

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165569	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER West Point Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 607 6th Street West Point, IA 52656	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy, the facility failed to perform check and changes on a resident for at least 8 hours for 1 of 3 residents reviewed for incontinence cares (Resident #1). The facility reported a census of 32 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated the resident had impairment in one upper and lower extremity. The MDS revealed Resident #1 dependent on toileting hygiene and required substantial/maximal assistance with chair/bed to chair transfer. The MDS indicated the resident was frequently incontinent of bladder. The MDS revealed medical diagnoses for hemiplegia following cerebral infarction (stroke) affecting the left non-dominant side. The Care Plan revealed a focus are revised on 10/9/24 for assistance with Activities of Daily Living (ADLs) related to history of cerebral vascular accident (CVA) (stroke) with weakness/impairment to one side of the upper and lower extremity, decreased mobility, and balance/gait impairments. The intervention revised on 2/6/24 indicated assistance of 1 staff member for toileting due to resident incontinent of bladder. The Care Plan revealed a focus area revised on 1/2/25 for bladder incontinence due to history of CVA (stroke). The intervention dated 1/2/25 indicated clean peri-area with each incontinent episode. The Nurses Note dated 11/10/25 at 12:25 PM, revealed [name redacted] has been quiet during this shift, denying any pain or discomfort. He has been observed resting in bed with his eyes closed, respirations even and unlabored. He was incontinent of bladder earlier, and peri care was provided. Bed in lowest position and call light is in reach. The Nurses Note dated 11/14/25 at 6:45 PM revealed resting easy in recliner. No SOB (shortness of breath) noted. Denies needs or wants. Call light in reach. The Summary Report for Resident #1 regarding allegations of neglect (no dated indicated) revealed the following timeline of events beginning November 14, 2025 and November 15, 2025a. 3:10 PM- POC (Plan of Care) showed Resident #1 toileted and continent at this time with bladder elimination. b. 6:30 PM- Staff B, Certified Nurse Aide (CNA) notified Staff A, CNA that both residents in 28 are ready for bed.c. 6:38 PM- Resident #1 utilized call light to ask for assistance. Staff A states that he assisted Resident #1 to his recliner per his request. Staff A states Resident #1 told him to get the f**k out at this time. Staff A assisted Resident #1 roommate Resident #2 before exiting the room. d. 9:15 PM- Staff C, Registered Nurse (RN) administered medications to Resident #1 and inquired if he was ready for bed. Resident #1 declined. e. 10:00 PM- Staff D, CNA reported observing Resident #1 in his recliner at this time during shift change rounds.f. 10:30 PM- Staff E, RN stated at this time Resident #1 requested his water pitcher and bedside table to be placed closer to him.g 12:00 AM- Staff D reported observing Resident #1 in his recliner at this time during rounds. h. 12:33 AM- POC showed Resident #1 did not void at this time.i. 2:00 AM- Staff D reported observing Resident #1 in his recliner at this time during rounds.j. 2:33 AM- POC shows Resident #1 did not void at this time. k. 4:00 AM- call light report</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 165569	Facility ID: 165569 If continuation sheet Page 1 of 3

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>brief because call lights were going off and Staff G didn't go into Resident #1 room during shift rounds. Staff G stated after rounds she went into Resident #1 room to get his roommate up and could smell an ammonia smell and then Staff F came into the room to get Resident #1 up and noticed Resident #1 saturated in urine. Staff G stated Resident commented he was not checked on because Resident #1 didn't want Staff A taking care of him. Staff G stated Resident #1 wore a pull up incontinent brief and day shift were the only ones who used those with Resident #1. Staff G stated Resident #1 couldn't use the urinal when Resident #1 wore the pull up brief because he only used one hand. Staff G asked when they did shift rounds if they physically checked the residents and Staff G stated no, they would trust the staff, but now the staff always do physical checks. Staff G stated Staff A should of told the nurse or the other aide about Resident #1 kicking Staff A out of his room if Resident #1 was refusing cares. During an interview on 1/22/26 at 12:12 PM, Staff D stated Resident #1 was not a check and change at the time of the incident and Staff D did not physically check on him throughout the night of November 14th. Staff D stated she did rounds every 2 hours and would look in Resident #1 room and Resident #1 would be asleep. Staff D stated all she knew was Resident #1 refused to go to bed for Staff A. Staff D stated if residents were a one assist, staff would wake them up to check if the residents needed to use the bathroom. Staff D stated if she knew more about Resident #1 refusing Staff A, Staff D would of done a better job with checking on Resident #1 and made sure Resident #1 dry and clean. During an interview on 1/22/26 at 1:04 PM, Staff B stated Resident #1 had a habit of being incontinent and needed to be changed. Staff B stated she regularly checked Resident #1 for incontinence and Resident #1 usually incontinent between 2-4 AM rounds. Staff B stated Resident #1 sometimes would use the urinal. During an interview on 1/22/26 at 2:04 PM, Staff E, RN queried on the incident in November with Resident #1 and Staff E stated he was not aware of Staff A being kicked out of Resident #1 room by the nurse in report or other staff. During an interview on 1/22/26 at 2:23 PM, Staff C, RN queried on the incident in November with Resident #1 and Staff C stated Staff A never told Staff C about being kicked out of Resident #1 room. Staff C stated if she would of known, Staff C would of checked on Resident #1 and asked another CNA to go into Resident #1 room. During an interview on 1/22/26 at 3:13 PM, the Director of Nursing (DON) queried on her thoughts of the incident and the DON stated she wished the CNA would of passed it on the nurse that Resident #1 told the CNA to leave his room. The DON stated the resident being upset was not a reason for staff to not attempt to physically do check and changes. The Facility Rounding on Resident Policy dated 11/18/25 revealed all residents were to be rounded on approximately every 2 hours and at the end of each shift. Incontinence check, with peri-cares or toileting as necessary.</p>		