24 at 11:40 AM, the Administrator said she thought Resident #17's behaviors got better because the staff didn't say anything to her about getting hit or scratched for some time. When asked about team meetings to discuss, plan interventions and monitor progress, she said that they didn't use incident reports to track the episode, but they use different care pathways that triggered Care Plan goals.</p> <p>On 4/2/24 at 8:40 AM, Staff T, (RN, DON) said they would look back a week before to determine the MDS areas of concern. She acknowledged Resident #17's MDS dated ,d+[DATE], should include the incidents of behavioral concerns the prior week. When asked about the Care Plan intervention to monitor episodes and attempt to determine underlying cause, document behavior and potential causes. She replied they usually had those conversations and planning at the Care Conferences, then document it in the meeting notes.</p> <p>The Care Conference Notes dated 1/18/24 at 10:15 AM, listed the attendance as only Staff T and the Social Worker. The Problems/Needs area of the report showed a concern that the resident gets irritated with staff at times. The Resident/family concerns section showed no concerns at this time other than the resident scratching the staff at times. The document didn't include solutions or ideas for interventions that worked and/or didn't work.</p> <p>The Care Plan Development policy dated March 2017, directed the facility to develop a comprehensive plan of care. The facility would review the plan of care periodically for the need for updating, modifying or additions.</p> <p>The undated Fall Protocol policy, instructed immediately after a fall, the nurse would; assess the resident's physical condition before moving, continue to monitor the residents physical and mental status every shift for a minimum of 24 hours and document in the nurse's notes.</p> <p>According to a facility policy titled: QAPI Quality Assurance Performance Improvement, dated 10/5/17, reflected the facility strived to provide excellent quality resident/patient care and services. The policy defined Quality as meeting or exceeding the needs, expectations, and requirements of the patients cost effectively while maintaining good resident/patient outcomes and perceptions of patient care.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on observation, interviews and record review the facility failed to ensure residents had assistance with Activities of Daily Living (ADL) for 5 of 14 residents reviewed (Residents #1, #8, #11, #13, and #14). During an observation of meals, Residents #14, #11, and #8 required assistance with eating had to wait over an hour after other residents finished their breakfast, to be able to eat their meal. In addition, the facility failed to provide baths for Residents #1 and #13 as directed by their plan of care. In a 30 day timeframe Resident #1 only had 3 showers and Resident #13 had only 2 showers.</p> <p>Findings include:</p> <p>1. Resident #14's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status score (BIMS) score of 0, indicating severely impaired cognition. The MDS indicated Resident #14 wandered. She required supervision and assistance with meals. The MDS included diagnoses of renal insufficiency (poor kidney function), non Alzheimer's dementia, malnutrition (inadequate intake of nutrients) and anxiety.</p> <p>A nutrition assessment on 2/16/24 at 3:58 PM, showed that Resident #14 was admitted to the facility with malnourishment due to dementia diagnosis, and her weight was down 2 pounds since admission.</p> <p>The Mini Nutrition dated 2/16/24 at 2:37 PM listed Resident #14's weight at 133.4 pounds (lbs.) on 2/12/24. Resident #14 had a moderate decrease in food</p> <p>intake in the last 3 months. The Mini Nutrition Score reflected a 5.0, indicating malnourished.</p> <p>The Nutrition Admission/Annual/Sig Change assessment dated [DATE] at 3:58 PM indicated Resident #14 had a slight weight loss since her admission. She ate an average of 49% by herself with staff cueing. The assessment described Resident #14 as malnourished due to a dementia diagnosis. She had a moderate decrease in oral intake with a decrease in weight of 2.1 lbs. from admission.</p> <p>The Alert Note dated 3/20 at 5:10 PM reflected Resident #14 ate 50% or less for 2 or more meals that day. The note indicated she did feed herself with staff supervision. The staff attempted to assist her, but she refused.</p> <p>The Care Plan Focus revised 2/19/24 identified Resident #14 needed assistance with ADLs related to her hip fracture. The Intervention instructed to assist her with eating by providing verbal cues to physical assistance.</p> <p>The Care Plan Focus revised 2/20/24 indicated Resident #14 had a risk for weight changes related to altered nutrition intake secondary to diagnosis of dementia, anxiety, severe protein-calorie malnutrition, depression, left greater than 25% of her meals uneaten, and hospice.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #11's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive deficits. He required maximum assistance with eating and dressing. He required total assistance with hygiene and transfers. The MDS included diagnoses of Down Syndrome, chronic kidney disease, obstructive and reflux uropathy (troubles with urination). Resident #11 required a mechanically altered diet while a resident.