STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165548	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR SPRINGS OF WEST DES MOINES L L C	7951 E P TRUE PARKWAY WEST DES MOINES, IA 50266

(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 2/14/17 The following deficiency relates to the investigation of complaint #64671 and incident #64917 & #64918. (See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/02/2017

POC accepted 2/14/17 VVimmer

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F 323	Continued From page 1 Based on observations, record review, staff and family interviews, the facility failed to provide adequate supervision related to resident to resident contact for (4) four out of (5) five residents reviewed (Residents #4, #3, #2 and Resident #1). The facility reported a census of 52 residents. Findings include: 1 a.) The Minimum Data Set (MDS) assessment dated 11/8/16 documented Alzheimer's disease as one of Resident #4's diagnoses. The BIMS assessment noted that Resident #4 scored 4 out of 15, which rated the resident's cognitive status as severely impaired. According to the MDS, Resident #4 depended on staff for supervision while walking with a walker inside and outside of his/her room. The Care Plan dated 11/17/16 indicated Resident #4 had a self-care deficit related to memory loss. The Progress Note dated 1/3/17 at 5:51 a.m. noted Resident #4 had been in the common area when another resident (Resident #3) had been observed rubbing Resident #4's left arm and breast. The residents had been separated immediately and Resident #4 had been assisted back to his/her room. b.) The MDS assessment dated 11/30/16 documented Alzheimer's disease and insomnia as Resident #3's diagnoses. The assessment noted that Resident #3 wandered, had inattention and disorganized thinking that fluctuated, depended on staff for supervision while walking inside and outside of his/her room and could only understand others and make him/herself	F 323		

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understood some of the time.

The Care Plan dated 12/13/16 indicated Resident #3 had a self-care deficit related to memory loss. The Care Plan instructed staff to provide supervision when the resident ambulated and named wandering into other residents' rooms as a specific behavior.

The Progress Note dated 1/3/17 at 5:50 a.m. noted Resident #3 had been observed rubbing another resident ' s left arm and breast (Resident #4). The residents had been separated immediately and Resident #3 had been placed on 15 minute checks.

A witness statement dated 1/3/17 and signed by Staff F, CNA (certified nurse aide), revealed as she exited a resident's room she noticed Resident #3's hand on Resident #4's shoulder. As Staff F approached the residents, Resident #3 slid his/her hand and brushed Resident #4's breast and said "this is good". Staff F stated she pulled Resident #3's hand away quickly and instructed Resident #3 to follow her to keep the residents apart. Staff F then called the nurse to report the incident.

An interview on 1/10/17 at 12:13 p.m. with Staff F, revealed she had been training Staff G, CNA on the overnight shift on 1/3/17. According to Staff F, Resident #3 had been up all night and had been sitting with her and Staff G in chairs against the wall across from the TV. According to Staff F, they tried to get him/her into bed a few times, but he/she returned to the great room. Staff F said she and Staff G started rounding about 4:30 a.m., and Resident #3 started pacing around the room about 10 minutes after their 1st couple of room

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checks. Staff F said she was supposed following Staff G to evaluate her performance for her final night of training. According to Staff F, when Staff G went into another resident ' s room for a couple minutes, Resident #4 had just entered the great room and sat in a chair right before she went into another resident ' s room. According to Staff F, Resident #3 had been pacing near the activity table when she went into another resident ' s room. She said that resident had been awake and she talked with him/her for a short time. As she exited that resident ' s room, the CNA said she saw Resident #3 standing in front of and just to the left of Resident #4 with his/her right palm on Resident #4's shoulder. According to the CNA, Resident #4's walker had been positioned between the two residents. Staff F said Resident #3 asked Resident #4 if he/she was OK and Resident #4 just looked up at him/her. Staff F said Resident #4 seemed as confused as usual. The CNA said she attempted to distract Resident #3 by calling his/her name as she walked towards them, hoping he/she would take his/her hand off of Resident #4. Staff F said as she got closer, Resident #3 slid his/her palm down toward Resident #4's left breast and said "that's good". The CNA said once she got to them, she pulled Resident #3's hand away. Staff F said Resident #3's hand touched Resident #4's breast, but he/she had not grabbed it or squeezed it. The CNA said she moved Resident #3 away from Resident #4 and radioed Staff H right away. Staff F said the great room should be supervised at all times when residents are out there. She said Staff H had not been on the unit at the time. Staff F said she should have stayed with Resident #3 because of his/her anxious behavior. Staff F said she thought it would be OK because she had not intended to stay in the other resident ' s room as

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long as she had. Before that incident, Staff F said she had never seen any indication that Resident #3 could be sexually inappropriate.

