STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165569	A. Building B. Wing	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Point Care Center Inc	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, staff interviews and facility policy review, the facility failed to notify the Physician after the resident expressed thoughts of self harm for 1 of 1 residents reviewed for change of condition (Resident #21). The facility reported a census of 30 residents. Findings Include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS documented the resident had medical diagnoses including Non-Alzheimer's dementia, and depression. The MDS revealed the resident took antipsychotic, antidepressant, and antianxiety medications. The Care Plan documented a Focus Area dated 3/1/23 for a mood problem related to cognitive decline, and inability to safely return to her home. The interventions dated 3/1/23 directed the staff as follows: a. Assist the resident, family, and caregivers to identify strengths and positive coping skills and reinforce them. b. Monitor/record/report mood patterns with signs and symptoms of depression, anxiety, sad mood as needed to the Medical Doctor (MD) as per the facility behavior monitoring protocols. The Electronic Medical Record (EMR) revealed the following diagnoses: a. Major depressive disorder, single episode, unspecified. b. Unspecified depression. c. Unspecified dementia, unspecified severity, with other behavioral disturbance. The Physician Orders revealed the following orders: a. Ordered on 10/10/23 and discontinued on 10/17/23- Clonazepam oral tablet disintegrating 0.25 milligram (mg) - give 1 tablet by mouth one time a day every other day for anxiety for 7 days. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Ordered on 8/21/23 and discontinued on 12/21/23- Sertraline HCl (hydrochloride) oral tablet 25 mg- give 1 tablet by mouth one time a day. c. Ordered on 2/17/23 and discontinued on 11/13/23 Risperidone oral tablet 0.25 mg- give 0.5 mg by mouth one time a day. The Progress Note dated 8/23/23 at 8:55 PM, revealed after resident in bed staff heard her crying. Certified Nurse Assistant (CNA) stated when she talked with the resident, the resident stated, I just want my children here and for us all to die together so I can be with them. 1:1 placed with resident and resident calmed down and checked by nurse and resident asleep. The facility lacked documentation the family or the doctor notified of the residents thoughts/behaviors. The Progress Note dated 10/14/23 at 3:16 PM, revealed the resident stated to another resident that if I had a gun, I'd shoot myself. This nurse went and talked with resident. The resident stated that she really didn't want to kill herself, she just felt useless. Resident kept requesting to go to see her mother, who was ill. This nurse put 1 on 1 supervision with the resident, then went and got the basket of clothing protectors and asked for resident's help folding them. This nurse called family to let them know and see if one of them could visit with the resident. Resident folded the clothing protectors in the basket and then smiled at this nurse and stated that made her, feel happier. Another resident joined her in folding some of the clothing protectors. This nurse went back to laundry and pulled a load out of the dryer and gave them to both residents. Both sat there and folded them chatting with each other. The facility lacked documentation of notification to the doctor of the residents thoughts of harm. During an interview on 1/17/24 at 11:26 AM, Staff F, Registered Nurse (RN) queried on the situation when the resident made comments about wanting to shoot herself and Staff F stated she believed they spoke to the Physician. Staff F asked if the Physician notified, would it be documented and she stated yes. During an interview on 1/17/23 at 3:46 PM, Staff T, RN queried what she done when residents expressed thoughts of harm and she stated she asked a few more questions such as did they have a plan and why did they think that way and then she would talk to the Assistant Director of Nursing (ADON) and let the Physician know. During an interview on 1/18/24 at 1:15 PM, the ADON queried on Resident #21's behaviors and she stated she knew about a time when the resident said something about a gun and she stated they called the family. The ADON asked if the Physician needed notified and she stated yes they should. The ADON queried about another time the resident spoke of wanting her family with her so they could all die together and the ADON confirmed the Physician should of been notified. During an interview on 1/22/24 at 12:44 PM, the Interim Director of Nursing (DON) queried on her expectations when a resident made comments of self harm and she stated it would depend on the resident and if they were capable of following through and look at the situation and she would look at urinary symptoms, look to see if resident started new medication or had family visits and let the doctor know of the situation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Resident Change of Condition Physician Notifications Policy dated 1/22/18 revealed the following information: a. The attending Physician or Physician On-Call notified with changes in a resident's condition or health status. 1. Significant change in mental or psychosocial status. 2. Other conditions as deemed necessary. b. Document time of call, Physician or Nurse Practitioner or other person spoke to, reason for call and results or orders received.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on Facility Reported Incident (FRI) review, observations, staff interviews, and facility policy review, the facility failed to protect the residents' right to be free from mental abuse and verbal abuse by a staff member for three of six residents reviewed for abuse (Resident #30, #84, and #134), resulting in a resident report of the employee being mean to them, resident display of negative reactions including being irate and displaying increased behaviors around the employee, and staff report of the employee taunting a resident. The facility reported a census of 30 residents. Findings Include: Review of a Self-Report Reporting Information for an Incident which occurred 10/9/23 at 10:00 AM, documented the following per the Incident Summary: A staff member wrote a statement stating Staff B, Certified Nursing Assistant (CNA) on 2nd sift talks badly to the residents. She stated that residents have told her to get out of their room. The statement reports Resident #4 was told she could take herself to the bathroom and she is not helpless. Resident #4 has a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Staff B told Resident #30 she wasn't going to help her if she was going to keep acting crazy. Resident #30 has a BIMS of 6 out of 15 and is very confused. The statement reports that Resident # 13 was told he was lazy and could do more for himself. Resident #13 was then reported to say Staff B didn't like him at another facility and she still didn't like him now. Resident #13's BIMS is 14 out of 15. At this time, we do not know when any of these things were said. We assume it was in their rooms. Review of the Summary of Investigation of Incident section dated 10/11/23 documented, in part, the following: At this time [Facility Name Redacted] has completed its investigation of the allegation of verbal abuse/personal degradation. While the residents that have a BIMS of 10 or above, report there is no problem with Staff B, CNA, staff report Staff B has said things to our confused/dementia residents that could be considered shameful, degrading, and possibly causing humiliation or harm to their personal dignity. Review of a Situation, Background, Assessment, Request (SBAR) form to the Nurse Practitioner (NP) dated 10/13/23 documented, Allegation of verbal abuse was reported to us + (and) reported to State-CNA made faces + comments to some residents about you could do more for yourself, you are lazy, if you fall, then one less person I have to care for. The SBAR included four resident names, Resident #1, Resident #4, Resident #13, and Resident #30, with notation the first three residents denied anything and the fourth had dementia. Review of the clinical records for Resident #1, Resident #4, Resident #13, Resident #30, and Resident #134 revealed the following residents had intact cognition per their BIMS scores present on the Minimum Data Set (MDS) assessment, as indicated below: 1. The MDS assessment dated [DATE] revealed Resident #1 scored 15 out of 15 on a BIMS exam, which indicated intact cognition. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] revealed Resident #4 scored 14 out of 15 on a BIMS exam, which indicated intact cognition. 3. The MDS assessment dated [DATE] revealed Resident #13 scored 14 out of 15 on a BIMS exam, which indicated intact cognition. The following residents had severely impaired cognition per their BIMS scores present on the MDS assessment, as indicated below: 4. The MDS assessment dated [DATE] revealed Resident #30 scored 6 out of 15 on a BIMS exam, which indicated severely impaired cognition. 5. The MDS assessment dated [DATE] revealed Resident #134 scored 3 out of 15 on a BIMS exam, which indicated severe cognitive impairment. On 1/17/24 at 2:24 PM, Resident #134 observed in their room in a recliner chair. Review of Medical Diagnoses for Resident #134 revealed a diagnosis of anxiety disorder. When queried, Resident #134 unable to state the name of where they currently were. Interview with staff at time of survey revealed Resident #84's described reaction to Staff B. Resident #84 was not included in FRI documentation. The BIMS information for Resident #84 included the following: 6. The MDS Assessment for Resident #84 dated 10/6/23 revealed the resident scored 00 out of 15 on a BIMS exam, which indicated severely impaired cognition. Review of medical diagnoses for Resident #84 revealed the resident had a diagnosis of dementia without behavioral disturbance. Review of a statement by Staff C, CNA, dated 10/9/23 at 10:45 AM, documented, I [Staff C] seen [First Name matching that of Staff B, CNA talk badly to the residents, she goes in their rooms with poor ethic she will refuse to help those she doesn't like, I've seen and heard residents say she's mean she's evil, I heard residents tell her to get out of their room. Staff B told Resident #4 she's not helpless she could take herself to bathroom. Staff B told Resident #30 she wasn't going to help her if she was going to keep acting crazy. Staff B would refuse to help Resident #1 more than once I would have to go answer Resident #1's call light cause she wouldn't [Staff B] and would talk bad to Resident #13 saying he was lazy and he could do more for himself I heard Resident #13 say to Staff B, you didn't like me at [another facility name redacted] and you still don't like me here. