STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165188	A. BUILDING _____ B. WING _____	C 06/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BRIDGE CARE & REHABILITATION	1015 WEST SUMMIT WINTERSET, IA 50273

(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 6/27/17 The following deficiencies relate to the investigation of complaint #68591 and incident # 68650. (See Code of Federal Code of Regulations (42-CFR) Part 483, Subpart B-C). Complaint #68293 was not substantiated	F 000	Please accept this facility's credible allegation of compliance as of 6/27/17. The preparation of the following plan of correction does not constitute admission or agreement by the provider of the truth or alleged violations or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provision of federal/state law.	
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.	F 225	F225 The facility states it is the intent to ensure that residents are protected from abuse. Staff has been educated on the requirements to continue to separate the accused abuser from the resident until the state investigation is completed. Abuse training will be reviewed at quarterly QA. F226 The facility states it is the intent to ensure that residents are protected from abuse. Staff has been re-educated on the requirements to report any suspected abuse immediately to the Administrator. Both the accusing staff and the accused staff were given memorandums of understanding that stated they must report immediately. All staff was just in-serviced on this policy in May. Abuse training will be reviewed at quarterly QA.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/30/2017

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.

POC accepted 7/10/17 VV

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F 225	Continued From page 1 (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 corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy review and interviews the facility failed to maintain	F 225	F312 The facility states it is the intent for all residents to have cares provided and repositioning per care plan. Daily audits conducted on residents for changing and repositioning x2 weeks through 7/9/17. Random audits will be conducted by DON or designee bi weekly x1 month, weekly x1 month, then randomly ongoing to ensure proper position changing. Results of audits will be discussed weekly at department head meeting, quarterly at QA meeting, and on an as needed basis for revisions.	

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F 225	Continued From page 2 separation of Staff B from Resident #1 until the outcome of the Department's (Department of Inspections and Appeals investigation) investigation for one of five residents. Interview with the Administrator revealed Staff B returned to work on 6/3/17 and could work with Resident #1 if another staff was present; however this was prior to knowing the outcome of DIA investigation which occurred from 6/20/17 to 6/26/17. The facility reported a census of 56 residents. Findings include: Record review revealed Resident #1's face sheet listed diagnosis including Alzheimer's disease and pneumonia. The Minimum Data Set (MDS) assessment dated 3/30/17 identified Resident #1 scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) cognitive test indicating cognitive impairments. Resident #1 required two staff assistance for bed mobility, transfers, dressing, toilet use and one staff assistance for personal hygiene. An untitled, unsigned, undated typed narrative reference to an investigation of Staff B abuse allegation. The narrative indicated on 6/1/17 at approximately 4:30 p.m., Staff A and Staff B performed case to Resident #1. Staff A reported she witnessed Staff B slap Resident #1's hand away when he/she was trying to grab at her. The resident had no evidence of injury [when assessed later]. After interviews with staff, the facility determined there was no concern regarding Staff B's care. The facility would retrain both aides on how to handle combative residents safely and during cares and would ensure staff know proper protocol.	F 225		

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F 225	Continued From page 3	F 225		

In an interview on 6/20/17 at 3:46 p.m. Staff A, certified medication aide, indicated on the afternoon of 6/1/17 at around 4:30 p.m. she entered the room of Resident #1 to assist Staff B with cares. Resident #1 was grabbing at Staff B and Staff B slapped Resident #1 firmly on his/her hand and stated, "Stop grabbing me". Staff A proceeded to try and redirect Resident #1, who didn't seem bothered by the incident. Staff A stated they finished providing cares and moved on to other residents as they were very busy. At around 7:00 p.m. Staff A stated she thought about the earlier incident and it potentially being abuse. Staff A reported the incident to Staff C, who instructed her to call the facility tomorrow and report it to the Administrator. Staff A stated she thought about the incident and read some literature regarding abuse reporting and at around 10:00 p.m. reported the incident to Staff D, who promptly reported to the Administrator. By that time Staff B was no longer working.