</p> <p>The Clinical Physician's Orders reviewed 3/21/24 listed an order dated 7/21/23 for a general diet with pureed texture.</p> <p>The Care Plan Focuses reflected the following:</p> <p>a. Revised 6/29/23: Resident #11 didn't have natural teeth and he choose to not wear dentures. The Interventions directed the staff to assist Resident #11 to eat with set-up assistance and verbal cues.</p> <p>b. Revised 12/12/23: Resident #11 had a risk for a weight change related to altered nutrition intake, needed for mechanically altered diet, and difficulty with communication.</p> <p>3. Resident #8's MDS assessment dated [DATE] identified a BIMS score of 1, indicating severely impaired cognition. She required supervision and assistance with eating. In addition, she required total assistance with hygiene and transfers. The MDS included diagnoses of anemia, renal insufficiency (poor kidney function), diabetes mellitus, and Alzheimer's Disease. Resident #8 required a mechanically altered diet while a resident at the facility.</p> <p>The Care Plan Focuses indicated the following:</p> <p>a. Revised 9/12/23: Resident #8 needed assistance with activities of daily living (ADLs) related to weakness and impaired vision. She liked to eat food with fingers.</p> <p>b. Revised 11/13/23: Resident #8 had a risk for a weight change related to altered nutrition intake secondary to diabetes and anemia. The Interventions directed the staff to offer a pureed food diet, encourage good oral intake at meals, monitor for chewing and swallowing issues</p> <p>On 3/20/24 observed the following:</p> <p>a. At 8:10 AM #8 and #11 sat at the breakfast table waiting for food while other residents finished eating.</p> <p>b. At 8:34 AM</p> <p>- Residents #8 and #11 still didn't have their food and waited for assistance to eat.</p> <p>- Resident #14 had two family members come to gather her belongings. When her family discovered she didn't eat yet, her husband sat down next to her and helped her eat.</p> <p>c. At 9:00 AM Residents #8 and #11 still haven't ate and continued to sit waiting at the table.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Blackhawk Life Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  73 West 5th Street Lake View, IA 51450	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. At 9:19 AM Residents #8 and #11 haven't ate and didn't have food in front of them yet, and the dining room didn't have other residents at the tables.</p> <p>e. At 9:26 AM when asked why Resident #8 and #11 didn't eat yet, Staff X, Dietary Aide, said they couldn't serve the residents with pureed food orders until they had an aide that could assist them with their meal.</p> <p>f. At 9:30 AM while Resident #8 drank a chocolate drink and it spilled down her blouse and onto the floor.</p> <p>g. At 9:31 AM witnessed the Director of Nursing (DON) sit with Resident #11 and assisted him with his meal.</p> <p>4. Resident #1's MDS assessment dated [DATE], identified a BIMS score of 4, indicating severe cognitive deficits. She hallucinated and had delusions. She required set up and clean up for meals. Resident #1 required total assistance with hygiene, toilet use, and bathing. The resident was frequently incontinent of bladder and bowel. The MDS included diagnoses of anemia (low blood iron), renal insufficiency, Alzheimer's disease and borderline personality disorder (impulsive mental health behaviors).</p> <p>The Care Plan Focus revised 7/17/23 indicated Resident #1 needed assistance with care and mobility due to her weakness, poor balance, and decreased mobility. The Interventions directed she required the assistance of 2 staff with transfers in and out of the shower with an assist of one during bath. She preferred to have a bath once a week, on Tuesdays.</p> <p>The Care Plan Focus revised 2/16/24 reflected Resident #1 had a history of altered skin integrity. The Interventions instructed the staff report any new areas of skin concern noted with daily cares to nurse.</p> <p>The Nurses Note dated 3/19/24 at 6:04 PM reflected Resident #1 didn't get a shower or bath that day because the bath aide left at 4:30 PM.</p> <p>The POC Response History related to showers/baths reviewed on 3/20/24 for the previous 30 days indicated Resident #1 had a bath on 2/20/24, 3/6/24, and 3/12/24. The dates of 2/27/24 and 3/3/24 listed not applicable.</p> <p>5. Resident #13's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. He required partial assistance with baths and showers. In addition, he required substantial assistance with toilet use and dressing. The MDS included diagnoses of anemia, hemiplegia or hemiparesis.</p> <p>The Care Plan Focus revised 9/15/23 reflected Resident #13 needed assistance with ADL's related to a stroke with left sided weakness and limited balance. He preferred to bathe once a week as he didn't do too much to get dirty, so he preferred to bathe on Tuesdays.</p> <p>The Nurses Note dated 3/19/24 at 6:03 PM, indicated Resident #13 didn't get a bath that day because the bath aide left at 4:30 PM.