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a statement by Staff D, CNA, dated 10/11/23 documented, I, [Staff D], have witnessed Staff B verbally abusive + Taunt residents at [Facility Name]. It's mostly with residents with memory issues. Their demeanor changes when she enters the room + they start to have behaviors. Another CNA + I had to go into Resident #30's room to get her up because she would not for Staff B. Resident #30 said Staff B was hateful + mean to her + we calmed her. Staff D noticed Staff B peaking though the curtain taunting her with faces. I have heard the same resident who was experiencing pain say she was going to throw herself out of her chair + kill herself + Staff B told her to go ahead and do it then, less work for us, etc. Resident #134 said how mean Staff B is to her. Staff D had been in the room when Staff B said things back mocking their pain + confusion. Staff B walks into rooms with sour faces, a bad attitude, + is just mean to some residents. Especially the residents who react to her negative energy. Staff D cannot remember every word said but, Staff B should not take care of the elderly who have memory loss, who are confused or scared she mocks them, she is not supportive + she is mean to them. Review of a statement by Staff E, Registered Nurse (RN), documented, had noted Staff B making negative sarcastic comments to residents over the past week. Staff E had also overheard a couple residents making a comment along the lines of you just don't like me. Staff B had made negative statements about residents to me and within earshot of me that certain residents get on her nerves and she does not like caring for them. On Friday night 10/6/23, several CNA's were sitting discussing similar situations they have encountered with Staff B in the recent past 1-2 weeks. On 1/10/24 at 3:04 PM Staff D, CNA queried about her statement and Staff B. Staff D explained she really enjoyed working with Staff B, then started noticing Staff B was kind of talking with the residents with memory disabilities kind of mean. Per Staff D, she heard the employee had been turned in. Staff D explained she provided a statement about Staff B's treating a few of the residents, clarified as two residents, and Staff D explained she needed to go and take care of residents because they did not want Staff B near them. Staff D provided the first names of the two residents, Resident #30 and Resident #134. Staff D explained she looked back and Staff B was poking through the curtain mocking a resident (Resident #30), and didn't care for that, and Staff B's negative energy rubbed off on residents and something had to be said. Staff D explained she needed to go in and do cares because Resident #30 did not want Staff B, would not listen to her and be around her. Per Staff D, with Resident #134, right when the resident was having a really hard time and said something like, Oh, I'm just going to fall or something, Staff B said just go ahead. Per Staff D, she knew Staff B would never let someone actually fall, and didn't know if Staff B said it loud enough for resident to hear, but think the employee did so (loud enough to hear). When queried about reporting, Staff D explained she just wasn't sure, thought this was not Staff B, and explained she had worked with Staff B prior. Staff D explained when they were approached by a staff, Staff D realized it was an actual problem, and explained now when it happened they would not think the staff was just going through something rough and would notify right away. Staff D explained she was approached by the Director of Nursing (DON). Staff D explained this occurred with just people with memory problems and nobody who was actually alert. When queried about the residents' reaction, Staff D explained when Staff B was in the room they would get immediately irritated, and further explained it probably did not just happen when Staff D was at the facility, and probably happened often. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/11/24 at 12:11 PM, during an interview with Staff J, CNA, about concerns with staff treatment to residents, Staff J explained there was one lady who was let go. Staff J explained she wouldn't want her taking care of people. Staff J provided a first name of that matching Staff B, and last name starting with the same letter as Staff B's name. Per Staff J, she believed the employee was accused of abuse, and explained she believed it was valid. Per Staff J, the employee was very vulgar, straight to the point, very blunt, and was like children talking to her. Staff J explained she was the one that took report from the employee the night the allegation was made. Staff J explained there was a resident down [redacted] hall, Resident #21, who had a [Brand Name camera device with monitoring display screen] in their room. Per Staff J, the [Camera Device] can hear (described as like a baby monitor). Staff J explained if right outside the room giving report you could hear, and there was a resident across the hall from Resident #21, later identified by first name of Resident #30, who was louder, and Staff B said, quit that fake crying. Per Staff J, she heard it directly, Staff B left, and the nurse working with Staff J asked if Staff B was like that a lot. Staff J explained the other part of the camera was at the Nurse's Station so when giving report the staff member probably heard Staff B telling resident she was faking. Staff J explained Staff B was trying to finish report, Resident #30 was hollering and crying, and Staff B made the comment. When queried if she thought residents could hear the comment, Staff J responded they were all in bed. Per Staff J, she had worked with Staff B in the past and that seemed to be her normal. Per Staff J the above described happened, Staff J was off for a few days, Staff J came back, and heard the staff member had been reported. On 1/16/24 at 12:21 PM, a display screen with an image was observed at the Nursing Station. When queried whose device it was, Staff L, Restorative Aide explained for Resident #21. Observation of Resident #21's resident room revealed a camera device on the wall. On 1/16/24 at 12:45 PM, Staff M, Licensed Practical Nurse (LPN) explained she worked night shift, 10:00 PM to 6:00 AM. When queried about concerning statements by staff to resident, Staff M denied knowing of any. When queried if a resident had a camera device, Staff M explained Resident #21. When queried if the device had audio, Staff M responded yes, and it had the option to turn audio off. When queried if she ever heard anything concerning though the camera device, Staff M denied hearing anything. On 1/17/24 at 9:53 AM, interview conducted with Staff Q, CNA. When queried about staff to resident treatment concerns, Staff Q explained not for staff at the facility now. Per Staff Q there was one lady, matching first name of Staff B, that she worked with one day. Staff Q explained she did not like how Staff B spoke to residents, and Staff Q thought Staff B was too burnt out and got frustrated with the residents. Per Staff Q, Staff B wasn't yelling at residents, and Staff Q explained she did not say anything to anyone else, and didn't think it was a form of abuse. Per Staff Q, Staff B was very stern speaking, and described the employee as fed up and over it. Staff Q was not able to remember anything said to the residents. When queried if the facility had spoken to her about staff to resident concerns, Staff Q explained they had for a different situation (involving a different allegation type). When queried if directed towards certain residents or more widespread, Staff Q responded with everybody. Staff Q explained mainly what she remembered the residents met Staff B's energy and gave it right back. When queried how Staff B responded, Staff Q explained she knew Staff B argued with a couple of residents and they would argue right back with her. When queried as to specific residents, Staff Q responded she did not think at the facility any more. