STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GARDENS CARE CENTER	455 31ST STREET MARION, IA 52302

(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 5/10/17 Complaint # 67376-C was investigated on 4/20 - 4/27/2017 and was substantiated with the following deficiency. See code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(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 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:	F 225	See Attached	5/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5/16/2017

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.

[signature] 5/18/17

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.

F225
S/S=D

I. Resident #2 has been assessed and found to have no identified health or psychosocial concerns related to the abuse allegation. The physician and resident representative has been notified of the allegation.

II. The abuse protocols were reviewed with the residents at the Resident Council meeting on 5/4/17, and asked the residents to report any concerns immediately to nursing and/or any administrative staff. Social Service, Director of Nursing and Administrator checked with residents and no other resident allegations were identified.

III. On 4/27/2017, the Social Worker and Director of Nursing were educated on the reporting guidelines of the facility abuse policy and on maintaining investigations. The staff was educated on the facility abuse policy and regarding the reporting guidelines for allegations of abuse on 4/27/2017.

IV. The Administrator, Director of Nursing, Social Worker and/or Designee will complete random audits of any resident allegations and timely reporting of allegations, weekly for four weeks, monthly for two months, then quarterly for two quarters. Results of the audits will be reviewed at the QAPI meetings for revisions as needed.

V. Compliance Date: 5/10/17

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F 225	Continued From page 1 (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 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 to the Department of Inspections and Appeals for 1 of 4 residents (Resident #2). The facility identified a census of 78 residents.	F 225		

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F 225	Continued From page 2 Findings include: According to the Minimum Data Set (MDS) dated 1/25/2017, Resident # 2 had intact cognition. The MDS identified Resident #2 required extensive assistances of two staff to transfer from one surface to another and could not ambulate. The resident had been diagnoses with Parkinson's Disease, diabetes and stroke. The Care Plan identified Resident #2 had a communication problem identified 1/27/2017 and directed staff to ask yes or no questions and monitor for non-verbal communication. The Resident had anxious behavior symptoms identified on 11/4/2016. Observation on 4/26/2017 at 8:55 a.m., revealed a certified nurse aide (CNA) assisted Resident #2 with a urinal; the resident made his/her needs known. Observation on 4/26/2017 at 10:10 a.m., revealed Resident #2 transferred with the assistance of one staff from the wheelchair to the toilet. The resident used his/her right hand to hold onto the grab bar and had the ability to make his/her needs known. During an interview on 4/20/2017 at 9:15 a.m., Resident #2 reported he/she assumed staff were taking Coca Cola from his/her room. The resident revealed an Aide hit him/her in the head with the urinal one evening and that he/she reported it to Staff E, LPN (Licensed Practical Nurse). Resident #2 stated he/she did not know the Aides name, and it did not hurt, but it should not have happened. The Progress Notes failed to provide documentation of a physical assessment,	F 225		

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F 225	Continued From page 3 physician notification, and family notification regarding the allegation of mistreatment reported March, 2017. During an interview on 4/26/2017 at 9:50 a.m., Staff C, LPN indicated on 3/31/2017, a CNA came and reported Resident #2's allegation regarding the urinal. Resident #2 told Staff C the incident occurred two days prior, he/she had reported it to Staff E, LPN and Staff E told the resident that Aide would not care for him/her any more. The resident reported no other concerns. During an interview on 4/25/2017 at 2:50 p.m., Staff E, LPN indicated Resident #2 never reported a concern. Staff E knew the resident and reported anytime the resident had a problem or concern, he/she immediately called family. The resident waited for nothing or no-one. During an interview on 4/26/2017 at 10:35 a.m., Staff B, Social Worker reported he/she learned of Resident #2's allegation on a Friday, the end of March. The DON and her talked to Resident #2 and found inconsistencies with the allegation. The DON checked the resident's forehead and found no mark. The resident failed to name the staff but knew him/her to be African American. The DON interviewed Staff F, CNA (Certified Nurse's Aide) who worked at the time of the allegation. Staff F denied the allegation and now worked on another hall. An interview with Staff F on 4/25/17 at 2:30 p.m., revealed last month [March 2017] she received a call from the DON. The DON informed Staff F that Resident #2 alleged during the second shift, she hit him/her in the head with a urinal. Staff F reported Staff E was the nurse at the time and	F 225		

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F 225	Continued From page 4 she (Staff F) wrote a statement at the time saying that did not occur. During an interview on 4/25/2017 at 3 p.m., and 4/26/2017 at 11 a.m., the DON reported she conducted the investigation involving Resident #2. Resident #2 reported staff hit him/her in the head with a urinal. Staff C, LPN revealed Resident #2 reported the incident and indicated it occurred a couple of nights prior. Resident #2 told the DON that the African American staff member hit him/her in the head with the urinal on the evening shift and that he/she reported the incident to Staff E, LPN at the time it occurred. The DON reported they conducted an investigation regarding the concern reported regarding Resident #2. They conducted staff and resident interviews. The DON failed to provide documentation the facility conducted an investigation, resident assessments after allegations were made, and notified physician and family members. On 4/27/2017 at approximately 10:30 a.m., the DON presented copies of statements written by staff on 4/26/17 and 4/27/2017. The DON stated she requested staff write new statements since he/she failed to find original statements written at the time of the facility investigation. During an interview on 4/26/2017 at 10:30 a.m., the Administrator reported the Director of Nursing (DON) and Staff B, Social Worker conducted the investigation involving Resident #2 and determined they had no evidence to substantiate mistreatment. Resident #2 had a history of making false allegations, and had reported the concern to Staff E, LPN (Licensed Practical Nurse) immediately, however Staff E denied having been told.	F 225		

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F 225	Continued From page 6 The facility Abuse Prevention, Identification, Investigation and Reporting Policy included: Policy Statement: All residents have the right to be free from abuse, neglect, and any physical or chemical restraint not required to treat the resident's medical symptoms. The policy identified Resident Abuse under the Federal Certification Guideline defined as follow: Abuse means the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Mental abuse includes but is not limited to, humiliation and threats of punishment. Mistreatment is defined as inappropriate treatment. The policy identified the facility is to report all allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported immediately to the charge nurse. The charge nurse is responsible for immediately the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, no later than 24 hours if the events that cause the allegation involve abuse but do not result in serious bodily injury. Investigation: Should an incident or suspected incident of Resident abuse as defined above be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident. The administrator	F 225		

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F 225	Continued From page 6 or designee will complete documentation of the allegation of Resident Abuse and collect any supporting documents relative to the alleged incident. The investigation should include consideration of the following, based on circumstances of the allegations, as applicable: 1. Review the completed documentation of the allegation of Resident abuse 2. Review the Resident's medical record to determine events leading up to the incident 3. If there is indication that injury has or may have occurred, a physical assessment must be completed by the Director or Nursing or charge nurse immediately 4. Documentation of an physical assessment conducted will be made in the Resident's chart and a copy of this documentation will be included in the abuse investigation file 5. The Director of Nursing or designated nurse will notify the Resident's attending physician of the alleged incident, the responsible family member as documented on the Resident's chart will be notified of the incident and advised of the status of the investigation and the actions and reporting being taken. 7. Interview the persons reporting the incident and the alleged perpetrator and document witness statements.	F 225		