

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16F001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Davis Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22425 Overland Avenue Bloomfield, IA 52537	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506</p> <p>Based on clinical record review, and resident and staff interviews, the facility failed to ensure residents are treated with respect and dignity for 2 of 2 residents (Resident #1, #5) in the sample. The facility reported census was 20.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS), dated [DATE], listed Brief Resident #1 Brief Interview for Mental Status (BIMS) score as 15 out of 15 indicating intact cognition. The assessment indicated the resident dependent on others for assistance with transfers, mobility and personal hygiene. Resident #1 assessed as having adequate hearing, and spoke clearly with distinct intelligible words.</p> <p>During an interview on 7/18/24 at 3:30 p.m., Resident #1 stated a while back Staff A, Licensed Practical Nurse (LPN) entered her room, talking to her roommate about not talking her medications. Resident #1 stated she spoke up defending her roommate, telling the nurse she shouldn't speak to her [the roommate] like that. Resident #1 stated Staff A, turned to her and told her she was fat and lazy and that her family doesn't visit because they can't stand her. Resident #1 stated another staff, Staff B, Certified Nursing Assistant (CNA) witnessed the interaction. Resident #1 reported the interaction upset her and she reported her concern to the Assistant Director of Nursing (ADON).</p> <p>During an interview on 7/22/24 at 4:10 p.m., the ADON stated on 7/10/24 Resident #1 informed her about the incident that occurred with Staff A, LPN on 7/7/24. The ADON stated she reported the allegation to the Administrator and they initiated and investigation. Staff A was immediately removed from the schedule. During the course of the investigation, two staff, Staff B, CNA and Staff D, CNA had witnessed Staff A being disrespectful and using profanity directed towards residents.</p> <p>The ADON stated both aides failed to report the incidents and when queried why, stated because it was the charge nurse and didn't know who to report to. The ADON stated both aides had received the Dependent Adult Abuse Mandatory Training. The ADON stated both aides and all staff were re-educated on mandatory reporting protocols.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/22/24 at 3:00 p.m., Staff B, CNA stated the other evening [7/7/24] she was asked by Staff A to witness her passing medications. Apparently, Resident #5 resident refused medications earlier and Staff A wanted a witness if she refused again. Staff A attempted to give Resident #5 her medications and she refused. Staff A became upset and used an expletive to relay her frustration to the resident. This made the roommate [Resident #1] upset. Per Staff B, Resident #1 told Staff A she should not talk to her [roommate, Resident #5] that way. Staff B reported Staff A responded to Resident #1 with expletives. Staff B stated she reported Staff A's behavior to the on-coming nurse. Staff B stated there were other times Staff A was rude or disrespectful, and she used profanity often.</p> <p>During an interview on 7/22/24 at 2:19 p.m. Staff D, CAN stated she worked shifts with Staff A and during that time she found Staff A to be extremely rude and disrespectful towards residents. Staff D recalled the night of 7/7/24 when Resident #5 refused her medications. Staff A told another resident, Resident #1, who was complaining about the food, it's not like it's going to hurt you to miss a meal. Staff D stated Staff A is just mean and especially towards residents who are overweight. When queried whether Staff D reported the behavior of Staff A to anyone, Staff D stated she did not, noting Staff A was the charge nurse.</p> <p>2. The MDS, dated [DATE], listed Resident #5 BIMS score as 99, an indication the interview could not be completed. The diagnoses listed on the assessment included: paranoid schizophrenia, post traumatic stress disorder, anxiety and depression. The resident's experienced physical and verbal behavior symptoms such as hitting, kicking, threatening others, screaming/cursing at others daily. Resident #5 rejected care daily.</p>		