STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING _____ B. WING _____	C 02/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 VKK 3/13/17 Correction date 3/2/2016 The following deficiencies relate to the investigation of complaint #66703 and mandatory #64572. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 172 SS=D	483.10(f)(4)(i)-(vi) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS (f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (i) The facility must provide immediate access to any resident by: (A) Any representative of the Secretary, (B) Any representative of the State, (C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.), (D) The resident's individual physician, (E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq), (F) Any representative of the agency responsible	F 172	* See Attached Response	10/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel M. Gilmore, MS/ADM		03/02/2017

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 172	Continued From page 1 for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and (G) The resident representative. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. (vi) A facility must meet the following requirements:	F 172	* See Attached Response	10/18/16

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F 172	Continued From page 2 (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of facility Bill of Rights, staff and ombudsman interviews, the facility failed to ensure one of five resident reviewed was able to visit with a visitor of their choosing. (Resident #3) The facility census was 91 residents. Findings include: 1. The Minimum Data Set (MDS) assessment	F 172	*See Attached Response	10/18/16

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F 172	Continued From page 3 dated 9/25/16, documented Resident #3 was admitted to the facility on 9/13/16 with diagnoses that included non-Alzheimer's dementia, dementia without a behavioral disturbance systolic and diastolic heart failure. The MDS assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition and required extensive assistance with most activities of daily living (ADL'S). A Care Plan initiated 10/5/16, indicated the resident had a limited ability to participate in activities related to dementia and having been easily distracted and with an ADL self care performance deficit, the potential for behaviors and with an anticipated long term care stay related to dementia with impaired memory, safety awareness, reasoning, judgement and recent behavior problems in the previous facility related to anxiety. An Ombudsman email dated 2/22/17, included the following information: On 10/5/16, the Ombudsman spoke with a friend of the resident who verbalized he/she was not been able to visit the resident at the facility. On 10/18/16, the Ombudsman spoke with the Administrator at the facility who stated the resident's Power of Attorney (POA) requested the friend not visit the resident. The facility had been re-educated at the time about the resident's right to have visitors and the POA had no authority to restrict the visits. On 10/27/16, the Ombudsman spoke with the facility and was informed the friend visited the	F 172	* See Attached Response	10/18/16

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F 172	Continued From page 4 resident the day prior (10/26/16). During interview on 2/22/17 at 4:02 p.m., the Administrator confirmed the facility restricted the resident's friend from visiting on request of the POA until they were further educated by the Ombudsman. Review of the Resident's Bill of Rights form dated 2/2011, documented each resident had the right to communicate, associate and meet publicly or privately with any person of the resident's choice, unless to do so would infringe upon the right of others.	F 172	*See Attached Response	10/18/16
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225	*See Attached Response	12/2/17

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F 225	Continued From page 5 licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate	F 225	*See Attached Response 3/2/17	

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F 225	Continued From page 6 corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy, the facility failed to report an allegation of abuse timely to the Department of Inspections and Appeals (DIA) for one (1) of five (5) residents reviewed. The facility reported a census of 91 residents. Findings include: According to the Minimum Data Set (MDS) dated 11/28/16, Resident #1 had diagnoses included aphasia, non-Alzheimer's dementia, anxiety and a transient cerebral ischemic attack. The resident sometimes had the ability to make self understood and understand others and exhibited moderately impaired cognitive skills. The resident exhibited physical behaviors 4-6 days a week and verbal and other behaviors 1-3 days a week. The resident required extensive assistance of two staff to transfer, ambulate and for toilet use and had been dependent on staff with dressing and personal hygiene. Resident #1's Care Plan with a focus area initiated on 12/8/16, indicated he/she had demonstrated physical and verbal behaviors related to dementia. The approaches included the following: a. The resident resided in the Chronic Confused and Demented Illness (CCDI) unit of the facility for decreased amounts of stimulation. b. The resident had a tendency for verbally and physically aggressive behaviors with all cares. Staff should assure he/she had been safe and re-approach later. c. Staff should intervene before Resident #1's	F 225	* See Attached Response	3/2/17

