STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. BUILDING _____ B. WING _____	C 06/17/2016

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CASA DE PAZ HEALTH CARE CENTER	**2121 WEST 19TH STREET SIOUX CITY, IA 51103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date _____ Complaint #59838-C was substantiated. Investigation of facilty-reported incidents #59999-I and #60291-I resulted in deficiency. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225		

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

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.

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prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility policy review, the facility failed to report a resident to resident abuse allegation no later than 24 hours after knowledge of the allegations for 2 of 5 residents reviewed (Residents #1 & #2). The facility identified a census of 62 current residents.

Findings include:

1. According to the MDS (minimum data set) assessment dated 5/19/16, Resident #1 had diagnoses that included Non-Alzheimer's dementia, mild cognitive impairment and dysphagia. The MDS identified the resident had a Brief Interview for Mental status score of 9 which indicated moderate cognitive impairment. The MDS identified the resident required the assistance of one with bed mobility and transfers and as independent with ambulation and locomotion on and off his/her living unit. According to the MDS the resident had verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing

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at others) during 1 - 3 days of the 7-day assessment period.

The care plan dated 5/11/16 revealed the resident understands consistent, simple, directive sentences. The care plan directed staff to prove the resident with necessary cues and to stop and return if agitated as needed. Staff updated the care plan on 5/23/16 to record an altercation with another resident and the plan then directed staff to monitor resident interactions with other residents. On 5/26/16 the resident moved to a lower level.

Review of the Incident Report dated 5/23/16 at 5:40 PM revealed staff heard the resident yell 'get away from me' 2 to 3 times. The resident had been yelling at Resident #2 who was next to him/her trying to get by in his/her wheel chair. Resident #1 turned in his/her wheel chair and hit Resident #2 on the left forearm twice.

Review of the Progress Notes dated 5/23/16 at 11:30 PM revealed staff heard the resident yell 'get away from me' 2 to 3 times. The resident had been yelling at Resident #2 who was next to him/her trying to get by in his/her wheel chair. Resident #1 turned in his/her wheel chair and hit Resident #2 on the left forearm twice. Staff separated Resident #2 from the resident immediately.

2. According to the MDS assessment dated 3/9/16, Resident #2 had diagnoses that included Non-Alzheimer's dementia, seizure disorder and diabetes mellitus. The MDS identified the resident had short term and long term memory problems and severely impaired cognitive skills for daily decision making. According to the MDS the

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resident had behavioral symptoms not directed toward others. (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) daily.

The care plan dated 3/14/16 directed staff to monitor resident mood and behaviors and update medical doctor of any changes as needed. Staff updated the care plan on 5/23/16 to reflect an altercation with another resident. The plan then directed to monitor resident interactions with other residents. On 6/2/16, an update to the care plan directed staff to monitor interactions with other residents for appropriateness.

Review of the incident report dated 5/23/16 at 5:40 PM revealed staff witnessed the resident yelled at and then hit on the left forearm by Resident #1. Resident #1 yelled at the resident to get away from him/her. The resident had not done anything but had been propelling him/herself in the wheel chair to go past. Resident #2 said that Resident #1 hit him/her.

Review of the Progress Notes dated 5/23/16 at 5:40 PM revealed staff witnessed the resident getting yelled at and then saw Resident #1 hit Resident #2 on the left forearm. Resident #1 had been yelling at the resident to get away from him/her. Resident #2 had not done anything but had been propelling him/herself in the wheel chair to go past Resident #1. The resident said that Resident #1 hit him/her. Staff immediately separated the resident from Resident #1. Staff continued to monitor both due to the resident wanders around.

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F 225	Continued From page 4 During an interview with the Director of Nursing on 6/16/16 at 8:45 AM she stated that Staff G, RN did not call her to report the incident to her. She further stated that she looked at the incident reports every morning. She had seen the incident report for Resident #2 the following day (5/24/16) and mistook it to be the previous day. She thought there had been no new incidents. The following day (5/25/16) she reviewed the incident reports again and realized she had made the mistake. The reported the incident to the Department at that time (5/25/16). Review of the Policy and Procedure titled Abuse Prevention Program and Reporting Policy dated 4/14 directed staff to report for resident to resident abuse as follows: a. Report must be made within 24 hours: if the suspected criminal activity does not result in serious bodily injury, it must be reported within 24 hours of forming the suspicion.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident review the facility failed to ensure dignity preserved for 1 of 5 current residents reviewed (Resident #4). The facility identified a census of 62 current residents.	F 241		

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Findings include:

1. According to the Minimum Data Set (MDS) dated 4/18/16, Resident #4 had diagnoses including diabetes mellitus, renal failure, seizure disorder and anxiety disorder. The MDS identified the resident did not experience behavioral symptoms. The MDS identified the resident had a brief interview for mental status score of 15 which indicated intact cognitive skills for decision making. According to the MDS the resident independent with bed mobility transfers, ambulation, dressing and toilet use. According to the MDS the resident frequently incontinent of urine.