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/17/23 at 2:55 PM, when queried about treatment from staff to residents, Staff E, former employee, explained a staff would make offhand comments towards resident in the hall or their tone of voice was a little rough. Staff E explained she noticed the employee's tone of voice, and figured it was kind of her personality as the employee would be that way to other staff. Staff E explained they never heard anything she needed to report. Staff E explained when they heard discussion by CNAs, then it needed to be reported. Staff E explained it boiled down to one CNA. Staff E queried if this would be the same situation described in her statement, included with FRI documentation, and acknowledged yes. Per Staff E, the employee would not give a simple response when a resident would ask for something. Staff E further explained with a regular exchange for the resident, the employee would throw in something extra and put an edge on it. When queried about resident response, Staff E explained some of them seemed to not be really comfortable around her. Per Staff E, none of the residents refused to let the employee care for them that Staff E could recall. Staff E explained it was on a midnight shift when she overheard conversation from CNAs, and she felt like someone needed to report it as it was openly talked about in front of Staff E. Staff E further explained the discussion was around how a CNA from second shift spoke to residents when doing walking rounds per her recollection. Per Staff E, the discussion surrounded on how they did not think how the employee was talking was right. On 1/17/24 at 4:14 PM, during an interview with Staff R, CNA explained Staff B used to agitate the [h*ll] out of every single resident she would go into. Per Staff R, she would follow Staff B and would take report from Staff B, and multiple residents were agitated to high [NAME] and she needed to calm them down almost every day. Staff R explained there was one resident who was at the facility for four days, Resident #84, who would be irate, throwing things at Staff B. Per Staff R, Resident #84 had dementia, and she would assist in getting the resident settled down and then the resident was fine for the rest of the night. Staff R explained Staff B had a very short temper, very short attention span, and if did not do what she wanted, she was going to yell at them. Staff R further explained the following about Resident #30: Per Staff R, Resident #21 had a [brand name device like baby monitor], and the volume of the monitor would be kept up at night in case the resident started talking. Staff R explained the volume of the monitor was turned up when she got to the facility. Per Staff R, she turned it up and heard Staff B in the hallway mocking Resident #30 because Resident #30 used to have behaviors and scream. Staff R explained they heard Staff B yelling back at the resident in the hallway, heard through Resident #21's monitor. Staff R explained the following example: Resident #30 would yell she wanted out of there and wanted to go home, and Staff B in a mocking tone did it back, not to the resident's face, but in the hallway. Staff R explained she could hear it on Resident #21's monitor. When queried if she thought Resident #30 could hear Staff B, Staff R responded no as the resident was pretty hard of hearing, but she still didn't like it and was not appropriate. Staff R explained she knew Resident #4 had said the staff member was short with her, and Resident #4 said Staff B had a real short attention span, got short with her, and made her hurry. Per Staff R, it was irritating when the same few people were always upset. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45338 Based on Facility Reported Incident (FRI) review, staff interviews, and facility policy review the facility failed to ensure allegations of mental abuse and verbal abuse from a staff member to residents was reported to the State Agency within required regulatory timeframe for five of six residents reviewed for abuse included as part of a Facility Reported Incident and/or included in staff statements as part of the FRI (Resident #1, #4, #13, #30, and #134). The facility reported a census of 30 residents. Findings Include: Review of a Self-Report Reporting Information for an Incident which occurred 10/9/23 at 10:00 AM, documented the following per the Incident Summary: A staff member wrote a statement stating Staff B, Certified Nursing Assistant (CNA) on 2nd sift talks badly to the residents. She stated that residents have told her to get out of their room. The statement reports Resident #4 was told she could take herself to the bathroom and she is not helpless. Resident #4 has a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Staff B told Resident #30 she wasn't going to help her if she was going to keep acting crazy. Resident #30 has a BIMS of 6 out of 15 and is very confused. The statement reports that Resident #13 was told he was lazy and could do more for himself. Resident #13 was then reported to say Staff B didn't like him at another facility and she still didn't like him now. Resident #13's BIMS is 14 out of 15. At this time, we do not know when any of these things were said. We assume it was in their rooms. Review of a statement by Staff E, Registered Nurse (RN), documented, had noted Staff B making negative sarcastic comments to residents over the past week. Staff E had also overheard a couple residents making a comment along the lines of you just don't like me. Staff B had made negative statements about residents to me and within earshot of me that certain residents get on her nerves and she does not like caring for them. On Friday night 10/6/23, several CNA's were sitting discussing similar situations they have encountered with Staff B in the recent past 1-2 weeks. Review of the Summary of Investigation of Incident section dated 10/11/23 documented, in part, the following: At this time [Facility Name Redacted] has completed its investigation of the allegation of verbal abuse/personal degradation. While the residents that have a BIMS of 10 or above, report there is no problem with Staff B, (CNA), staff report Staff B has said things to our confused/dementia residents that could be considered shameful, degrading, and possibly causing humiliation or harm to their personal dignity .Also, at this time staff is being educated starting today regarding the need to report verbal abuse immediately to the Director of Nursing (DON) and or the Administration instead of waiting a day or two to do so. When asking the staff members why they did not report sooner. They stated they were fairly new here and thought maybe it was just her way. It was not until they got together and started talking that they knew they needed to report this. (continued on next page)

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	165569	A. Building B. Wing	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Point Care Center Inc	607 6th Street West Point, IA 52656

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/23 at 2:55 PM, when queried about treatment from staff to residents, Staff E, Registered Nurse (RN), explained a staff would make offhand comments towards resident in the hall or their tone of voice was a little rough. Staff E explained she noticed the employee's tone of voice, and figured it was kind of her personality as the employee would be that way to other staff. Staff E explained they never heard anything they needed to report. Staff E explained when they heard discussion by CNAs, then it needed to be reported. Staff E explained it boiled down to one CNA. Staff E queried if this would be the same situation described in her statement as part of the facility reported incident, and acknowledged yes. Per Staff E, the employee would not give a simple response when a resident would ask for something, and with a regular exchange for the resident, the employee would throw in something extra and put an edge on it. When queried about resident response, Staff E explained some residents seemed to not be real comfortable around her. Per Staff E, none of the residents refused to let the employee care for them that Staff E could recall. Staff E further explained it was on a midnight shift when she overheard conversation from CNAs, and she felt like someone needed to report it as it was openly talked about in front of her. Per Staff E, the discussion was around how a CNA from second shift spoke to residents when doing walking rounds is what she remembered them talking about. Per Staff E, they were all discussing how they did not think how the employee was talking was right. On 1/18/24 at 4:16 PM when queried how the incident was reported to her, the Administrator explained an anonymous note was left on her desk. The Administrator acknowledged coordination with the DON to start asking questions, and that is when statements started coming in on 10/9 (2023). When queried who had left the note, the Administrator responded she heard it was a CNA and heard it was a nurse, she did not know. The Administrator responded it should have been reported to her and the State Agency. When queried about expectations for staff, the Administrator explained she would expect for them to call her as soon as saw something or heard something, explained she always told staff 2 hours she knew with injury, and minimum of 24 hours. When queried if this occurred in this instance, the Administrator responded, no, it did not. Per the Administrator, when she asked staff, the response was they were new, did not want to make any trouble, and wanted to talk about it. The Administrator further explained from what she understood, they had talked about it for more than one day. The Facility Policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 revealed the following per the Reporting section: All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation 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 shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on Facility Reported Incident (FRI) review, clinical record review, staff interviews, and facility policy review, the facility failed to conduct a thorough investigation following allegations of mistreatment, mental abuse, and verbal abuse from a staff member to residents for six of six residents reviewed for abuse, four of which were named in a Facility Reported Incident (FRI) (Resident #1, #4, #13, and #30), one additional resident referenced in a staff statement included in the FRI documentation (Resident #134), and for one additional resident identified by staff upon interview (Resident #84). The facility reported a census of 30 residents. Findings Include: Review of a Self-Report Reporting Information for an Incident which occurred 10/9/23 at 10:00 AM, documented the following per the Incident Summary: A staff member wrote a statement stating Staff B, Certified Nursing Assistant (CNA) on 2nd sift talks badly to the residents. She stated that residents have told her to get out of their room. The statement reports Resident #4 was told she could take herself to the bathroom and she is not helpless. Resident #4 has a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Staff B told Resident #30 she wasn't going to help her if she was going to keep acting crazy. Resident #30 has a BIMS of 6 out of 15 and is very confused. The statement reports that Resident # 13 was told he was lazy and could do more for himself. Resident #13 was then reported to say Staff B didn't like him at another facility and she still didn't like him now. Resident #13's BIMS is 14 out of 15. At this time, we do not know when any of these things were said. We assume it was in their rooms. Per the Resident Section of the Self-Report, the names of Resident #1, Resident #4, Resident #13, and Resident #30 were listed. The residents listed in this section of the report had the following Brief Interview for Mental Status (BIMS) scores: 1. Per the Minimum Data Set (MDS) dated [DATE], Resident #1 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. 