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F 225	Continued From page 7 agitation escalated, and guide the resident away from the source of distress or calmly engage in conversation; if the resident remained aggressive, staff should calmly walk away and approach later. According to the Witness Interview Notes (provided by the Administrator) on 12/1/16 at approximately 10:15 a.m. an Licensed Practical Nurse (LPN) reported an alleged abuse incident between Staff A and Resident #1. Staff B had witness an alleged abuse incident of Staff A striking Resident #1's hip with an open hand. Staff A was on break when the Administrator received the report and was immediately separated with an onset of an investigation. During an interview 2/8/17 at 10 a.m., Staff B, CNA indicated on 12/1/16 just after 10 a.m., herself and Staff A assisted the resident out of bed who had been feisty at the time by hitting and pinching the 2 staff members. Staff A and B assisted the resident into the bathroom and sat him/ her on the toilet while the resident continued hitting the staff. Staff A raised her voice and kept trying to redirect the resident in a positive manner. Staff B stated Staff A displayed a gruff voice which she thought irritated the resident more. While Staff A held the resident's bilateral hands/wrists to stop him/her from hitting and pinching them the resident had been able to get one wrist free and did something to Staff A but she was unaware of what that was so Staff A slapped the resident's bare left hip. Staff B had not known how hard [the resident had been slapped] but she was able to hear a slap sound. Staff B then asked Staff A what she just did, and Staff A said, you are not going to report me, are you? The 2 staff members continued cares and Staff B	F 225	* See attached Response 3/2/17	

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F 225	Continued From page 8 immediately reported the incident to Staff C, LPN. During an interview 2/8/17 at 10:20 a.m., Staff C indicated on 12/1/16 somewhere between 9:30 and 10:30 a.m., Staff B came out of the unit and told her Staff A just slapped the resident's hip because something happened between them during cares. Staff C informed the Director of Nursing (DON) and Administrator within 3 minutes. The facility did not report the incident to Department of Inspections and Appeals (DIA) until Sunday 12/4/17 at 10:05 a.m. During an interview 2/8/17 at 8:55 a.m., the Administrator confirmed the alleged incident had not been reported timely. The facility Abuse Policy revised 8/16 directed staff of the following: Reporting: If a staff member or employee had been required to make a report pursuant of this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who should notify DIA immediately in no later than 24 hours of any allegation, even on the weekend or holiday.	F 225	*See attached Response 3/2/17	

Grandview Heights Rehab & Healthcare

910 E. Olive Street

Marshalltown, Iowa 50158

2567 Facility Response

The following narrative responses represent Grandview Heights Rehab & Healthcare's credible allegation of compliance related to findings to Survey activity by the Iowa Department of Inspections and Appeals concluded on February 22, 2017.

F00 **Correction Date: 3/2/2017**

F172 Right to/Facility Provision of visitor access

Facility Response: A resident has the right and the facility will provide immediate access to any resident by immediate family, other relatives, or other visitors, subject to the resident's right to withdraw consent at any time. Limitations to access are provided for in Iowa law. A visitor may be restricted by the facility for the following reasons: (1) The resident refuses to see the visitor, (2) The resident's physician documents specific reasons why such a visit would be harmful to the resident's health, (3) The visitor's behavior is unreasonably disruptive to the functioning of the facility. Visitor access implementation will be monitored by the Administrator.

Correction Date: 10/18/2016

F225 Investigate/Report Allegations of Abuse Timely

Facility Response: All allegations of abuse to residents of Grandview Heights Rehab & Healthcare by staff members, family members, visitors, or other residents will be investigated immediately, and will be reported to the Department of Inspections and Appeals by the facility representative within 24 hours of the event. If the investigation has not yet been concluded, the Department of Inspections and Appeals will still be notified within 24 hours as to the status of the investigation. Investigations and monitoring will be done by the Administrator.

Correction Date: 3/2/2017

Daniel M. Larmore, MS

Daniel M. Larmore, MS/Administrator