In an interview on 6/26/17 at 1:21 p.m. Staff B, certified nurse aide, stated she first heard that someone had alleged she slapped Resident #1 during a phone call from the Administrator on 6/2/17. Staff B stated at around 4:00 to 4:30 p.m. on 6/1/17 she and Staff A entered Resident #1's room to provide incontinence cares. Staff B stated she helped with rolling the resident while Staff A provided the peri cares. Staff B insists they both entered the room together as she would never start cares with Resident #1 by herself. Staff B stated she she did not recall Resident #1 ever being overly aggressive or her needing to remove his/her grasp. Staff B adamantly denies ever slapping Resident #1 on his/her hands.

In an interview on 6/26/17 at 11:16 a.m. Staff C,

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F 225	Continued From page 4 Licensed Practical Nurse, stated she was passing medications at around 7:00 p.m. on 6/1/17 when Staff A approached her with a concern that Staff B slapped the hand of Resident #1 while providing cares. Staff A was uncertain whether this should be reported. Staff C stated she told Staff A she needed to contact the Administrator. Later that same shift Staff C was approached by Staff D, who instructed her to fill out an incident report and to assess Resident #1 regarding the alleged abuse. Staff C stated she thought it was at this time Staff A had reported the allegation of abuse to the Director of Nursing. Staff C stated she assessed Resident #1 and found no indications of injury, markings or bruising on his/her hands. In an interview on 6/21/17 at 6:30 p.m. Staff D, Licensed Practical Nurse, stated shortly after 10:00 p.m. on 6/1/17, Staff A approached her and reported earlier that day she witnessed Staff B slap Resident #1's hand during cares. Staff A stated she reported the incident to Staff C who stated to call and report to the Administrator tomorrow. Staff D stated she called the Administrator per protocol and collected a statement from Staff A. Staff B had already left for the day. Staff D instructed Staff C to assess Resident #1. Staff D stated there were no markings, bruising or injury to Resident #1's hands. In an interview on 6/20/17 at 4:55 p.m. the Administrator stated she received notice of an allegation of abuse after 10:00 p.m. on 6/1/17 from Staff D. The alleged perpetrator, Staff B was already off and not scheduled back until the weekend (6/3/17). The Administrator conducted an investigation the following day (6/2/17) and	F 225		

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F 225	Continued From page 5 after reviewing everyone's input determined the actions of Staff B was not abuse. Staff B returned to work on 6/3/17 without restrictions, including being able to provide care to Resident #1. Staff B was instructed to always have two staff present with Resident #1 when providing cares. At the conclusion of the facility's investigation on 6/2/17 they determine the allegation of abuse was not substantiated. The facility may allow Staff B to resume working with residents other than the resident the perpetrator is alleged to have abused. A review of the policy for Protection revealed the facility failed to implement separation until the findings of the Department's investigation. A review of the policy indicated: The policy titled Abuse Prohibition and Prevention Program, dated 6/1/11, instructed: b. Point 5.6 Protection - During the investigation, the Community and Agency will protect the client as appropriate, including but not limited to separation and/or redirection of clients. A review of the facility policy for Protection revealed an employee will be immediately suspended from duty until the Agency Administrator reviewed finding of the investigation.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that:	F 226		

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F 226	Continued From page 6 (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to operationalize the abuse policy and procedure for protection of residents from potential further abuse during an investigation by failing to report immediately; and failed to implement a comprehensive policy to maintain separation of an alleged perpetrator (Staff B) from an alleged victim (Resident #1) until the outcome of the Department of Inspection and	F 226		