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/21/24 at 12:22 PM, Resident #13 said he didn't get his bath Tuesday for some reason. He said that he was okay with just one a week, but at the time of the interview, no one offered him another opportunity.</p> <p>On 3/25/24 at 4:25 PM Resident #13 said no one offered him another opportunity to have a bath or shower. He added the next day is Tuesday, so maybe he'll get one if nothing else breaks down.</p> <p>The POC Response History related to showers or baths reviewed on 3/21/24 for the previous 30 days listed Resident #13 received a bath on 3/6/24 and 3/12/24. The documentation listed not applicable for 2/23/24, 2/27/24, 3/1/24, and 3/8/24.</p> <p>On 4/2/24 at 8:40 AM, Staff T, RN DON, said she expected the kitchen staff to page for an aide when they were ready for residents to eat. She said that the bath aides try to get through the bath list if they are unable to, the residents should be offered a bath the next day if they didn't get one on their scheduled day.</p> <p>On 3/20/24 at 2:35, Staff J, CNA, said that getting through the entire list of residents on their bath days is challenging sometimes. There are days when 2 3 residents don't get the bath because she just can't get to them.</p> <p>On 3/25/24 at 12:10 PM, the Administrator said that they did not have a policy related to feeding assistance and they follow the individualized Care Plans for the resident needs. She said they didn't have a specific policy on offering baths and showers, adding the Care Plans detailed their preferences.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41785</p> <p>Based on clinical record review, observation, and staff interview, the facility failed to ensure that residents were safe from accidents related to mechanical lift transfers for 3 of 5 residents reviewed (Residents #5, #9, and #12). A mechanical full body lift machine tipped over during a transfer with Resident #12 and the resident landed in a recliner without injury. In addition, the staff failed to tighten the sling for a sit-to-stand transfer machine for observed transfers of Resident #5 and Resident #9.</p> <p>Findings include:</p> <p>1. Resident #12's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #12 required extensive assistance from 2 persons for bed mobility, dressing, and toilet use. In addition, he required total assistance with transfers. The MDS included diagnoses of heart failure, renal insufficiency (poor functioning kidneys), diabetes, morbid (severe) obesity.</p> <p>The Care Plan updated 6/23/23 included the following:</p> <p>a. Resident #12 received hospice level of care.</p> <p>b. Resident #12 needed assistance with care due to his physical decline. The Interventions indicated the following:</p> <ul style="list-style-type: none"> <li>- He used a bariatric bed with a foot extender</li> <li>- The staff lifted his recliner to accommodate his height.</li> <li>- He preferred to sleep in his recliner rather than the bed.</li> </ul> <p>c. Resident #12 used high risk medication for heart failure, atrial fibrillation, chronic kidney disease and diabetes. He chose to stop his medications and go on hospice services.</p> <p>d. Resident #12 had chronic pain related to joint replacements, morbid obesity, arthritis and diabetic polyneuropathy (damage to multiple peripheral nerves by diabetes).</p> <p>e. Resident #12 had an ADL self-care deficit. The Intervention instructed he didn't walk and he required a full-body mechanical lift for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Nurses Note dated 7/2/23 at 10:10 AM reflected Staff L, Registered Nurse (RN), Staff K, Licensed Practical Nurse (LPN), and Staff M, RN, had Resident #12 in the full-body mechanical lift to transfer him from the bed to his recliner. Staff M positioned herself behind recliner to help guide him into the chair and to assist with getting his hips pulled back. Staff K used the lift to get Resident #12 up in air so he could be moved. As Staff K pulled the lift back with the legs open, Staff L had Resident #12's feet and was turning him to align him with the lift, the legs on lift started to close. As this occurred the lift tipped over falling to the south. Staff M moved the recliner quickly so Resident #12 landed in recliner from the waist up, with his feet on the floor still hooked to the lift. The base of the lift came up to the north side hitting Staff L in both shins. While the upper lift landed on Staff K's left side of her back. Both filled out employee incident reports. They removed Resident #12 from the lift, so they could remove the lift off Staff K and assess their injuries. Staff M called additional staff to the room. The staff reconnected Resident #12 back up to the lift, while 1 staff member stood on each lift leg, they lifted Resident #12 in the air. With the legs to the life open and on each side of the recliner, the staff stepped off the lift and pushed the lift back further to get Resident #12 back in his recliner. The staff repositioned Resident #12 in his recliner in good position, and then the staff unhooked the lift. Resident #12 didn't have complaints of pain or discomfort. Staff M notified the DON immediately of the incident.