2. Per the MDS dated [DATE], Resident #4 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. 3. Per the MDS dated [DATE], Resident #13 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. 4. Per the MDS dated [DATE], Resident #30 scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Review of a Situation, Background, Assessment, Request (SBAR) form to the Nurse Practitioner (NP) dated 10/13/23 documented, Allegation of verbal abuse was reported to us + (and) reported to State-CNA (Certified Nursing Assistant) made faces + comments to some residents about you could do more for yourself, you are lazy, if you fall one less person I have to care for. The SBAR included four resident names, Resident #4, Resident #1, Resident #13, and Resident #30, with notation the first three residents denied anything and the fourth had dementia. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a staff statement included as part of the FRI included information for Resident #134. Resident #134 was not included in the list of resident names included in the Resident Section of the Self-Report form. The BIMS for Resident #134 included the following: 5. Per the Minimum Data Set (MDS) dated [DATE], Resident #134 scored 3 out of fifteen on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. Interview with staff at time of survey revealed Resident #84's described reaction to Staff B. Resident #84 was not included in the FRI, and was not referenced in witness statements by staff provided with the FRI. The BIMS information for Resident #84 included the following: 6. The MDS assessment for Resident #84 dated 10/6/23 revealed the resident scored 00 out of 15 on a BIMS exam, which indicated severely impaired cognition. Review of medical diagnoses for Resident #84 revealed the resident had a diagnosis of dementia without behavioral disturbance. Interviews conducted during the time of survey with Staff J, CNA, Staff Q, CNA, and Staff R, CNA revealed the following additional information including specific alleged incidents with residents, staff, and Staff B: On 1/11/24 at 12:11 PM during an interview with Staff J, CNA, about concerns with staff treatment to residents, Staff J explained there was one lady who was let go. Staff J explained she wouldn't want her taking care of people. Staff J provided a first name of that matching Staff B, and last name starting with the same letter as Staff B's name. Per Staff J, she believed the employee was accused of abuse, and explained she believed it was valid. Per Staff J, the employee was very vulgar, straight to the point, very blunt, and was like children talking to her. Staff J explained she was the one that took report from the employee the night the allegation was made. Staff J explained there was a resident down [redacted] hall, Resident #21, who had a [Brand Name camera device with monitoring display screen] in their room. Per Staff J, the [Camera Device] can hear (described as like a baby monitor). Staff J explained if right outside the room giving report you could hear, and there was a resident across the hall from Resident #21, later identified by first name of Resident #30, who was louder, and Staff B said, quit that fake crying. Per Staff J, she (Staff J) heard it directly, and when she came up, Staff B left, the nurse working with her asked if Staff B was like that a lot. Staff J explained the other part of the camera was at the Nurse's Station so when giving report the staff member probably heard Staff B telling resident she was faking. Staff J explained Staff B was trying to finish report, Resident #30 was hollering and crying, and Staff B made the comment. When queried if she thought residents could hear the comment, Staff J responded they were all in bed. Per Staff J, she had worked with Staff B in the past and that seemed to be Staff B's normal. Staff J explained that happened, then Staff J was off for a few days, came back, and heard the staff member had been reported. On 1/16/24 at 12:21 PM, a display screen with image was observed at the nursing station. When queried whose device it was, Staff L, Restorative Aide explained for Resident #21. Observation of Resident #21's resident room revealed a camera device on the wall. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/24 at 9:53 AM, interview conducted with Staff Q, CNA. When queried about staff to resident treatment concerns, Staff Q explained not for staff at the facility now. Staff Q explained there was one lady, matching first name of Staff B, that she worked with one day. Staff Q explained she did not like how Staff B spoke to residents, and Staff Q thought Staff B was too burnt out and got frustrated with the residents. Per Staff Q, Staff B wasn't yelling at residents, and Staff Q explained she did not say anything to anyone else and didn't think it was a form of abuse. Per Staff Q, Staff B was very stern speaking, and described the employee as fed up and over it. Staff Q was not able to remember anything said to the residents. When queried if the facility had spoken to her about staff to resident concerns, Staff Q explained they had for a different situation (different allegation type than this incident). When queried if the behavior was directed towards certain residents or more widespread, Staff Q responded with everybody. Staff Q explained mainly what she remembered the residents met Staff B's energy and gave it right back. When queried how Staff B responded, Staff Q explained she knew Staff B argued with a couple of residents and they would argue right back with her. When queried as to specific residents, Staff Q responded she did not think at the facility any more. On 1/17/24 at 4:14 PM during an interview with Staff R, CNA explained Staff B used to agitate the [h*ll] out of every single resident she would go into. Per Staff R, she would follow Staff B and would take report from Staff B, and multiple residents were agitated to high [NAME] and she needed to calm them down almost every day. Staff R explained there was one resident who was at the facility for four days, Resident #84, who would be irate, throwing things at Staff B. Per Staff R, Resident #84 had dementia, and she would assist in getting the resident settled down and the resident was fine for the resident of the night. Staff R explained Staff B had a very short temper, very short attention span, and if did not do what she wanted, she was going to yell at them. The Facility Reported Incident (FRI) did not include Resident #84. Staff R further explained there was a resident, Resident #30. Staff R explained Resident #21 had a [brand name device like a baby monitor], and the volume of the monitor would be kept up at night in case the resident started talking. Staff R explained the volume of the monitor was turned up when she got to the facility. Per Staff R, she turned the volume up and heard Staff B in the hallway mocking Resident #30 because Resident #30 used to have behaviors and scream. Staff R explained they heard Staff B yelling back at the resident in the hallway, heard through Resident #21's monitor and mocking. Staff R explained the following example: Resident #30 would yell she wanted out of there and wanted to go home, and Staff B in a mocking tone did it back, not to the resident's face, but in the hallway. Staff R explained she could hear it on Resident #21's monitor. When queried if she thought Resident #30 could hear Staff B, Staff R responded no as the resident was pretty hard of hearing, but she still didn't like it and was not appropriate. Staff R explained she knew Resident #4 had said the staff member was short with her, and Resident #4 said Staff B had a real short attention span, got short with her, and made her hurry. Staff R explained she always told the nurse of the situations which occurred, most of the time she let them know hey, this just happened and I got the resident calmed down. Staff R explained the specific phrasing she believed she used to communicate about Staff B. Per Staff R, it was irritating when the same few people were always upset, and she knew she told. Staff R explained she knew Staff M, Licensed Practical Nurse (LPN) had been present when she said something. Staff R explained she would report to a nurse. When queried if she was asked by the facility about the situation similar to current interview, Staff R said no. