STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165537	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiawatha Care Center	405 North 15th Avenue Hiawatha, IA 52233

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35434 Based on observation, clinical record review, policy review, and resident and staff interviews, the facility failed to ensure staff treated residents with dignity and allowed them to make their own choices and decisions for 3 of 11 residents reviewed for resident rights (Residents #4, #10, and #11). The facility reported a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 12/30/24, listed diagnoses for Resident #4 which included fracture of the right pubis (the side of the hip bone), Alzheimer's disease, and anxiety. The MDS stated the resident required partial to moderate assistance for chair transfers and did not walk due to a medical condition or safety concerns. The MDS listed his Brief Interview for Mental Status (BIMS) score as 5 out of 15, indicating severely impaired cognition. Care Plan entries, dated 12/30/24, stated the resident had a diagnosis of Alzheimer's and self-transferred. The Care Plan directed staff to explain the need for assistance with transfers to prevent injuries and to place the resident at the nursing station if (self-transfers) continued. On 1/6/25 at 12:19 p.m., Resident #4 sat in his wheelchair near the nursing station and began to stand up. Staff A Licensed Practical Nurse (LPN) stated What are you doing? in a loud, harsh voice. The resident stated he intended to stand up after which Staff A stated No you're not, you broke your leg. The resident attempted to stand again and Staff A told him that he fell and broke his hip and now you are paying the price. Staff A stated this in a loud voice and multiple other residents and staff were in the area within earshot. 2. The MDS assessment tool, dated 11/23/24, listed diagnoses for Resident #10 which included cancer, pain in the right hip, and heart failure. The MDS stated the resident was dependent on staff for chair transfers and listed a BIMS score of 14 out of 15, indicating intact cognition. Care Plan entries, revised 1/6/25, stated the resident was adjusting to the facility and required assistance with transfers. The entries directed staff to offer 1:1 support when anxious and allow her to express her feelings. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 11:33 a.m., Resident #10 stated night shift staff told her she was not allowed to get up. She stated last night around 1:30 a.m., she asked to get up and staff told her she had to wait. She stated she woke up again at 3:30 a.m. and at that time staff agreed to get her up. She stated she mentioned this to the CNAs (Certified Nursing Assistants). 3. The MDS assessment tool, dated 1/2/24, listed diagnoses for Resident #11 which included adult failure to thrive, depression, and insomnia. The MDS stated the resident required supervision assistance with transfers and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. Care Plan entries, dated 1/2/25, stated the resident was new to the facility and would demonstrate satisfaction with her placement and cares. On 1/7/25 at 3:53 p.m., Resident #11 stated Staff E CNA told her she could not sleep with her dentures in and did not return them to her for the night as the resident preferred. She stated another time, Staff E told her she had to go to bed even though she told her she was not tired. The undated facility policy Dignity stated each resident shall be cared for in a manner which promoted and enhanced his sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The policy stated individual needs and preferences of residents were identified through the assessment process and residents were supported in exercising their rights. An Employee Disciplinary Report, dated 1/2/25, stated Resident #10 complained that Staff E didn't have a lot of patience and told Resident #10 that if she could stand, she needed to do this. Resident #11 stated that Staff E told her she had to go to bed even though she didn't want to and would not allow her to sleep in her dentures after she stated she wanted to. On 1/7/25 at 10:35 a.m., Staff A stated with regard to the comment she made to Resident #4 that she did not mean it strongly and it came out wrong. On 1/7/25 at 10:52 a.m., Staff B CNA stated Resident #10 informed her on 1/3/25 that she wanted to get up early and the night shift told her it was too early for her to get up. Staff B stated the resident told her staff treated her like a dog. Staff B stated she reported this to Staff D Licensed Practical Nurse (LPN). On 1/7/25 at 11:08 a.m. Staff C CNA stated this morning Resident #10 told her she asked the night shift to get up and they told her she didn't need to get up. Staff C stated it was the resident's choice and she wanted to get up and was not allowed to do so. Staff C stated she did not report this to anyone yet. On 1/7/25 at 11:17 a.m., via phone, Staff D stated no one reported to her any allegations of mistreatment by the night shift staff. On 1/7/25 at 12:53 p.m., the Administrator stated he was not aware of any complaints Resident #10 had with the exception of what they had documented with Staff E. He stated he would provide documentation of this. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 2:28 p.m. the Director of Nursing (DON) stated staff reported to her that Resident #10 stated Staff E's approach to her bothered her. She stated she spoke to Staff E regarding the fact that this is their home and residents were never an inconvenience. She stated she would want CNAs to report it if the night shift would not get residents up or if residents stated they were treated like a dog. She stated if this happened it would be addressed and they would complete an investigation. She stated the only complaints she was aware of were the complaints with Staff E and she was not aware of allegations the night shift would not get Resident #10 up. She stated residents could get up in their chairs when they wanted. When asked about the comment made by Staff A to Resident #4 regarding him paying the price, the DON stated this was terrible and she would want it stated in a different manner. She stated staff could offer to take him to the restroom (when he tried to get up). On 1/8/25 at 11:30 a.m., the Administrator stated staff should treat residents with the utmost respect and dignity and they were allowed to get up when they wanted or sleep in. He stated he would want to know about allegations that residents reported being treated like a dog and not being allowed to get up during the night when they wanted. He stated if this was reported to him, the facility would carry out an investigation. He stated if it was determined to be anything which rose to the level of an allegation of abuse, they would suspend the staff member and report it. He stated he was not aware that Resident #10 made these allegations.