</p> <p>On 3/21/24 at 10:25 AM, the Administrator said that the Maintenance department looked at the mechanical lift after it tipped and thought a bolt might have come loose and the handle didn't lock when the legs opened up. The Administrator said they took the machine out of commission, then she went out the next day and rented another machine. She reported Maintenance did regular checks on the lift before it happened. Even though the monthly checks included one checkmark, she said that she trusted the Maintenance man to do a thorough inspection of the machines.</p> <p>On 3/21/24 at 10:45 AM, Staff N, Maintenance, said the mechanical lift had a welded area around the bolt on the base of the lift. The bolt broke loose before or after the fall. The bolt connected the mechanism from the handle to open and close the legs of the machine. He said he did monthly checks on the lifts and didn't have any concerns. He added he wouldn't see any wear and tear on the weld before it broke.</p> <p>On 3/21/24 at 10:58 AM Staff M, RN, said she assisted transferring Resident #12 when the lift tipped. She described her position as behind the recliner so she could pull on the sling and guide Resident #12 into the recliner once he would get into position. The legs of the lift couldn't open under the bed, so once they lifted Resident #12 off the bed, the nurse backed the lift away from the bed. While she backed up and turned the machine, she started to widen the legs at the same time. She said that this cause Resident #12's weight to shift causing the lift to tip. When she saw the lift tipping, she pushed the recliner forward to catch Resident #12. One of the nurses got between Resident #12 and the lift to protect him, when the top of the machine fell on her. The other nurse got hit by the legs of the machine as it fell. Staff M said the legs of the lift didn't completely open and she didn't see anything break or hear a clunk. They had more staff come in and help move Resident #12 up further in the recliner with the use of the lift. They had a staff member stand on each one of the legs of the machine while they lifted him up further in the recliner.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/21/24 at 11:05 AM, Staff K, Licensed Practical Nurse (LPN), said that she helped two other staff members transfer Resident #12 from the bed to the recliner on 7/2/23. Staff L, Registered Nurse (RN), controlled the machine, while she and Staff M, RN, maneuvered the sling with Resident #12 inside. She said they had difficulties turning him because of his weight. When Staff L tried to turn the machine and open the legs on the lift, the handle used to pull the legs open, snapped. She said that she heard a clunk, and one of the legs closed, jolting Resident #12. Due to the jolt, the machine become off balanced, sending Resident #12 forward, over the recliner, and the machine tipped over to the side. The lift fell on top of her, causing some rib injuries.</p> <p>On 3/24/24 at 2:06 PM, Staff H, CNA, described Resident #12 as so large that when she needed to transfer him with the mechanical lift, she made sure she had 3 more people there to help. Staff H described the lift as unsteady before the fall, the legs felt rickety, they wouldn't open all the way, and the machine didn't steer very well. Sometimes, the legs closed on their own, and the staff knew that it didn't work correctly. Staff H said she told the Maintenance staff person that the machine rattled and had something loose, but it didn't get repaired.</p> <p>On 3/24/24 at 2:53 PM, Staff V, Certified Nurse Aide (CNA), remembered the total body mechanical lift malfunctioned before it tipped over with Resident #12 attached. She explained around 6 PM, she toileted a resident when she found a bolt on the floor under the machine. She and another aide tipped it over to see where it came from and put a sign on it to not use it. Maintenance worked on it then. The remote on the machine would cut in and out, and the lever would stick sometimes when they went to open and close the legs. She said the facility had a Maintenance book, for the staff to enter things that needed attention, but it took a long time to get things repaired.</p> <p>On 3/25/24 at 8:00 AM, Staff N denied remembering anyone coming to him about concerns of the mechanical lift not working properly before it broke. He did remember repairing a standing mechanical lift. Staff N went through the Maintenance request slips from May, June and July of 2023. He explained he didn't have concerns communicated regarding the lever/legs not functioning properly.</p> <p>On 3/25/24 at 12:23 PM Staff L, RN, remembered controlling the mechanical lift on 7/2/23 when it tipped over with Resident #12. She said she had the legs open when she lifted him from the bed and pulled it backwards. As she stepped to the side, she helped reposition the resident in the sling. Once she started to help turn Resident #12, one of the legs on the machine started to close, causing the machine to tip to the side. The base of the machine scraped up her leg. Staff M pushed the recliner under Resident #12, while Staff K got between Resident #12 and the machine to help position him. As the machine tipped, the top handles, where the sling hooks onto, fell down on top of Staff K. Staff L said that she didn't hear any clunking, but the legs just closed. She explained that had happened several times before with that machine, when she transferred residents. She reported it to the office on more than one occasion. She said all of the staff knew the mechanical lift didn't function properly. She didn't have any knowledge of any other residents falling from the machine, but it particularly worried the staff about transferring very large residents. She said she didn't fill out a Maintenance sheet, because she assumed that since so many people knew about it, someone already did that.