An interview on 1/17/17 at 6:00 p.m. with Staff G revealed she had only worked for the facility for about 3 weeks. She said she worked on Birch neighborhood when Resident #3 touched Resident #4, but she had been in another resident's room when it happened. Staff G said Staff F told her Resident #3 had touched Resident #4 inappropriately. Staff F had told her if she ever saw a resident touch another resident she should report it to the charge nurse right away, even if it had not been sexual. Staff G said she just assumed that Staff F had been in the common area when it happened because she went into a resident's room alone. When she entered the great room again, she saw Resident #3 still walking around, Resident #4 sitting on the sofa in the middle of the common area and the nurse present. Staff G said the facility staffed each neighborhood with one CNA on the overnight shift, so they do not take breaks. Staff G said she had not really been told to supervise the great room with a resident present. The CNA said radios are used to contact the charge nurse if help is needed. Staff G said sometimes residents end up in the recliners in the great room if they cannot sleep, and the great room may be left unattended for up to 15 minutes if she needed to change another resident. Staff G said leaving residents alone in the great room while she helped other residents could be risky and made her uncomfortable.

An interview on 1/9/17 at 2:53 p.m. with Staff H, LPN (Licensed Practical Nurse), revealed that she had not been on Birch neighborhood at the

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time Resident #3 touched Resident #4. The LPN said Staff F radioed her to report resident to resident contact. The LPN said Staff F told her she saw Resident #3 rubbing Resident #4 s shoulder and when she went to separate them, Resident #3 touched his/her breast. Staff H said when she got to the unit a couple minutes after Staff F called her, Resident #3, Resident #4 and Staff F were on the unit. The LPN said Staff G had been in another resident's room. Staff H said Resident #4 had been sitting down, Resident #3 had been walking around the neighborhood and Staff F had been in the doorway of another resident's room that she had been speaking with. The LPN said that once she verified everyone's location, she took Resident #4 into his/her room and assessed him/her. She said the resident's demeanor was pleasant and cooperative. The LPN said Resident #4 did not remember anything about what happened, and there were no visible signs of physical injury. After Resident #4's assessment, Staff F assisted Resident #4 to bed. The LPN said she remained on Birch until about 5:15 - 5:30 a.m. Resident #3 had been in the great room with her until she left. The LPN stated she informed Staff F to do 15 minute checks on Resident #3. Staff H said she called the ADON (Assistant Director of Nursing) about 5:45 a.m. Staff H said there had never been any red flags that would indicate Resident #3 would have been capable of being sexually inappropriate.

The Progress Note dated 12/25/16 at 9:11 p.m. noted Resident #3 as restless and wandered a large part of the shift. The Progress Note dated 12/14/16 at 3:27 a.m.; 11/26/16 at 5:52 p.m. and 11/24/16 at 8:50 p.m. ; noted Resident #3 had been wandering around the neighborhood. The Progress Note dated 11/22/16 at 3:36 a.m. noted

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F 323	Continued From page 6 Resident #3 walking independently throughout the neighborhood most of the shift. 2. An observation on 1/9/17 revealed that Staff A, CNA (certified nurses ' assistant), and Staff B, CNA had both left the common area of a locked dementia unit occupied by five residents unattended as they went into other residents ' rooms between 1:25 p.m. and 1:34 p.m. An interview on 1/10/17 at 3:20 p.m. with Resident #7's family member revealed they visited their family member on December 2, 2016. The family member said after not seeing a staff member for 15 minutes, they finally summoned a housekeeper on Birch neighborhood through the common kitchen area the two neighborhoods shared. According to the family member, they noticed a resident that had been unsuccessfully looking for assistance for at least five minutes before their search began. An interview on 1/17/17 at 1:30 p.m. and subsequent interviews with the Administrator revealed staff should never leave the neighborhoods unattended. The Administrator said staff relieves each other for breaks, so there may be only one staff on the unit from time to time, but never completely unattended. When asked to clarify what she meant by unattended, the Administrator said that staff are taught to call someone to supervise the common area if both of the CNAs have to help a resident that required their assistance. The Administrator said if CNAs have to leave the common area unattended to help residents in their rooms, they are expected to peek out into the common area from time to time and to keep the time spent in residents' rooms to a minimum. The Administrator said she	F 323		

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had not been fully aware that two recent incidents of resident to resident contact occurred while the common area had been left unattended. The Administrator also said their facility did not have a written policy related to resident supervision or staffing.