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On interview, two staff referenced the monitor in Resident #21's room, one who reported what they heard on the monitor by Staff B, and another who alleged she was asked about Staff B by a nurse who heard via the monitor. The Facility Reported Incident did not reference Resident #21 or the monitor. On 1/18/24 at 4:16 PM when queried how the incident was reported to her, the Administrator explained an anonymous note was left on her desk. The Administrator acknowledged coordination with the Director of Nursing (DON) to start asking questions, and that is when statements started coming in on 10/9 (2023). When queried who had left the note, the Administrator responded she heard it was a CNA and heard it was a nurse, she did not know. On 1/18/24 at 4:27 PM, the Administrator explained residents with confusion would not be able to vocalize being treated wrongly unless there were outbursts, increased fighting back, or resisting cares, and explained she had not heard that anything had been extraordinarily off with the residents who had dementia. The Facility Policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 revealed the following: The Administrator or designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, observations, staff interviews, and facility policy review, the facility failed to update a Care Plan when a resident started a diuretic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #19). The facility reported a census of 30 residents. Findings Include: The MDS (Minimum Data Set) assessment dated [DATE] revealed Resident #19 scored a 5 of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS revealed the resident received a diuretic. The Care Plan lacked documentation for a Focus Area and interventions for Resident #19's diuretic medication. The Electronic Medical Record (EMR) revealed the following medical diagnoses: a. Heart failure, unspecified. b. Unspecified systolic (congestive) heart failure. c. Chronic kidney disease, Stage 3 unspecified. d. Hypertensive chronic kidney disease with Stage 1 through Stage 4 chronic kidney disease, or unspecified chronic kidney disease. The Physician Orders documented the following medication orders: a. Ordered 11/10/23- Bumetanide oral tablet 1 milligram (mg)- Give 1.5 mg by mouth one time a day. During an observation on 1/8/24 at 1:44 PM, Resident #19 sat in her Geri chair in high semi-Fowlers position and the Certified Nurse Aide (CNA) escorted her from the dining room. Alarm in place on the arm of her Geri chair. During an interview on 1/18/24 at 1:28 PM, the Assistant Director of Nursing (ADON) stated they all worked on the Care Plans. The ADON queried if Resident #30 on a diuretic, and if the diuretic needed documented on the Care Plan and she stated the facility usually didn't put diuretics on the Care Plan. She stated they Care Planned blood thinners, antipsychotics, and antidepressants. During an interview on 1/22/24 at 12:35 PM, the Interim Director of Nursing (DON) queried on the expectation of a diuretic addressed on the Care Plan and she stated she didn't think they Care Planned the diuretic. She stated they Care Planned antipsychotics, anticoagulants, and antianxiety medications but didn't think they Care Planned the diuretics. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated Facility MDS/Care Plan Review Policy didn't address the need for medications to be addressed on the Care Plan. The undated Facility MDS/Care Plan Review Policy revealed the focus areas, goals, or interventions on the Care Plan were good to review for assistance with what to document on.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, staff interviews, and facility policy review, the facility failed to recheck a blood pressure, notify the doctor, and document a follow up Progress Note after a elevated blood pressure reading of 190/88 with a stomachache and back pain for 1 of 2 residents reviewed for closed records (Resident #30). The facility reported a census of 30 residents. Findings Include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 scored a 4 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS revealed diagnoses of hypertension and non-Alzheimer's dementia. The Electronic Medical Record (EMR) revealed a diagnosis of hypertension. The Physician Orders documented the following medication: a. Ordered 10/31/23- metoprolol tartrate oral tablet 25 milligrams (mg) - give 1 tablet by mouth two times a day The Skilled Evaluation Progress Note dated 11/26/23 at 8:07 PM, revealed the following vitals: a. Temperature 97.7. b. Blood Pressure (BP) 123/64. c. Pulse 74 beats per minute (bpm). d. Respirations 16 breaths per minute. e. Pulse Oximetry (O2) 96%. The Progress Note dated 11/26/23 at 9:09 PM, documented Resident #30 complained of stomachache and back pain. As needed (PRN) Tylenol administered and gave warm blankets wrapped around stomach and back. Temperature 97.4, pulse 74 bpm and regular, respirations 20 breaths per minute, BP 190/88 laying position, left arm. While resident laid down stated I'm going to be sick and gagged with only spit coming out. Also passed a large amount of gas at that same time. The resident got up into recliner so that she sat in upright position if she vomited. After a few minutes she stated she wanted to get into bed again. Encouraged her to sit up but replied I'm not that sick. Assisted back to bed into comfortable position on her side, with wastebasket at bedside and fresh warm blanket. The facility lacked documentation for a recheck of the elevated blood pressure, notification to the doctor of blood pressure and symptoms, and a follow up Progress Note for resident's symptoms or if the Tylenol effective for pain relief. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/17/24 at 11:23 AM, Staff F, Registered Nurse (RN) queried what she'd do when a resident had a high blood pressure reading and she stated she waited a little bit and then rechecked the blood pressure and if the reading still showed the blood pressure elevated she contacted the provider. She stated she'd let the oncoming nurse know of the elevated blood pressure. Staff F confirmed when she took a blood pressure reading, she documented the reading in the chart. She stated the system now had alerts to inform the nurses if they needed to chart on a resident and the interventions that completed. During an interview on 1/17/24 at 3:46 PM, Staff T, RN queried if she remembered the last time she cared for Resident #30 and she stated yes. She stated Resident #30 had a stomach ache and had a huge bowel movement and went to sleep and then she checked on her throughout the shift. Staff T asked about the elevated blood pressure she documented and she stated she didn't remember the blood pressure and if the resident had an elevated blood pressure reading she rechecked it manually. Staff T stated sometimes Resident #30 hard to get vitals assessed. Staff T stated she normally documented when she rechecked the blood pressure. She stated if the blood pressure elevated she would probably call the on-call. Staff T stated she might of called the on-call but didn't know and it would be documented. During an interview on 1/18/24 at 1:38 PM, the Assistant Director of Nursing (ADON) queried on Resident #30 elevated blood pressure and she stated she would have called the family and rechecked the blood pressure. During an interview on 1/22/24 at 12:39 PM, the Interim Director of Nursing (DON) queried on Resident #30's elevated blood pressure and the expectation of nurses evaluating elevated blood pressure and the DON explained the nurse should re-take the blood pressure and document another Progress Note and if the blood pressure continued to be high notify the Physician. She stated if a wrist blood pressure cuff used, the nurse would recheck the blood pressure manually. She stated she took care of the resident that evening and the resident commented about a stomach ache and then had a bowel movement and the Interim DON stated she checked on her during and at the end of her shift. The undated Facility Resident Vital Parameters Policy revealed the following information: a. Upon admission admitting nurse requested parameters for vital sings. b. Nurse put parameters into weights and vitals tab on EMR. c. When vitals taken, they needed documented in weights and vitals tab which prompted the nurse of vital signs out of parameter. d. Nurse needed to recheck vital signs that were out of parameters and notify the Physician. e. Documentation of the time of the call, what Physician the nurse spoke with, and what vitals were out of parameter and any new orders received. The Facility Resident Change of Condition Physician Notifications Policy dated 1/22/18 revealed the following information: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The attending Physician or Physician On-Call notified with changes in a resident's condition or health status: 1. Change in vital signs. 2. Pain (new or unmanaged). b. Document time of call, Physician or Nurse Practitioner or other person spoken to, reason for call and results or orders received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165569	A. Building B. Wing	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Point Care Center Inc	607 6th Street West Point, IA 52656

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on clinical record review, Incident Report review, observations, and staff interviews the facility failed to ensure a resident with severely impaired cognition remained free from burns from hot liquid when the resident was found with a cup on their lap during shift change to night shift, resulting in blisters to the left abdomen and thigh and documented pain for one of four residents reviewed for accidents (Resident #7). This resulted in an Immediate Jeopardy (IJ) to the health and safety of a resident who resided at the facility. The facility reported a census of 30 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 1/11/24 at 2:15 PM. The IJ began on 1/1/24. Facility staff removed the Immediate Jeopardy on 1/16/24 at 9:57 AM by completing the following: a. All residents were assessed via the Hot Liquids Safety Evaluation form for safety, when handling hot liquids. b. Any resident found to be at risk for inability to handle hot liquids safely will be placed on a Hot Liquids Safety list. The list will be kept in the Dietary Department and Nursing Department where all staff can visualize. This list will be updated by the Nursing Office. c. All facility staff were educated regarding the Hot Liquid Assessments, the list and where it is kept. d. Audits to be completed to assure staff compliance with the Hot Liquids Safety List will be done at every meal x 7 days, daily x 7 days, weekly x 2 months and then monthly times 2 months. e. Results of all Audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Meeting monthly for any observations and recommendations. The scope lowered from J to D at the time of the survey. Findings Include: 1. The Minimum Data Set, dated dated dated [DATE] for Resident #7 revealed the resident was rarely to never understood and required supervision or touching assistance for eating. The Care Plan dated 10/14/22, revision date 12/27/23, for Resident #7 revealed, in part, the following: a. The resident needed assist with Activities of Daily Living (ADL) related to (R/T) a cerebrovascular accident (CVA- stroke) with right sided lower extremity (LE) weakness, right sided upper extremity flaccidness which places the resident at risk for falls/injury. b. The resident not able to eat in the dining room at this time due to there being too much stimulus, causing the resident to yell out and be disruptive to others. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. The resident does eat better in own room or during the week can go into the Activity Room and eat with [Name Redacted] or [Name Redacted] there. Resident likes it in this room, and eats better and stops yelling. d. The Intervention dated 3/4/22 documented to assist the resident with eating by supervising and making sure able to eat the food on own. Sometimes need physical assistance due to having to use left hand. e. The Intervention dated 1/2/24 documented, Intervention for burn/blister: Resident will not be given any hot liquids without supervision and all trays/hot liquids will be removed from room when staff leaves room or family leaves room. Resident is to be up to dining room if possible for all meals. The Diet Order 3/14/22 documented, Mechanical soft diet, Ground meat texture. Review of the resident's Nutrition Quarterly assessment dated [DATE] revealed the following per the ability to feed self-section: feeds self with supervision and cueing, and the current mental status section revealed, severe impairment. The Incident Report dated 1/1/24 at 10:30 PM for Resident #7 documented the following Incident Description Nursing Description: Third shift Certified Nursing Assistant (CNA) alerted Staffing Nurse about areas on left abdomen and thigh. Appears to be blistered areas with redness around blisters. Cup removed from lap before transferring to bed, with what appeared to be coffee in it cold at this time. The Resident Description documented, Unable to state what happened. The Immediate Action Taken Section documented, Resident cleaned per CNA and made comfortable in bed. CNA notified this nurse also by text of issues. CNA stated nurse came down measured areas and applied cool wash cloth. The Injuries Observed at Time of Incident Section documented abdomen and left thigh. The Mental Status Section documented Resident #7 alert to person. Predisposing Physiological Factors marked included the following for the resident: Confused, drowsy, incontinent, impaired memory, recent change in cognition, and weakness/fainted. The Other Info Section of the Incident Report documented, Resident was left with supper tray in room in reach and coffee was on tray which was spilled into lap. Due to dementia and issues with coordination resident is to be supervised with meals. The Nurses Note dated 1/1/24 at 10:44 PM documented, resident was found to have blisters on lower left abdomen and left upper thigh area. two blisters present on abdomen. one blister present on upper thigh area. no complaints of (C/O) of pain at this time. Blisters maybe caused by hot food spilling on the resident. The Progress Note authored by the Assistant Director of Nursing (ADON) dated 1/2/2024 10:18 AM documented, was reported to this nurse through text on 1/1/2023 that resident was found sitting in recliner with food tray and cup on her lap. When assisted to bed CNA noted that resident had redness and blisters to left thigh and abdomen. Called nurse to room who placed cool cloth on areas and measured areas. Daughter was notified this AM along with [Name Redacted] Advanced Registered Nurse Practitioner (ARNP) and Hospice. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Visit Note Report from Hospice dated 1/2/24 documented the following Chief Complaint/Problem: Patient (Pt) has burns/blister from spilling coffee on her last night. The Assessment Section documented, Pt has fluid filled vesicles on the left upper thigh and left lower abdominal quadrant. The Assessment documented, Speech is unclear. Pt can occasionally get something simple like Yes No or Out spoken, and also documented, Cognitive decline interferes with Pt's ability to express pain, rate pain, characterize pain. The Visit Note Report dated 1/2/24 documented the following wound descriptions: a. Wound #1: The resident had a left proximal thigh burn, onset date 1/1/24, documented as 5 centimeters (cm) length by 2 cm depth by 0 cm depth. The Wound Care Provided Section documented, Large blister intact with clear/yellow colored fluid. There is an area of redness surrounding. Unable to determine of area is painful or if Pt just refusing care as she is refusing all assessment. b. Wound #2: Burn to the abdominal left lower quadrant, onset date 1/1/24, documented as 5 cm by 8 cm by 0 cm. The Wound Care Provided Section documented, there are 3 separate blistered areas. Pt resistive to assessment and only able to get a rough measurement of the cluster of blisters versus each individual blister. There is redness surrounding the wound. Pt would not allow measurement of the redness. Unable to determine if the area is painful as Pt was resistive and uncooperative with assessment in general. The Narrative for the Visit Note Report dated 1/2/24, documented, in part, as needed (PRN) visit completed due to (D/T) Pt spilling coffee on herself last night causing redness and blistered areas on the left lower abdomen and left upper thigh. There is one fluid filled/intact blister on the left thigh and 3 fluid filled/intact blisters on the left lower abdomen. There are areas of redness surrounding these areas. Review of a Quality Monitoring/Performance Improvement Plan (PIP) dated 1/2/24 documented, Resident received burn from coffee. The Corrective Action Section of the form documented corrective action was needed, and revealed, in part, the following: a. A CNA from [Agency Name]-lied to [Facility Name] staff when they asked her how Resident #7 ate. She stated she ate good. In fact, it appears she did not check on her. CNA no longer able to come to facility. b. Nurse from [Agency Name]-Appears she did not check on Resident #7 in person as Resident #7 not gotten ready for bed appropriately. This nurse no longer will be allowed to work at [Facility Name]. The Physician Order dated 1/2/24 at 11:00 AM documented: cleanse left abdomen and left thigh gently with soap and water. Pat dry apply Xeroform Vaseline gauze to areas. Change daily and PRN. Check every shift to make sure dressing is in place to burn/blister. One time a day for wound healing discontinue (DC) when healed and as needed for wound healing and every shift for wound healing. Check to make sure Xeroform is in place. Review of the resident's Treatment Administration Record (TAR) dated January 2024 revealed treatment initiated 1/2/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Nurses Note dated 1/2/24 at 6:48 AM documented: Skin sheet done on resident for blisters on upper left thigh and lower left abdomen. Multiple blisters noted on abdomen. Blisters are fluid filled with redness noted around the blister. Skin was warm to the touch and it was noted that the blisters were uncomfortable/painful for resident. ADON/skin nurse notified. Hospice called and notified of burns to skin. The Notes Section of the Incident Report dated 1/2/24 documented the following: a. Resident will not be given any hot liquids without supervision and all trays/hot liquids will be removed from room when staff leaves room or family leaves room. Resident is to be up to dining room if possible for all meals. b. Have spoken to CNA'S and Nurses personally and had them sign regarding not leaving before they do a physical round (eye balling) each resident even the ones that they are not directly responsible for to see if anything needs done. c. [Staff G, CNA] the CNA from staffing will not be allowed back into the facility due to her lying to a staff CNA about resident eating fine and no issues. (resident was not fed by CNA and tray was left in room) d. It was reported that Resident #7 spilled her ice water on her that was in a sippy cup. Her gown was completely wet and the linens all had to be changed. Staff is being educated to of course not give hot or warm fluids at all and visually check on Resident #7 every two hours at minimum. e. Dietary Aide stated coffee was served to Resident's room tray in a lidded cup. Cook states at approximately 7:10 pm while passing evening (HS) Snacks she did not witness any coffee cup on Resident's lap but that she wasn't looking for it. Food tray was not on her lap at that time, nor did resident show any signs of discomfort or pain, Dietary staff have been instructed not to serve Resident any hot beverages and that Resident will no longer be a room tray but will be seated in the dining room with assistance with eating. The Nurses Note dated 1/4/24 at 5:24 AM documented, in part, dressing completed to left lower abdomen and left upper thigh. 2 large clear fluid filled blisters present to abdomen wound. Areas cleansed, dried, applied Xeroform gauze et covered per orders. Facial grimacing noted during dressing change, resident continued to push this nurse's hands away while applying the dressings. The Note dated 1/9/24 on the Incident Report documented, Summary: Staff did not know how Resident #7 even got coffee on her super tray until all staff input made it clear Resident #7 nods her head yes to most everything. The CNA that took her supper ticket to the kitchen did not know this information. This is why no temporary staff will be on any halls by themselves until oriented a minimum of 8 hours. All residents have had an evaluation for hot liquids done, the list of residents that should not get hot liquids in their rooms or without 1:1 supervision will be kept in the kitchen and the Care Plans updated. Resident #7 will no longer receive hot liquids even with 1:1 due to pouring ice water on her head even while her daughter was sitting next to her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Alert Note dated 1/9/24 at 10:39 AM documented, Skin Note: Blister to left thigh is scabbed as this is where she has peeled the skin off of. Area is 6 cm across by 4.5 cm. Area was cleansed and new dressing applied no signs/symptoms (S/S) of pain with this. Left abdomen has one boomerang shaped area measures 6 cm by 5 cm and 5 cm by 3 cm with epithelial tissue present as she did not peel skin off of this, no S/S of infection. Smaller 2 cm by 1 cm area to inner left abdomen. No S/S of infection to any areas. No complaints of (C/O) pain with cleansing or treatment change. On 1/10/24 at 1:14 PM, Staff F, Registered