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F 226	Continued From page 7 Appeals (DIA)'s investigation for one of five residents. The facility reported a census of 56 residents. Findings Include: Record review revealed Resident #1's face sheet listed diagnosis including Alzheimer's disease and pneumonia. The Minimum Data Set (MDS) assessment dated 3/30/17 identified Resident #1 scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) cognitive test indicating cognitive impairments. Resident #1 required two staff assistance for bed mobility, transfers, dressing, toilet use and one staff assistance for personal hygiene. An untitled, unsigned, undated typed narrative reference to an investigation of Staff B abuse allegation. The narrative indicated on 6/1/17 at approximately 4:30 p.m., Staff A and Staff B performed case to Resident #1. Staff A reported she witnessed Staff B slap Resident #1's hand away when he/she was trying to grab at her. The resident had no evidence of injury [when assessed later]. After interviews with staff, the facility determined there was no concern regarding Staff B's care. The facility would retrain both aides on how to handle combative residents safely and during cares and would ensure staff know proper protocol. According to the investigation Check List dated 6/2/17 given to the surveyor during the investigation revealed on 6/1/17, Resident #1 had been assessed for safety on 6/1/17 at 10:30 p.m. In an interview on 6/20/17 at 3:46 p.m. Staff A,	F 226		

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F 226	Continued From page 8	F 226		

certified medication aide, indicated on the afternoon of 6/1/17 at around 4:30 p.m. she entered the room of Resident #1 to assist Staff B with cares. Resident #1 was grabbing at Staff B and Staff B slapped Resident #1 firmly on his/her hand and stated, "Stop grabbing me". Staff A stated they finished providing cares and moved on to other residents as they were very busy. At around 7:00 p.m. Staff A stated she thought about the earlier incident and it potentially being abuse. Staff A reported the incident to Staff C, who instructed her to call the facility tomorrow and report it to the Administrator. Staff A stated she thought about the incident and read some literature regarding abuse reporting and at around 10:00 p.m. reported the incident to Staff D, who promptly reported to the Administrator. By that time Staff B was no longer working.

In an interview on 6/26/17 at 1:21 p.m. Staff B, certified nurse aide, stated around 4:00 to 4:30 p.m. on 6/1/17 she and Staff A entered Resident #1's room to provide incontinence cares. Staff B adamantly denies ever slapping Resident #1 on his/her hands during cares.

In an interview on 6/26/17 at 11:16 a.m. Staff C, Licensed Practical Nurse, stated she was passing medications at around 7:00 p.m. on 6/1/17 when Staff A approached her with a concern that Staff B slapped the hand of Resident #1 while providing cares. Staff A was uncertain whether this should be reported. Staff C stated she told Staff A she needed to contact the Administrator. Later that same shift Staff C was approached by Staff D, who instructed her to fill out an incident report and to assess Resident #1 regarding the alleged abuse. Staff C stated she thought it was at this time Staff A had reported the allegation of

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F 226	Continued From page 9 abuse to the Director of Nursing. In an interview on 6/21/17 at 6:30 p.m. Staff D, Licensed Practical Nurse, stated shortly after 10:00 p.m. on 6/1/17, Staff A approached her and reported earlier that day she witnessed Staff B slap Resident #1's hand during cares. Staff A stated she reported the incident to Staff C who stated to call and report to the Administrator tomorrow (6/2/17). Staff D stated she called the Administrator per protocol and collected a statement from Staff A. Staff B had already left for the day. A review of the policy indicated: The policy titled Abuse Prohibition and Prevention Program, dated 6/1/11, instructed: a. Point 5.5 Investigation - Any allegations of mistreatment, neglect, or abuse will be immediately reported to the Executive Director, agency Administrator or designee and appropriate state enforcement/regulatory agencies. b. Point 5.6 Protection - During the investigation, the Community and Agency will protect the client as appropriate, including but not limited to separation and/or redirection of clients. A review of the facility policy for Protection revealed an employee will be immediately suspended from duty until the Agency Administrator reviewed finding of the investigation. In an interview on 6/20/17 at 4:55 p.m. the Administrator stated she received notice of an allegation of abuse after 10:00 p.m. on 6/1/17 from Staff D. The alleged perpetrator, Staff B was already off and not scheduled back until the weekend (6/3/17). The Administrator conducted	F 226		