Resident #4 ' s care plan initiated 11/8/15 directed staff to praise him/her for appropriate behavior and good decisions. The care plan dated 3/14/16 directed staff to encourage Resident #4 to make decisions and assist when needed. The care plan also directed staff to attempt to redirect the resident as needed.

Review of the Policy and Procedure titled Cell Phones and Related Devices dated 7/1/15 directed staff of the following:
a. It is the policy of the company that unless specifically designated otherwise, all use of personal cellular phones and/or other related devices such as IPad, tablets, etc., will not be allowed in the workplace. Company telephones will be limited to certain areas and times within the workplace.

Review of the Employee Handbook (not dated) directed the following for social media:
a. Employees that choose to participate in social

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networks, should refrain from making any references to The Company, the residents here, their co-workers or the management of the Company on their personal social media accounts. For the purpose of this policy, social media shall include all forms of social media including but not be limited to: Facebook, Twitter, Myspace, YouTube as well as on-line chat rooms.

During an interview with Staff D, CNA on 6/15/16 at 1:45 p.m. she reported being Resident #4 ' s certified nurse aide (CNA) when the resident asked her for a robe. She found a robe in storage and brought the robe to Resident #4. Staff D stated Resident #4 took a bow from the front desk. The resident then dressed in a brief only and put the bow over their groin area. Resident #4 had the robe over the brief. She stated the resident had been in his/her room and she went to tell him/her the DON returned to her office. Resident #4 went into the office and sang Happy Birthday and danced. At the end of the song/dance, Resident #4 opened the robe (showing the brief with the bow over his/her private area) then closed the robe and left the office. A follow up interview with Staff D on 6/17/16 at 8:45 a.m. she stated she knew what the resident had on under the robe [brief only] and did not try to stop him/her.

During an interview with Staff C, CNA (Certified Nursing Assistant) on 6/15/16 at 1:30 p.m. she reported Resident #4 stated he/she wanted to sing and dance for the DON's (Director of Nursing) birthday. The resident asked if he/she could go naked. Staff C responded to the resident, " no he/she could not go naked. " Resident #4 came to the office with a robe on. The resident ' s robe had been closed [covering

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him/herself] and then Resident #4 opened the robe and had only been wearing a brief. Staff H took a picture of the DON. Staff C reported afterwards cooperate came to talk with the staff and advised them to not let that happen.

During an interview with Staff H, Office Manager on 6/15/16 at 5:00 p.m. she stated Resident #4 came to the front desk and asked for a red bow. There had been a purple bow at the desk and he/she asked if he/she could have it. The resident also said he/she wanted to do a strip tease and she told Resident #4 he/she can't and he/she had to be covered. She had been in the office when Resident #4 had been singing Happy Birthday to the DON and she videotaped the DON laughing with her cellphone. She had been sitting in front of the desk and the resident had been behind her. The sound on the video did contain the resident singing along with laughter from the DON. She did show the video to some staff that were working that day but only remembered the DON and Administrator. She deleted the video from the cell phone after instructed by the Administrator. She further stated the video had not been shared to another cell phone or uploaded to Facebook or any social [media] site and the cell phone did not have capabilities to send a video. She did see a photo of the DON on Facebook after the incident.

During an interview with the Activities Supervisor on 6/17/16 at 1:30 p.m., she stated the Administrator asked her to talk to the resident to investigate. She talked to the resident on 4/29/16 at 11:30 AM. He/she stated Staff C and Staff D helped him/her. The resident felt remorseful and thought he/she had been getting someone in trouble. Resident #4 brought up the fact that someone filmed it and wanted to make sure it

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would be deleted.

During an interview with the Resident #4 on 6/17/16 at 11:00 a.m., he/she stated he/she did not know a picture would be taken and did not want a picture taken. Resident #4 further stated he/she saw Staff H, Office Manager had a camera and told the Activity Director to have it deleted.

During an interview with the DON on 6/16/16 at 8:45 a.m. she stated Resident #4 sang Happy Birthday [to her] earlier in the morning over the intercom. She thought that had been all the resident was going to do. She later went into her office and then Resident #4 came into the office dressed in a blue robe. The resident sang a made up version of Happy Birthday and had been swaying (moving back and forth). Towards the end of the song the resident opened the robe and had a brief on with a bow on the front of the brief. The resident closed the robe and left the office. She further stated corporate staff came to the facility to investigate and instructed staff should have tried to stop Resident #4. She also stated if Resident #4 had something in mind he/she would do it and she understood staff at least talked him/her out of being naked. She further stated the Marketing Coordinator took a still photograph of her and did post it to Facebook. The still photograph did not show any part of the resident and the post did not identify anything about the facility or the resident. The Facebook post had been deleted. The DON reported there were a lot of people [staff] outside the door when the incident occurred.