Nurse (RN) explained eating assistance required for Resident #7 depended on the day, and some days the resident was fine and able to do herself. Staff F explained the resident often refused help. Per Staff F, they offered more than one person to assist, the resident ate in the dining room, and ate in her room if her daughters at the facility. Staff F explained she did not let the resident stay in her room because Staff F liked to watch her. The Nurses Note dated 1/10/24 at 2:25 PM documented, Resident remains on Hospice [Company Name Redacted] cares. No noted behaviors this shift. See Nursing Note about eating. Blisters are open and draining. Blister on thigh is red with slough. On 1/10/24 at 3:15 PM, interview with Staff D, CNA revealed the following: Per Staff D, Resident #7 usually ate on her own really, did not use utensils, and used her fingers. Staff D explained if the resident ate in her room someone always supposed to be in to help and the resident no longer got coffee unless someone assisted. Staff D explained need to cue the resident if the resident falling asleep, and further explained the resident ate with her fingers pretty good. Per Staff D, if Resident #7 was too weak sometimes, then the resident did not want to get up. Per Staff D if the resident did not have energy, they would go in and feed Resident #7. Staff D explained for the most part the resident did really good. The Nurses Note dated 1/10/24 at 8:49 PM documented, no noted behaviors, blisters on wound on thigh is red around the boarder with white slough on the center of the wounds. Wound on stomach is red around the board no noted slough. Ate supper with assistance from staff. On 1/11/24 at 8:45 AM, the ADON explained the Night Shift Nurse had been a staffing nurse, and the ADON received a call from the Night Shift Aide on behalf of Staff I, Licensed Practical Nurse (LPN), Staffing Nurse. The ADON explained they (ADON) filled out the incident report. Per the ADON, Staff G, staffing CNA worked with Resident #7 that night. The ADON explained she received a call from a facility CNA (3rd shift), Staff J, CNA. On 1/11/24 at 8:50 AM, observation revealed Resident #7 in their room in their recliner chair. Observation of wound care to the resident's thigh conducted with Staff H, Hospice Registered Nurse (RN). An area observed to the left thigh with yellow wound bed and redness around wound bed. Staff H explained the following about the area to the resident's left thigh: The last time Staff H saw the area, skin was covering, and now it was yellow with red around. Per Staff H, the area was much worse than when she last saw it. Per Staff H, the resident picked at the blister. Staff H explained she would call the doctor about an antibiotic cream. Staff H explained the area had to hurt, and acknowledged it came from coffee. Review of the Visit Note Report from dated 1/11/24 revealed the following wound description for Wound #1: (continued on next page)

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	165569	A. Building B. Wing	01/22/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident's left proximal thigh wound: The measurement section documented 6 cm by 4.5 cm by 0.2 cm, depth description noted full thick, with scant purulent drainage. The Narrative Section of the Visit Note Report documented, in part, Performed her wound dressing change on her thigh. It does appear infected, reached out to [Name Redacted] Nurse Practitioner (NP) for orders, awaiting her return call with new orders. Wounds on abdomen do not appear infected at this time. On 1/11/24 at 11:57 AM, interview conducted with Staff J, CNA, who explained the following about the incident: Staff J explained she worked nights, did not remember the incident date, and came in on nights at approximately 9:45 PM with another staff member (Staff K, CNA). Staff J explained the nurse for her shift was a Staffing Nurse, and explained on second shift a Staffing Nurse and Staffing Aide present when she came in. Per Staff J, the Staffing Aide (on the shift prior) had never worked at the building before, and had been in charge of South Hall where Resident #7 resided. Staff J explained the other two staff who worked with the Staffing Aide were facility staff. Staff J explained the Staffing Aide floated and helped. Staff J explained in getting report from the Staffing CNA, the Staffing CNA said she had never been in the facility before and was not able to tell Staff J much. Staff J explained when Staff J got to the facility a couple people were up in the dining room, and Staff K went ahead and started walking the halls. Staff J further explained Staff K said there were a lot of people up, and Staff J explained at that point it was easier to let the Staffing CNA go. Staff J and Staff K started a round, and offered to see if anybody wanted to go to bed. Staff J explained since the Staffing CNA had been on the South hall, they went ahead and started the round on South hall right after 10:00 PM. Staff J explained Resident #7 was the first person they addressed on the South hall. Per Staff J, she and Staff K went in and Resident #7 was still in the recliner, which Staff J explained had never happened as the resident was always in bed when she got to the facility. Staff J explained Resident #7's blanket was peeled back, underneath the resident wore blue snap pants, and there was a puddle around the resident's pants, dark, brown, and dried. Staff J explained it was like the second shift aides had not touched the resident since first shift put the resident in the recliner before they left. Per Staff J, the resident was so soaked her brief had seeped through. Staff J explained the resident's tray was on top of her on her lap. Per Staff J, the resident was known for that to pull things down on her. Staff J explained the resident was Care Planned to have a soda on the side of the bed and would pick it up and dump on herself. Per Staff J, the resident was not safe to have hot liquids in her room. When queried how this information was communicated prior to the incident, Staff J responded common sense, and if spilling soda pop on her, then wouldn't put coffee. Per Staff J, if Staffing (Agency) staff were not shown, then they did not know, and the facility had more Staffing (Agency Staff) in the facility than regular people. Staff J explained the resident had regular dishes, the tray itself was still on the nightstand, the only thing on the tray was the tray and plate, and everything else was in her lap (cups/bowl). Staff J explained maybe the brown ring in her lap could have been coffee, and she and the other staff member thought urine because the resident was soaked through the back. Per Staff J, she and Staff K took everything off the resident's lap and set it on the nightstand, used the Hoyer (mechanical lift) to get the resident to the bed, cleaned the resident up, took the resident's pants down, and realized the resident had started to blister on the left bottom part of the resident's abdomen and one spot on her top part of her thigh. Staff J explained it was all red all around and yellow/bubbly. (continued on next page)

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	165569	A. Building B. Wing	01/22/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff J explained when she and Staff K started rounding she told the Staffing Nurse to keep an eye on the hall as they were going to be busy for a while. Staff K explained the Staffing Nurse was down taking care of another resident, she waited for the nurse for a few minutes, the nurse looked at Resident #7, and said yeah it has to be a burn for sure. Staff J explained the resident was given a bed bath, cleaned up, the nurse came in and did measurements, and hourly checks were done after that. On 1/11/24 at 3:27 PM interview conducted with Staff I, Licensed Practical Nurse (LPN), who explained they worked the day after the incident, came in at 10 PM (on 1/2/24) to 6 AM (on 1/3/24). Per Staff I, she came in on her shift, received report, and was told there were blisters on the Resident #7's left leg and left side of her lower abdomen. Staff I explained she knew they were from a hot liquid. When queried about symptoms of pain for the resident, Staff I said yes, and explained just applying the dressing around the area the resident flinched and was very cautious. Staff I explained she could tell it was painful. Per Staff I, prior to the incident that resident had to have the special cups with sippy type device to hold onto it, and explained the resident did sit at the assisted table on a regular basis. Staff I explained sometimes the resident wanted your help and also very independent wanted to do herself. Staff I explained assistance was more supervisory. The Physician Order for Resident #7 dated 1/12/24 documented, Cefadroxil Oral Suspension Reconstituted 250 MG/5 ML (milligram/milliliter) with instruction to give 5 ml by mouth every 12 hours for infection for 7 Days. On 1/16/23 at 912 AM, Staff F, Registered Nurse (RN) explained Resident #7 started on antibiotic for the thigh area, as worried about infection as the resident liked to pick at it. On 1/16/24 at 1:28 PM, Staff N, LPN acknowledged she did work 1/1/24 (date of incident). Staff N explained she got to the facility at 8 PM to 6 AM, explained she had worked for the facility as a CNA, and came in at 8 PM for training. Staff N explained when the overnight staff came in at 10:00 PM or 10:30 PM, the aides came in and said it looked like spilt food all over the resident. Staff N explained getting the resident laid down, and had blisters to the lower left abdomen and left upper thigh. Per Staff N, a cool washcloth applied, and she call the ADON to let her know. Staff N further explained Resident #7 sat in the recliner, and staff called her in to see food spilt all over. Per Staff N, the blisters were noticed once got the resident into the bed. Staff N was unable to recall the names of the aides. When queried if the resident spoke, Staff N explained the resident did not really talk to her. Staff N explained she asked the resident if in pain, and the resident shook her head no. On 1/16/24 at 1:33 PM when queried if she worked the night of the incident, Staff O, Medication Aide/CNA explained she thought so, and later clarified she did. Per Staff O, she did not normally go down that hall (where Resident #7 resided) and did meds on two other halls. Staff O explained she knew there was a Staffing CNA that night who had passed the trays on the hall where Resident #7 resided. Per Staff O, she saw the CNA take the cart, and didn't see the staff member actually pass the trays. Staff O explained she knew the resident had been getting room trays or eating down with family in her room and before the incident she was not aware of the resident spilling drinks on herself. (continued on next page)