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F 226	Continued From page 10 an investigation the following day (6/2/17) and after reviewing everyone's input determined the actions of Staff B was not abuse. Staff B returned to work on 6/3/17 without restrictions, including being able to provide care to Resident #1. Staff B was instructed to always have two staff present with Resident #1 when providing cares. A review of the facility policy for Protection revealed any allegation of abuse will be immediately reported to the Executive Director, Agency Administrator. Staff A & Staff B reported they were present working with Resident #1 on 6/1/17 between 4-4:30 p.m., and staff did not report the alleged abuse to the Administrator until 10:00 p.m. At the conclusion of the facility's investigation on 6/2/17 they determine the allegation of abuse was not substantiated. (The facility may allow Staff B to resume working with residents other than the resident the perpetrator is alleged to have abused.) A review of the policy for Protection revealed the facility failed to implement separation until the findings of the Department's investigation.	F 226		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews, the facility failed to	F 312		

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F 312	Continued From page 11 provide routine toileting assistance and positioning for three of five residents reviewed. (Resident #1, #3 & #5) The facility census was 56 residents. Findings include: 1. The Minimum Data Set (MDS) assessment date 3/30/17, documented Resident #1 had diagnoses that included Alzheimer's disease and peripheral vascular disease and required total assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene and was incontinent of bowel and bladder. The plan of care indicated limitations with activities of daily living, incontinence and potential for pressure ulcer development related to immobility with interventions that included: a. Staff to check and change for incontinence. b. Provide pericare after each incontinence. c. Staff to assist with repositioning every 2-3 hours routinely. During observation on 6/21/17 at 7:40 a.m., the resident was positioned in his/her broda chair in the dining room. At 9:48 a.m., staff propelled the resident into the shower room where staff provided pericare while the resident remained in the chair. The resident remained in the chair without position change until 1:28 p.m. at which time staff transferred him/her from the broda chair into his/her bed. The resident remained in bed until 5:20 p.m., when he was transferred tot he broda chair.	F 312		

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F 312	Continued From page 12 2. The Minimum Data Set (MDS) assessment dated 4/20/17, documented Resident #3 required limited assistance with bed mobility and transfers, but extensive assistance with dressing, toilet use and personal hygiene. The MDS assessment documented the resident as occasionally incontinent of bladder and continent bowel. During observation on 6/21/17 at 7:40 a.m., the resident was positioned in his/her wheelchair in the dining room. The resident remained in his/her wheelchair the entire morning until visiting family members reported the resident was requesting to use the bathroom. At 12:56 p.m., the resident was transferred onto the commode and voided. Staff reported the resident's brief was dry. The resident was transferred into bed. The resident remained in bed during checks at 2:35 p.m., 3:15 p.m. and at 5:20 p.m. 3. The Minimum Data Set (MDS) assessment dated 5/17/17, documented Resident #5 had a brief interview for mental status (BIMS) score of 15 indicating intact cognition and required total assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene and was incontinent of bowel and bladder. The plan of care indicated limitations with activities of daily living, incontinence and potential for pressure ulcer development related to immobility with interventions which included: a. Resident is totally dependent on staff for routine check and change with pericare. b. Staff to turn/reposition at least every 2 hours, more often as needed or requested.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165188	A. BUILDING _____ B. WING _____	C 06/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BRIDGE CARE & REHABILITATION	1015 WEST SUMMIT WINTERSET, IA 50273

(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 312	Continued From page 13 During observation on 6/21/17 at 7:40 a.m., the resident was positioned in his/her high back wheelchair in the dining room. The resident remained in his/her wheelchair throughout the morning without being repositioned or toileted. At 12:05 p.m., the resident was observed eating lunch in the dining room and remained in his/her wheelchair. At 1:05 p.m., the resident was observed in his/her bed. The resident remained in bed during checks at 2:35 p.m., 3:15 p.m. and at 5:40 p.m. During interview on 6/26/17 at 11:45 a.m., the resident stated most staff are not very good about getting him/her out of his/her wheelchair, noting some staff do not want to bother with it. During interview on 6/22/17 at 11:50 a.m., the Assistant Director of Nursing (ADON) stated it would be the expectation that staff check residents for incontinence before and after meals and periodically throughout the day and during rounds at night. Pericare was to be provided following each incontinent episode. The ADON stated residents should also be repositioned minimally every two hours which includes off loading residents from their chairs.	F 312		