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/25/24 at 3:30 PM, Staff A, CNA, said she knew the full body lift didn't function properly before Resident #12 fell . She said the lift had things loose and one leg automatically shut after it opened. Staff A said that she went directly to the Maintenance man and told him they had a problem with the lift. He told her to put it in the log book, but she felt it needed addressed right away because it wasn't safe. She said that it was a shame that it took an accident to get it addressed.</p> <p>During a follow-up interview on 3/26/24 at 1:39 PM, Staff N said he didn't know about the recommended, scheduled Maintenance on the lifts. It's basically just looking it over and he referred to the checklist he used with one checkmark per month. He said he looked at everything on the machines monthly and checked it off. When asked if the manufacturer had specific recommendations related to the scheduled Maintenance, he responded some of the manufacturers recommended greasing every so often. Staff N said the lift that broke was a Prolift brand, but he didn't have the manufacturers handbook. After the machine tipped and broke they disposed of the lift and the handbook. Staff N did not know when they purchased the Valaro lift they currently had or how old it may be.</p> <p>Observations revealed that the facility used a Valaro total body lift.</p> <p>According to the Valaro handbook, a maintenance schedule indicated that every 3 months:</p> <ol style="list-style-type: none"> <li>a. Pivot points should be lubed and the actuator greased with heavy duty #2 grease.</li> <li>b. Check the leg adjuster stop for signs of wear, check the movement of the lift,</li> <li>c. Check leg covers and replace if cracked,</li> <li>d. Check all external fittings tighten where needed,</li> <li>e. Remove padding and check hanger [NAME] and fittings.</li> <li>f. Hanger bolt must be repaired every three years</li> <li>g. Actuator bearing (ball screw nut) must be replaced when grinding wear was heard but not longer than 5 years.</li> </ol> <p>The manual included a recommended sample monthly inspection sheet and check off list.</p> <p>The Maintenance Repair Need sheet dated 6/12/23 indicated in the Ice Room the unnamed mechanical full-body lift battery charger sparked when a battery got plugged in. The date completed section listed the person couldn't make it spark.</p> <p>According to the Stand and Lift Monthly Checks in 2023, in July of 2023 Maintenance installed a new leg spreader handle kit that month on the Valaro lift.</p> <p>On 3/27/24 at 7:30 AM, the Administrator said the Maintenance Man looked at the three mechanical lifts that morning and he tightened a bolt on the Sit to Stand lift. He told her they could only tightened the bolts so many times until the threading strips. When asked about the replacement leg spreader handle kit done in July 2023, she thought it had a bolt issue that got tightened too many times. He called the company and asked what he needed to do, they recommended replacing it.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #5's MDS assessment dated [DATE] identified a BIMS of 12 (moderate cognitive deficit). He required total assistance from staff for sitting to standing, toilet transfers, and bed mobility. The MDS indicated Resident #5 had frequent incontinence of bowel and bladder. The MDS included diagnoses of obstructive uropathy (difficulty urinating), epilepsy (seizure disorder), anxiety disorder, psychotic disorder and lack of coordination.</p> <p>The Care Plan Focus revised 8/23/23 indicated Resident #5 couldn't walk anymore and required a mechanical assist to stand safely.</p> <p>On 3/19/24 at 3:27 PM, watched Staff C, CNA, and Staff D, CNA, assist Resident #5 with the Sit to Stand (standing) mechanical lift. As they positioned him with the standing mechanical lift, he wore boots and had his feet on the platform. The observation revealed the standing mechanical lift didn't have leg straps. The staff hooked up the sling and lifted him to a standing position. As he stood, the staff failed to tighten the belt around his torso. The sling was mostly in his armpits with his arms parallel to the floor. Resident #5 had his knees locked straight, with his bottom out, and his shins away from the shin guards. They took him to the bathroom and lowered him on the toilet.</p> <p>On 3/26/24 at 8:15 AM, witnessed two unidentified CNA's transferred Resident #5 using the standing mechanical lift while Staff U, RN DON, observed. As they transferred Resident #5 the sling raised up to his armpits. Staff U acknowledged most of the sling rested in the armpits and looked as if he supported most of his weight by his arms. She added as the sling had padding it made it easier on the armpit. She agreed it wasn't ideal, but she taught her staff not to chicken wing (arms above head) the residents with transfers.