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	165569	A. Building B. Wing	01/22/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/16/24 at 2:48 PM, Staff P, CNA explained she worked 4 PM to 8 PM on the date of incident (1/1/24). Per Staff P, an agency staff was working the hallway and it was the agency staff's first time at the facility. Staff P explained the agency staff passed trays, and had Resident #7 and another resident eating in their rooms. Per Staff P, after dinner she had seen the staff member coming towards the kitchen with a tray, which made Staff P think of Resident #7 as the resident did not always eat in her room and if Resident #7 was not hungry she would not eat it. Staff P explained it made Staff P ask the Agency Staff, and the Agency Staff reported Resident #7 ate everything. Staff P explained she was very busy before 8:00 PM, had four residents up, and passed on that she had not helped the Agency Staff member with Resident #7 or another resident yet, and explained those residents required assistance of Hoyer transfer. Staff P explained she did not come back down to check herself, and took the Agency Staff member's word for it when the staff said the resident ate everything. When queried if Resident #7 could eat in their room by themselves prior to the incident, Staff P responded yes, and further explained sometimes with medication the resident got sleepy, and when she ate in her room Staff P would wake her up and let her know food was there. Per Staff P, prior to the incident, the resident drank a lot of coffee, at least for dinner, and for the most part ate in the dining room. On 1/22/24 at 12:53 PM, when queried if the facility had a way to assess residents for hot liquids prior to the incident, the Interim Director of Nursing (DON) explained not that she was aware of. When queried if the resident was known to dump fluids on herself prior to the incident, the Interim DON responded no, and as long as the Interim DON had been at the facility the resident would drink cans of soda in her room, and would not dump that on herself. When queried where the resident ate, the Interim DON explained since she started at the facility the resident almost always ate in the dining room. Per the Interim DON the resident used to feed herself, and over the last six months the resident slowly started to not want to eat, and the resident needed cueing. Per the Interim DON, sometimes the resident would let you scoop food on her spoon for her, and wanted you to leave it. When queried how often CNA's and nurses rounded on the resident, the Interim DON explained normally the resident should be ok for every 2 hours. Per the Interim DON, they had not seen the resident drink hot liquids, and usually at night the resident drank water or soda, and when she would work days saw her drink orange juice or water in the morning. On 1/22/24 at 4:25 PM, the Interim DON provided an undated form titled Hot Liquids Safety Evaluation, and explained to be included with the plan of correction. The form documented, Directions to be completed at time of admission, readmission or change in condition: (1) Evaluate for the presence of risk factors for spills and burns from hot liquids. (2) Place a check mark for each risk factor in space provided for that evaluation date. (3) Initial and sign the evaluation. (4) Review evaluation during care team meeting to determine appropriate interventions to prevent spills and burns. (5) Record date intervention was initiated, notes and date it was discontinued (if applicable).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observations, staff interviews, and facility policy review, the facility failed to ensure a medication cart remained locked when staff not present for one of two medication carts. The facility reported a census of 30 residents. Findings Include: On 1/8/24 at 10:45 AM, observation of a medication cart present outside of room [ROOM NUMBER] of the facility revealed the cart unlocked, drawer of cart able to be opened without a key, and medication cards inside the cart. Staff were not observed to be present with the medication cart at time of observation. On 1/8/24 at 11:14 AM, observation of a medication cart in the same location of the facility revealed although the main lock for the medication cart depressed, the second drawer on the right side of the cart unlocked with the drawer slightly opened. Medication card visible inside of the drawer. On 1/8/24 at 11:18 AM, when queried if the drawer was the narcotic drawer, Staff A, Licensed Practical Nurse (LPN) confirmed. Staff A questioned how the main lock of the cart locked while the drawer was unlocked. On 1/22/24 at 12:50 PM when queried when medication carts should be locked, the Interim Director of Nursing (DON) responded any time the Nursing Staff are not standing there taking something out. The Interim DON also explained the Pharmacy was contacted who provided the carts, and it was explained the main lock could be locked with the narcotic drawer unlocked. The Facility Policy titled Storage of Medication revised 4/07 documented at point #7: a. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165569	A. Building B. Wing	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Point Care Center Inc	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)
F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 47336 Based on review of the Centers For Medicare & Medicaid Services (CMS)-2567 reports for the Surveys conducted at the facility, staff interviews, and facility Quality Assurance and Performance Improvement (QAPI) Plan, the facility failed to ensure an effective QAPI process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current Recertification and Complaint Survey previously identified during Surveys completed in the last seventeen months. The facility reported a census of 30 residents. Findings Include: Review of the facility's CMS-2567 form from a Complaint Survey which occurred 8/8/22 to 8/12/22 revealed the facility received a no actual harm level citation for freedom of abuse, reporting of alleged violations of abuse, and investigating/preventing/and correcting alleged violation of abuse. The facility also received a no actual harm level for labeling and storing of medications. The facility's current Recertification Survey, entrance date 1/8/23, resulted in repeat citations for freedom from abuse, timely reporting for alleged abuse, investigating/preventing/and correcting alleged abuse, and proper storage of medications. During an interview on 1/22/24 at 3:55 PM, the Administrator queried on the expectation of not repeating the same citations and she stated she would meet with the Director of Nursing (DON) and the Department Heads and talk with their employees and see what their fears are with reporting and find out what we need to do to get reports done in a timely manner. The Administrator stated she would get more involved in the investigations and she stated the expectation for the medication carts was to keep them locked at all times and they would conduct audits on the carts staying locked as an example The Facility Quality Assurance and Performance Improvement (QAPI) Program reviewed on January 2023 revealed the following information: a. Develop, implement and maintain an effective, comprehensive, data-driven QAPI program for services provided at the facility, focusing on indicators of outcomes of care and quality of life. b. provide a working framework for excellence in quality monitoring processes, identification of opportunities for improvement, implementing action steps to correct and/or improve measures, evaluates outcomes and demonstrates sustained compliance/outcomes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 47336 Based on personnel record review,Facility Assessment review, staff interviews, and facility policy review, the facility failed to conduct annual training on Quality Assurance and Performance Improvement (QAPI)) for all staff reviewed for QAPI training. The facility reported a census of 30 residents. Findings Include: The training competencies for 2023 reviewed for staff showed the training competencies lacked documentation for the facility staff completing QAPI training for the year of 2023. During an interview on 1/18/24 at 11:26 AM, the Administrator queried to supply the training competencies documentation for QAPI training and she reviewed her files and then stated they didn't schedule it. She then stated it should of been completed in December of last year. She stated her goal was to include everyone in QAPI and she spoke to all the new hires about QAPI when they were hired. During an interview on 1/22/24 at 4:10 PM, the Administrator stated she looked and found the last QAPI training conducted in the fall of 2022. The Facility Assessment Tool for 2024 revealed the following information for Staff Training/Education and Competencies: a. Describe the staff training/education and competencies necessary to provide the level and types of support and care needed for your resident population. 1. QAPI fundamentals, and the needed team involvement using Performance Improvement teams. 2024 goal would be open meeting to more staff and residents The Facility Quality Assurance and Performance Improvement Program (QAPI) Policy last reviewed on 1/23/23 documented the following information: a. Identified and scheduled mandatory education and/or skills training needed included elements and goals of the facility's QAPI program. b. Establish a staff competencies and annual education/competency calendar.