3. The investigation summary dated 12/30/16 documented that as Resident #1 walked by Resident #2 as he/she sat in a lounge chair in the common area, he/she slapped Resident #2 three times on the arm and once on the shoulder with an open hand.

a). The initial MDS assessment dated 1/9/17 documented dementia as one of Resident #2's diagnoses. The MDS also indicated Resident #2 had just been admitted on 12/29/16 and scored 6 out of 15 on the BIMS assessment, which rated the resident's cognitive status as severely impaired.

The Progress Note dated 12/30/16 at 9:05 p.m. indicated that as Resident #2 sat in the common area, another resident [Resident #1] approached him/her and hit him/her three times on the right arm and once on the right shoulder before staff could separate them.

b). The Minimum Data Set (MDS) assessment dated 12/20/16 documented Alzheimer's disease as one of Resident #1's diagnoses. The BIMS (Brief Interview for Mental Status) assessment noted that Resident #1 scored 4 out of 15, which rated the resident ' s cognitive status as severely impaired. According to the MDS, Resident #1 depended on staff for supervision while walking with a walker inside and outside of his/her room and could only understand others and make

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F 323	Continued From page 8 him/herself understood some of the time. The Care Plan dated 12/30/16 indicated Resident #1 had a self-care deficit related to memory loss. The care plan instructed staff to provide supervision as needed when the resident walked with a walker. According to the Care Plan, Resident #1 frequently got confused and may try to get his/her peers to do what he/she thought needed to be done. The Care Plan noted that sometimes Resident #1 may touch or even push other residents if he/she felt like they needed to hurry. The Care Plan indicated Resident #1 had a history of throwing things at people when he/she became upset or confused, and staff should separate him/her from peers when necessary. The Progress Note dated 12/30/16 at 9:00 p.m. indicated Resident #1 had been walking with his/her front wheeled walker when he/she stopped and slapped another resident three times on the right arm and once on the right shoulder before staff could separate them. The Progress Note dated 12/30/16 at 9:05 p.m. indicated Resident #1 hit staff while being redirected after he/she slapped another resident. An interview on 1/10/17 at 1:45 p.m. with Staff J, LPN (licensed practical nurse), revealed that Staff E, CNA called her to Aspen after supper and said Resident #1 slapped Resident #2 three times on the arm and once on the shoulder. The LPN said Resident #1 refused his/her pain medication that day and can become more aggressive when he/she has pain. The Progress Note dated 12/5/16 at 8:56 p.m. indicated Resident #1 slapped another resident	F 323		

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F 323	Continued From page 9 that afternoon. An interview on 1/10/17 4:05 p.m. with Staff E, CNA, revealed residents had been sitting in the common area on the Aspen neighborhood and watching a movie after supper. The CNA said she had just returned after helping a resident and then went to dispose of the trash. Staff B said she saw Resident #1 walking around with his/her walker amongst six other residents in the common area at the time she went into the trash room. According to the CNA, as she exited the trash room, she saw Resident #1 slap Resident #2 about four times on the right arm with an open hand. Staff E said she did not know what led up to the incident because she had been in the trash room. Staff E said the other CNA had been in another resident's room helping them and no other staff members were on the unit at the time. Staff E said she separated the residents by taking Resident #1 into the dining room to calm him/her down as she radioed the nurse. The CNA said the nurse came right away and stayed to calm Resident #1 as they helped other residents. Staff E said she did not know if a room full of residents should be left unattended. She said the residents have a routine after supper that required staff assistance and if you do not give it to them, they can cause a lot of drama. The CNA said the residents get angry and feel like we do not want to help them. The CNA said she thought they needed to designate someone to supervise Resident #1 after supper when they are busy with other residents. The CNA said she never talked to the Administrator or Director of Nursing about needing more help. An interview on 1/17/17 at 2:50 p.m. with Staff D, CNA, revealed she worked the floor on Aspen	F 323		

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F 323	Continued From page 10 starting at 2:00 p.m. The CNA said she had no idea that Resident #1 slapped Resident #2. Staff D said Resident #1 had not demonstrated any behaviors that she could recall. The CNA said they have been told the neighborhoods should never be left unattended. She said if they have to provide care for a resident that required assistance of 2, one person should do the preparation in the resident's room before the other person joined them. The CNA said they recruit the help of another staff person if they can. She said if other staff is unavailable and both CNAs have to go into a resident's room, they are supposed to look out into the great room periodically to ensure residents are safe. The CNA said she found herself in that predicament before. The CNA said she believed it jeopardized residents' safety, but stated they had a job to do. An interview on 1/17/17 at 4:15 p.m. with Staff C, CNA, revealed that Resident #1's dementia had progressed rapidly. The CNA said Resident #1 can get more forgetful and irritable with other residents, and lately required a lot more prompts and cues for redirection. The CNA said they are supposed to supervise the great room at all times when occupied by residents. She said staff relieves each other for breaks. The CNA said they are supposed to either call for additional staff when they need help or politely ask the residents to wait for their coworker to return from break. Staff C said there are times they have to leave the great room unattended. The CNA said they are supposed to look out into the great room from time to time if they are in a resident's room. She said it involved risks because she cannot supervise 100% of the time under those circumstances.	F 323		