</p> <p>3. Resident #9's MDS assessment dated [DATE] identified a BIMS score of 6, indicating severely impaired cognition. Resident #9 required total staff assistance from staff for sit to stand, chair to bed transfer, and toilet transfers. The MDS described her as frequently incontinent of bowel and bladder. The MDS included diagnoses of Alzheimer's disease, anxiety disorder, psychotic disorder, and polyneuropathy (Damage to multiple peripheral nerves). The MDS indicated she had occasional pain and transferred with the use of a mechanical lift.</p> <p>The Care Plan Focus revised 8/5/23, identified Resident #9 needed assistance with activities of daily living (ADLs) due to a history of falls and weakness.</p> <p>On 3/20 at 7:37 AM witnessed Resident #9 sitting on the toilet with the standing mechanical lift in front of her. Staff E, CNA, adjusted the sling to the lowest hook and then lifted her from the toilet with the standing mechanical lift. As the machine raised Resident #9 into a standing position, the sling slid up to her armpits with no support to her back, Staff A stood nearby encouraging her to stand straight and to use her legs. Once Resident #9 stood in the upright position, they failed to tighten the belt, and it hung loosely to her waist. As she hanged with her arms parallel to the floor, the sling held a majority of her weight, the staff wiped Resident #9's bottom. At 7:41 Resident #9 said I have to sit down, the staff encouraged her to use her legs and stand tall as they put on a clean brief. Resident #9 said let me sit down. When they finished applying her brief, they lowered her to the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/21/24 at 7:45 AM Staff T, RN DON, and Staff W, Certified Medication Aide (CMA), stayed in the room with Resident #9 while she sat on the toilet. When she finished on the toilet, they raised Resident #9 up with the standing mechanical lift. Resident #9 gasped and struggled to breath. When she stood in the machine, they failed to tighten the belt, and it hung loosely down the front. Resident #9 held onto the handles but struggled as her arms remained parallel to the floor with her knees bent. They cleaned up her bottom and applied a clean brief. Resident #9 said her arms hurt and Staff T encouraged her to stand up straight and said your chicken winged. Again, Resident #9 reported her arms hurt. When they lowered her into the wheelchair, Staff T asked Resident #9 where it hurt and she pointed to her right arm pit.</p> <p>The observations of the slings used for the 3 Residents with the Sit to Stand transfers, revealed the facility used slings (Volaro) different from the manufacturer/company as the Sit to Stand mechanical lift (Invacare).</p> <p>On 3/21/24 at 1:40 PM a representative from the sling manufacturer said the manufacturers would say that if they didn't test a sling on their machine, they wouldn't recommend using it on a machine from another company.</p> <p>On 3/21/24 at 1:30, a representative from Invacare (maker of the Sit to Stand) said that if they didn't test a sling on their machines they wouldn't recommend using it for patient transfers.</p> <p>On 3/21/24 at 2:53 PM, the Administrator said she talked to a representative from the Invacare company and asked about what slings could be used. His response was that they can use Invacare approved slings. She asked him what that means, how are they approved, and he told her any sling that matches the hooks on the machine and fits properly.</p> <p>In an email correspondence on 3/25/24 at 9:14 AM, the Invacare Product Manager said Invacare patient lifts are specifically designed and manufactured for use in conjunction with Invacare slings. Slings designed by other manufacturers have not been tested by Invacare and we cannot recommend them for use with Invacare lifts. The use of non Invacare slings on Invacare lifts would be at the sole discretion of the facility.</p> <p>On 3/25/24 at 12:10 PM the Administrator agreed that the sling waist belt around a resident on the Sit to Stand lift should have been snug when the residents stood in the machine.</p> <p>When asked about sling choices, she referenced the email, where the representative said use of non Invacare slings on Invacare lifts would be at the sole discretion of the facility. She said that they found for Invacare slings looked just like the ones they used.</p> <p>The undated Stand Up Patient Lift User Manual, instructed Invacare products were specifically designed and manufactured for use in conjunction with Invacare accessories. Invacare hasn't tested accessories designed by other manufactures and don't recommend them for use with Invacare products.</p> <p>A warning label on the side of the Invacare machine showed that staff should only use Invacare slings and lift accessories. The Invacare manual, Page 8 section I general Guidelines indicated that the belt must be snug, otherwise the patient can slide out of the sling during transfer, possibly causing injury</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Blackhawk Life Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  73 West 5th Street Lake View, IA 51450	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The undated Sit to Stand Policy and Procedure directed the staff to position the top of the harness around the upper body of the resident, 4- 5 inches under the arms, then secure the safety strap around the resident.