STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165034	A. BUILDING _____ B. WING _____	C 08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

(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 8-18-16 Facility reported incident #61746 was investigated. The following deficiency relates to the investigation. Facility reported incident #61746 was also investigated, but no deficiencies were identified with that incident. Additional findings regarding both facility reported incidents will be sent to the facility at a later date under separate cover. Complaint #62165 was investigated and not substantiated.	F 000		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to ensure Resident #2 was free from verbal and sexual abuse. The sample consisted of 4 residents and the facility reported a census of 66 residents. Findings include: 1. The Admission Record Report for Resident #2 identified an original admission date of 01-24-16	F 223		

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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F 223	Continued From page 1	F 223		

with a readmission on 03-17-16 and had diagnoses which included adenocarcinoma of cecum (at the beginning of the large intestine), fractured humerus (upper arm), vitamin D deficiency, severe malnutrition and severe frailty.

Resident #2 had a MDS (Minimum Data Set) assessment dated 06-23-2016. The MDS identified the resident with a BIMS (Brief Interview for Mental Status) score of 11 out of 15. A score of 11 identified the resident had a moderate cognitive impairment. The assessment indicated the resident as independent with bed mobility, transferring, ambulating, eating and personal hygiene. Resident #2 required staff supervision with dressing and extensive staff assistance with bathing.

The Care Plan dated 06-09-2016 identified a problem with potential grief reaction related to restarting chemotherapy treatment. The interventions directed the staff to do the following:

Attempt to involve in activities respecting choice and preferences;
Discuss feelings of sadness/hopelessness and options of appropriate channeling of these feelings;
Offer choices to enhance sense of control; and validate feelings

During an interview on 08-16-2016 at 3:50 p.m. Resident #2 stated there were several times in which the night shift nurse, Staff A had kissed him/her on the lips. Resident #2 stated this had happened 4 or 5 times in the last 2 or 3 weeks. Resident #2 stated he/she felt like Staff A held his/her mouth open and tried to " French kiss ". Resident #2 stated the first time he/she was

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F 223	Continued From page 2	F 223		

surprised. The second and third time the resident stated he though Staff A had an agenda and the fourth time he/she pushed Staff A away. Resident #2 stated he/she would ask who would be coming on to work. Resident #2 stated he/she would feel ' dread ' when learned it was Staff A coming on duty. Resident #2 stated he/she does not have those kind of needs

Resident #2 stated Staff A never touched any other part of his/her body, but he/she felt Staff A had plans, and/or an agenda and would have made further advances. Resident #2 also stated Staff A once stated, "You know if I was younger I ' d be working up to marrying you when you get out ".

On 08-17-2016 at 1:27 p.m. Staff A (Registered Nurse) was interviewed and admitted she had kissed Resident #2, adding it was on the top of the head, maybe three times at most. Staff A stated it was a kiss comparable to kissing a baby on the top of their head and there was no sexual meaning in it what so ever. Staff A stated that he/she did not expect anything in return from the kiss.

During the interview Staff A also described Resident #2 as being special. Staff A also stated she once commented to Resident #2, that "when you get better and I grow up, we should get married. " Staff A stated Resident #2 just laughed about the statement.

During an interview on 08-17-16 at 4:08 p.m. Staff B stated she was called into Resident #2 ' s room one night. The resident stated Staff A was being very rude and short with him/her. Staff B stated all of a sudden during the conversation,

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F 223	Continued From page 3 Resident #2 stated, "And that bitch had the nerve to grab my face and kiss me all over". Staff B stated Resident #2 became teary, then broke down and cried. Staff B stated the resident informed her it was not the first time this had happened. Staff B stated she didn ' t want to believe it, but when Resident #2 broke down [cried], she knew something had happened. Staff B stated the resident told her " If she is doing this to me, what is she doing to others? "	F 223		

Manorcare Health Services-Waterloo
201 W Ridgeway Ave
Waterloo, IA 50701

This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Iowa Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

F223

The facility strives to ensure that –

(1) Residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion,

(2) And that verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion are not used.

Corrective action taken for residents found to have been affected by deficient practice

- Staff Member A was immediately separated from Resident #2 and suspended on 7/12/2016.
- Social Services assessed patient for any changes in psychosocial status after report of the alleged abuse on the same day, 7/12/2016.

How the center will identify other residents having the potential to be affected by the same deficient practice.

- Residents on Staff Member A's same assignment who were interviewable were interviewed on 7/12-7/13/16.
- Residents on Staff Member A's same assignment who were not interviewable had body checks completed7/12-7/13/16.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Staff Member A was immediately suspended upon notification of the alleged abuse.
- Educated all staff that kissing residents is inappropriate.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

- QAA committee reviewed the alleged abuse and interventions that were put into place and had no further recommendations.

Date when corrective action will be completed.

- 8/18/2016