

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165303		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2016	
NAME OF PROVIDER OR SUPPLIER ABCM REHAB CENTERS OF INDEPENDENCE WEST CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1610 THIRD STREET NE INDEPENDENCE, IA 50644			
(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)		
F 000	INITIAL COMMENTS Correction Date <u>Sept. 23, 2016</u> The following information is related to investigation of facility report #62434 which was substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C. 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, staff and resident interviews the facility did not ensure that all residents were free from sexual abuse (Resident #2, #3). The sample consisted of 4 residents and the facility reported a census of 46 residents. Findings include: 1. According to record review, Resident #1 had an original admission date of 04/04/16 and had diagnoses which included Alzheimer's disease, Schizoaffective disorder, aggressive behavior and obsessive compulsive disorder. According to review of the facility Minimum Data			F 000			
F 223 SS=G				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.

OK - P Campbell *10/3/16*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2016
NAME OF PROVIDER OR SUPPLIER ABCM REHAB CENTERS OF INDEPENDENCE WEST CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1610 THIRD STREET NE INDEPENDENCE, IA 50644		
(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 223	<p>Continued From page 1</p> <p>Set (MDS) assessment dated 7/12/16, Resident #1 scored 8 (of 15 points) on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive decline. The assessment described Resident #1 as being independent with bed mobility, transferring, and ambulating, eating, dressing and personal hygiene.</p> <p>The Care Plan identified a problem with the resident Exhibiting behaviors in public. The interventions directed the staff to do the following:</p> <ul style="list-style-type: none"> * Resident #1 is stand by the assistance of one staff in the hallways and common areas. If staff observe Resident #1 trying to make inappropriate comments or actions towards another resident, please politely remove resident from the situation. * Identify and explain only once concept of behavior at a time. * Provide a "please do not disturb" sign for resident's door. * If resident disrobes in public, offer a blanket/towel and attempt to assist resident to get redressed in a private area * If resident makes sexual comments, inform resident that it is not appropriate conversation and redirect resident to something else. * Remain calm and avoid overreacting. Do not argue, use logic or deny resident of his/her needs. Do not scold resident. * Nurse to complete a behavior note each shift and report to the DON (director of nursing) and administrator as soon as possible if the resident 	F 223			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2016
NAME OF PROVIDER OR SUPPLIER ABCM REHAB CENTERS OF INDEPENDENCE WEST CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1610 THIRD STREET NE INDEPENDENCE, IA 50644		
(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 223	<p>Continued From page 2</p> <p>has inappropriate contact with another resident.</p> <p>* The nurse will provide information on what is correct behavior daily.</p> <p>*Use simple, concrete language.</p> <p>* When cognitive impairment is not severe, identify and describe the appropriate behaviors with resident.</p> <p>2. Resident #2's medical record was reviewed. Resident #2 had diagnoses which included dementia, high blood pressure and syncope and collapse. According to the MDS dated 8/2/16, Resident #2 had both long term and short term memory difficulties and had a moderate decline in cognitive skills for decision making. The assessment identified Resident #2 as independent in transferring, ambulation, eating and toilet use, but required staff assistance with dressing, personal hygiene and bathing.</p> <p>The Progress notes for Resident #2 dated 8/16/16 indicated an incident report. The reported identified another resident grabbed Resident #2 in the crotch and she/he walked up the hall and seen on camera.</p> <p>3. Resident #3 had diagnoses which included dementia, anxiety, Bell's palsy, hemiplegia and hemiparesis, and chronic obstructive pulmonary disease.</p> <p>According to the MDS dated 06/14/16 Resident #3 scored 4 (of 15) on the BIMS, indicating severe cognitive decline. The assessment tool also described Resident #3 as requiring extensive staff assistance with transferring, ambulation,</p>	F 223			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2016
NAME OF PROVIDER OR SUPPLIER ABCM REHAB CENTERS OF INDEPENDENCE WEST CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1610 THIRD STREET NE INDEPENDENCE, IA 50644		
(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 223	<p>Continued From page 3</p> <p>toilet use, dressing, personal hygiene and bathing.</p> <p>During an interview on 9/1/16 at 12:05 p.m. Resident #3 stated he/she was in the dining room (seated in a wheel chair) when Resident #1 pulled up beside him/her and started feeling him/her in the groin area. Resident #3 stated it took him/her by surprise and he/she told Resident #1, "Don't ever touch me there again."</p> <p>The Progress Notes dated 8/16/16 at 1:30 p.m. (by the social worker) for Resident #3 identified a late entry. The entry identified a male resident in the front dining room that touched her/him inappropriately in the groin area. The resident immediately became upset and swatted at the other resident ' s hands.</p> <p>During an interview on 09-01-16 at 1:06 p.m. Staff A stated the day of the incident (8/16/16), Resident #3 reported to her that Resident #1 "grabbed me in the crotch". Staff A added that the video camera footage was reviewed which confirmed the incident Resident #3 described as well as a second incident in which Resident #1 attempted physical contact with Resident #2. Staff A reported Resident #1 required a lot of redirection and monitoring and had a history of making sexual comments to staff. She added this was the first incident of Resident #1 involving other residents.</p>	F 223			