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41785</p> <p>Based on observation, interviews and record review the facility failed to implement incident and/or unusual occurrence reports for 3 of 3 residents reviewed (Residents #1, #12, and #17). The mechanical lift tipped over while transferring Resident #12, the facility failed to follow up with an incident report or investigation into the failure. Resident #1 sustained a skin tear on her arm and the facility failed to investigate the cause. Staff discovered that Resident #17 had scratches on her arms, the chart lacked an incident report or investigation into the cause.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #12's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #12 required extensive assistance from 2 persons for bed mobility, dressing, and toilet use. In addition, he required total assistance with transfers. The MDS included diagnoses of heart failure, renal insufficiency (poor functioning kidneys), diabetes, morbid (severe) obesity.</li> </ol> <p>The Care Plan updated 6/23/23 included the following:</p> <ol style="list-style-type: none"> <li>a. Resident #12 received hospice level of care.</li> <li>b. Resident #12 needed assistance with care due to his physical decline. The Interventions indicated the following: <ul style="list-style-type: none"> <li>- He used a bariatric bed with a foot extender</li> <li>- The staff lifted his recliner to accommodate his height.</li> <li>- He preferred to sleep in his recliner rather than the bed.</li> </ul> </li> <li>c. Resident #12 used high risk medication for heart failure, atrial fibrillation, chronic kidney disease and diabetes. He chose to stop his medications and go on hospice services.</li> <li>d. Resident #12 had chronic pain related to joint replacements, morbid obesity, arthritis and diabetic polyneuropathy (damage to multiple peripheral nerves by diabetes).</li> <li>e. Resident #12 had an ADL self-care deficit. The Intervention instructed he didn't walk and he required a full-body mechanical lift for transfers.</li> </ol> <p>A nursing note dated 7/2/23 at 10:10 AM showed that three nurses went to transfer the Resident #12 from the bed to recliner and the mechanical lift tipped over. The resident fell into the recliner and had no injuries, however, two of the staff sustained injuries from the machine falling.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/25/24 at 12:23 PM Staff L, RN, remembered controlling the mechanical lift on 7/2/23 when it tipped over with Resident #12. She said she had the legs open when she lifted him from the bed and pulled it backwards. As she stepped to the side, she helped reposition the resident in the sling. Once she started to help turn Resident #12, one of the legs on the machine started to close, causing the machine to tip to the side. The base of the machine scraped up her leg. Staff M pushed the recliner under Resident #12, while Staff K got between Resident #12 and the machine to help position him. As the machine tipped, the top handles, where the sling hooks onto, fell down on top of Staff K. Staff L said that she didn't hear any clunking, but the legs just closed. She explained that had happened several times before with that machine, when she transferred residents. She reported it to the office on more than one occasion. She said all of the staff knew the mechanical lift didn't function properly. She didn't have any knowledge of any other residents falling from the machine, but it particularly worried the staff about transferring very large residents. She said she didn't fill out a maintenance sheet, because she assumed that since so many people knew about it, someone already did that.</p> <p>On 3/21/24 at 10:25 AM, the Administrator said they didn't complete an incident report after Resident #12 fell from the lift because he didn't get hurt. The two staff who got hurt completed incident reports because they took the brunt of the machine.</p> <p>On 3/26/24 at 10:00 AM, the Administrator said because Resident #12 didn't get hurt, the nurses put details in their notes, they addressed the concerns, she didn't see a need for an incident report when the lift tipped over.</p> <p>2. Resident #1's MDS assessment dated [DATE], identified a BIMS score of 4, indicating severe cognitive deficits. She hallucinated and had delusions. She required set up and clean up for meals and was totally dependent on staff for hygiene, toileting and bathing. The resident was frequently incontinent of bladder and bowel. The MDS included diagnoses of anemia (low blood iron), renal insufficiency, Alzheimer's disease and borderline personality disorder (impulsive mental health behaviors).</p> <p>The Care Plan Focus revised 7/17/23 indicated Resident #1 needed assistance with care and mobility due to her weakness, poor balance, and decreased mobility. The Interventions directed Resident #1 required an assist of 2 with transfers and ambulation with a gait belt and walker.