During an interview with Staff I, RN (Registered Nurse) on 6/16/16 at 9:45 a.m. she reported she

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F 241	Continued From page 9 had not been at the facility on the DON's birthday and did not see any pictures or video. She talked with Resident #4 (afterwards) and he/she said the girls helped him/her get ready to do a dance. Resident #4 reported he/she went down in a robe and had a bow on his/her brief. She stated the resident had talked with the Administrator about what had happened. During an interview with the Administrator on 6/17/16 at 1:45 p.m., he stated the Office Manager did have a video on her cell phone and only had visual of the DON and not the resident. He heard the DON laughing and could also hear someone singing and could not understand the words. He asked her to delete it. Corporate told him the Marketing Coordinator took a picture of the DON and put it on Facebook which was later deleted. He further stated there had been no disciplinary action in regards to the incident. He reported they held an in-service with staff on 5/2/16 for Professional Boundaries. He also stated staff were not to have cell phones while on duty. Department Heads had phones to text and communicate at work due to the size of the building. He further stated they have not talked to staff about social media but they should have common sense not to use it concerning work. He further stated the Employee Handbook did reference social media.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff and resident interview, the facility failed to follow the care plan as written for 1 of 5 residents reviewed (Resident #4). The facility identified a census of 62 current residents.

Findings include:

1. According to the MDS (minimum data set) assessment dated 4/18/16 Resident #4 had diagnoses that included diabetes mellitus, renal failure, seizure disorder and anxiety disorder. The MDS identified the resident did not experience behavioral symptoms. The MDS identified the resident had a brief interview for mental status score of 15 which indicated intact cognitive skills for decision making. According to the MDS the resident showed independence with bed mobility transfers, ambulation, dressing and toilet use. According to the MDS the resident frequently incontinent of urine.

The care plan dated 3/14/16 directed staff to encourage the resident to continue to make decisions and assist when needed. The care plan also directed staff to attempt to redirect the resident as needed.

During an interview with Staff C, CNA (Certified Nursing Assistant) on 6/15/16 at 1:30 p.m. she reported Resident #4 stated he/she wanted to sing and dance for the DON's (Director of Nursing) birthday. The resident asked if he/she could go naked. Staff C responded to the resident, " no he/she could not go naked. " Resident #4 came to the office with a robe on.

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The resident ' s robe had been closed [covering him/herself] and then Resident #4 opened the robe and had only been wearing a brief. Staff H took a picture of the DON. Staff C reported afterwards cooperate came to talk with the staff and advised them to not let that happen.

During an interview with Staff D, CNA on 6/15/16 at 1:45 p.m. she reported being Resident #4 ' s certified nurse aide (CNA) when the resident asked her for a robe. She found a robe in storage and brought the robe to Resident #4. Staff D stated Resident #4 took a bow from the front desk. The resident then dressed in a brief only and put the bow over their groin area. Resident #4 had the robe over the brief. She stated the resident had been in his/her room and she went to tell him/her the DON returned to her office. Resident #4 went into the office and sang Happy Birthday and danced. At the end of the song/dance, Resident #4 opened the robe (showing the brief with the bow over his/her private area) then closed the robe and left the office. A follow up interview with Staff D on 6/17/16 at 8:45 a.m. she stated she knew what the resident had on under the robe [brief only] and did not try to stop him/her.

During an interview with Staff H, Office Manager on 6/15/16 at 5:00 PM she stated that Resident #4 came to the front desk and asked for a red bow. There had been a purple bow at the desk and the resident asked if he/she could have that one. The resident also said that he/she wanted to do a strip tease. She further stated that she told the resident he/she can't and had to be covered.

During an interview with the Director of Nursing

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F 282	Continued From page 12 on 6/16/16 at 8:45 AM she stated that earlier in the morning the resident sang happy birthday over the intercom. She thought that had been all the resident was going to do. She later went into her office and then the resident came into the office dressed in a blue robe. The resident sang a made up version of happy birthday and had been swaying. Towards the end of the song the resident opened the robe and had a brief on with a bow on the front of the brief. The resident closed the robe and left the office. She further stated that she understood that staff at least talked him/her out of being naked. During an interview with the MDS Coordinator on 6/16/16 at 2:40 PM she stated that staff want the resident to continue to make his/her own decisions. When the resident makes a decision, staff are to assist him/her to follow through.	F 282		