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F 323	Continued From page 11 An interview on 1/17/17 at 5:30 p.m. with Staff I, CNA/CMA (certified medical assistant), revealed she had been passing medications when one of the CNAs told her Resident #1 slapped Resident #2. She said although she had not seen it, she reported it to the nurse. Staff I stated she had not interacted with Resident #1 before the incident, but she sat with him/her in the dining room after the incident to try and calm him/her and persuade him/her to take their medication. The CNA/CMA said according to other staff, Resident #1 had been in pain earlier. According to Staff I, administration had told them staff had to be in the great room when residents are in there. The CNA/CMA said they relieve each other for breaks. She also said they are supposed to call for help to avoid leaving the great room unattended if they can. Staff I said she could not recall for sure, but might have been cleaning up the kitchen when the incident occurred. Staff I said she had not seen the incident, so if the other CNA was not on the floor, apparently the great room had been left unsupervised. An interview on 1/18/17 at 9:15 a.m. with Staff B revealed she worked the day shift on Aspen, but did not recall that Resident #1 had any behaviors that day. The CNA said that sometimes Resident #1 joked around and other times might say something like "I feel like punching you". According to the CNA, they are supposed to separate him/her from other residents when he/she acted that way. The CNA said the common area was always supposed to be supervised. The CNA said they are supposed to relieve each other for breaks, and they are supposed to recruit the help of another staff person as necessary. She said there are times when the neighborhoods are left unsupervised.	F 323		

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ARBOR SPRINGS OF WEST DES MOINES L L C	7951 E P TRUE PARKWAY WEST DES MOINES, IA 50266

(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 323	Continued From page 12 Staff B said she has had to leave the common area on another neighborhood unattended to assist a resident with emptying an ostomy bag. The CNA said she radioed the nurse and other CNA to let them know. Staff B said no problems occurred in her absence, but she felt uncomfortable leaving them unsupervised. She said she has also asked residents if they could wait for her coworkers to return before addressing their needs. An interview on 1/18/17 at 1:45 p.m. with Resident #8's spouse revealed he/she had been in the common area of Aspen neighborhood when Resident #1 had taken "a swat" at a new resident (Resident #2). As far as he/she knew, Resident #2 had not sustained injuries. The visitor stated that Resident #1 can get angry for no reason when he/she becomes confused. An interview on 1/19/17 at 8:55 a.m. with the Education Director revealed that scheduling is fluid or adjusted based upon the need. She said based on residents' needs, the census and how smoothly things are running, one staff may be sent home if authorized by the nurse. She said there were 3 neighborhoods at each end of the building. On the 1st shift there is either 1 CMA and 2 CNAs in each neighborhood and one nurse over the entire building, or 1 nurse and 2 CNAs in each neighborhood. According to the Education Director, the 2nd shift has one nurse and 2 CNAs in each neighborhood. On 3rd shift there is one nurse over the entire building and 1 CNA on each neighborhood.	F 323		

Arbor Springs Plan of correction

This plan of correction constitutes my credible allegation of compliance. The following deficiencies will be corrected by February 13th 2017.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law require it.

In Response to F323

Arbor Springs will continue to provide the needed supervision to keep our residents safe.

We will provide the needed supervision for Residents #1, #2 and #4. Resident #3 has passed away.

Thru our QAPI program and a PIP committee, the DON has been given the responsibility to lead this initiative. She will start immediately spending time in each neighborhood to observe care giving routines and supervision of common areas. This will be done for 1 week. She will then determine what areas need addressed and bring these areas to the PIP team. The PIP team will discuss and implement the appropriate changes needed.

The PIP committee has also determined that we will be staggering staff break times, increasing the use of ancillary staff in the neighborhoods and increasing the dietary department's responsibilities post meal. The PIP committee will also continue to meet and discuss effectiveness of the plan and make any adjustments if needed on a regular basis.

The Administrator and/or designee will be auditing each neighborhood on a routine basis to ensure the supervision is being provided to our common areas.

Education has been provided to all staff as all staff is part of the supervision provided to our common areas.

Administrator will audit and monitor POC.

Sejla Rekic

Administrator