</p> <p>The Care Plan Focus revised 2/16/24 reflected Resident #1 had a history of altered skin integrity. The Intervention directed to complete a wound assessment per skin integrity flow sheet.</p> <p>According to the Skin Condition Report dated 3/20/24, Resident #1 had a V shaped skin tear on left arm 2 centimeter (cm) x 0 cm. The section labeled cause of bruise or skin tear remained incomplete.</p> <p>The Nurses Note dated 3/20/24 at 1:53 PM indicated Resident #1 sustained a skin tear on her left forearm after coming back from the bathroom and lying down in bed after lunch. The area looked bruised and measured 2 cm x 2 cm. The note lacked the cause of the injury.</p> <p>On 3/21/24 at 12:25 PM, Staff A, Certified Nurse Aide (CNA), said when she and another aide transferred Resident #1 to the bathroom, they didn't notice the skin tear or any blood. When they got her off the toilet to go to her bed, they noticed the skin tear on her right arm, with dried blood around on the arm. The resident couldn't say what happened.</p> <p>The chart lacked an incident report or investigation into the cause of the skin tear and bruising.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Resident #17's MDS assessment dated [DATE], identified a BIMS score of 5, indicating severely impaired cognition. She required partial to moderate assistance with showers and upper body dressing. In addition, she required total assistance for toileting hygiene and putting on footwear. The MDS included diagnoses of unspecified dementia, without behavioral/psychiatric mood, anemia (low blood iron) and depression.</p> <p>The Care Plan included the following Focuses:</p> <p>a. 11/3/23: Resident #17 had impaired cognitive function and impaired thought processes related to dementia, but could verbalize her needs.</p> <p>c. 9/8/23: Resident #17 had a risk for behaviors related to dementia and would have daily incidents of refusing cares, not cooperating with staff, yelling or hitting at staff. The Interventions last updated 6/14/23, directed the staff to monitor behavior episodes and attempt to determine underlying causes, considering location, time of day, persons involved, and situations, then document behavior and potential causes.</p> <p>In a confidential interview, Staff F, Certified Nurse Aide (CNA), said Resident #17 often hit and scratched staff. They didn't feel the nurses and Administration did much to find solutions to these behaviors.</p> <p>In a confidential interview, Staff S, CNA, displayed fresh marks and scratches on the inside and outside of her lower arms. She said that she sustained these injuries from Resident #17 while providing care. She said that the resident would become agitated, and along with other CNA's, Staff S felt that they needed to come up with some better plans for assisting the resident with her agitation while protecting staff.</p> <p>A Skin Condition Report dated 12/31/23 reflected Resident #17 had 3 scratches on her left lower arm, surrounded by purple bruising. The report listed the cause Resident #17 scratched herself during cares. The document lacked an explanation for the bruising.</p> <p>Resident #17's clinical record lacked an incident report or investigation related to her skin concerns.</p> <p>On 4/1/24 at 11:00 AM, Staff U, Registered Nurse (RN, Director of Nursing, DON), said that when they have an incident with Resident #17 being combative, they talk about it at the time of the event to determine cause. She reported they didn't have a formal Interdisciplinary Team Meeting (IDT) to talk about root causes or possible solutions.</p> <p>On 4/1/24 at 11:40 AM, the Administrator said she thought Resident #17's behaviors got better because the staff didn't say anything to her about getting hit or scratched for some time. When asked about team meetings to discuss, plan interventions and monitor progress, she said that they didn't use incident reports to track the episode, but they use different care pathways that triggered Care Plan goals.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/25/24 at 12:10 PM, the Administrator said they don't do incident reports on everything that happened at the facility, as they would be doing reports all day long. She said that with the lift fall, they followed up, and got a different one. They did all the steps included in the incident report anyway.</p> <p>The Incident and Investigation Charting policy dated 12/1/16, described the purpose as to record the fact about the incident to notify the Administration that an incident occurred and to provide data for trending and tracking incidents. To use a systematic effort to determine what happened, how it happened, why it happened and whom it happened to. The Incident investigation was an important part of the Quality Assurance Program. The charge nurse completes an incident report and the investigation report. The resident would be placed on the facility hot chart which required a reassessment at least once per shift for 24 hours. The DON should review each report, sign, and date the form. The DON should forward the report to the Administrator for review. In addition, the DON shall review all incident reports with the Medical Director on a monthly basis.</p>