October 3, 2016

Plan of Correction related to facility reported incident # 62434

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 September 23, 2016

F223 §483.13(b) 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 does not use verbal mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

- Resident #3 and Resident #2 were assisted to their rooms by facility staff following the incidents and a full physical assessment was completed. Both residents were free of physical injury.
- Resident #1 was assisted to his room and his physical and mental needs were assessed for any signs of a condition change.
- The Independence Police Department was notified of the incident immediately per requirement and they initiated an onsite investigation within one hour of the incident.
- The care plan for Resident #1 was updated to include new safety interventions such as needing stand by assistance for added supervision when ambulating independently in the facility outside of resident's private room. Daily discussion/education with charge nurse was implemented regarding observation of and response to behaviors that may affect others for three months from day of incident.
- A behavior assessment was completed by a charge nurse every shift for three consecutive days to identify on-going needs and interventions related to Resident #1 behavior affecting others.
- Psychiatric consultation completed for Resident #1 to assess and treat following the incident.
- Facility Social Worker had one-on-one visits with Residents #1, 2, 3 daily for one week to assess psychosocial needs following the incident.
- The employees of the health care facility will make every effort to protect residents from offenses perpetrated by another resident. If a prospective resident has been identified as having risk factors, the facility will determine if it is able to meet the individuals' needs while protecting the other resident's right to safety. The nurses will include specific interventions designed to avert resident to resident occurrences within the resident's care plan. Employees have been reminded of their ethical and legal obligations to immediately report to their supervisor any direct observations, suspicions

24-hour Skilled Nursing • Rehab to Home • Physical, Occupational and Speech Therapy • Sub-acute Care • Restorative Program
Outpatient Therapy • Hospice Services • Respite Care • Medicare/Medicaid





ABCMI Rehabilitation Centers of Independence

PO Box 777 • Independence, Iowa • 50644

East Campus (319) 334-7015 • West Campus (319) 334-6039

or reports of one resident infringing on the rights of another resident, and to intervene to protect the rights and ensure safety of the individuals involved.

- The Director of Nurses or designee will monitor the above implemented program on a monthly basis for 3 months by way of staff interviews and chart reviews of residents with aggressive behaviors to evaluate appropriateness of interventions and supervision. The results of the audits will be evaluated through the facility quality assurance process and frequency of audits will be determined based on the subsequent outcomes.

24-hour Skilled Nursing • Rehab-to-Home • Physical, Occupational and Speech Therapy • Sub-acute Care • Restorative Program
Outpatient Therapy • Hospice Services • Respite Care • Medicare/Medicaid



ABCMI Corporation • Hampton, IA

www.abcmcorp.com

Enhancing Relationships