STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165190	A. BUILDING _____ B. WING _____	C 07/07/2017

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GOOD SAMARITAN SOCIETY - ALGONA	412 WEST KENNEDY STREET ALGONA, IA 50511

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F 000	INITIAL COMMENTS Correction Date: 7-19-17 Investigation of a facility self reported incident #69079-I and mandatory #68215-M resulted in the following deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	"Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual. All issues will be resolved By 7/19/2017	
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation of video recording, clinical record review, staff interviews and facility policy review, the facility failed to ensure 1 of 4 residents was free from abuse. The facility identified a census of 81 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 4/25/17 indicated Resident #2 had diagnoses that included non-Alzheimer's	F 223		

7-24-17 PG.

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

John E. Thun | Administrator | 07/21/2017

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 223	Continued From page 1 dementia, anxiety, depression, restlessness and agitation . The assessment indicated the resident usually made self understood and had the ability to understand others. Resident #2 scored 5 out of 15 on the Brief Interview for Mental Status (BIMS) cognitive assessment, which revealed cognitive impairments. The assessment revealed "other" behavior symptoms 1 to 3 days a week not directed towards others (e.g...pacing, rummaging etc) and as up independently in his/her room, required supervision of 1 staff when ambulating in the corridor and with no falls. A Care Plan included the following focus areas and interventions as dated: a. The resident had impaired cognitive function related to (r/t)dementia and depression evidenced by (e/b) confusion, asked repetitive questions, wandered, exit seeking and at risk for leaving. Resident #2 had kissed another male resident and other residents on the cheek. Resident #2 had placed his/her hand around another resident's wrist and had tried to scratch and bite staff. (initiated 2/2/16). The care plan directed staff to discuss concerns about confusion, disease process and Special Care Unit (SCU) placement with the resident/family. Resident #2 used a wanderguard and resided in the SCU unit. A sign had been posted outside his/her room and bathroom to help orientate him/her to new surroundings. Per family the resident had a nurturing disposition (initiated 2/2/16). The care plan informed staff that the resident understood consistent, simple and direct sentences (initiated 2/2/16). Resident #2 care plan revealed he/she was at risk for falls due to dementia, anxiety, depressive disorder, hypertension, a history of urinary tract	F 223	F223 Resident #2 was provided with immediate safety. This has the potential to affect all residents. Staff A complete his/her annual Abuse/neglect training on 3/22/17. Staff A was also educated on abuse and facility P&P on 5/13/17 by Director of Nursing. Staff A was compliant with dependent adult abuse and neglect per state requirement. Staff A was immediately removed from the resident and placed on suspension per facility P&P on 5/13/17 by Director of Nursing. Facility Director of Nursing and Social worker immediately Educated Special Care Unit staff members on Good Samaritan Society's abuse and neglect policy and procedures Education was also provided on s/s of self-stress and burnout along with tips and interventions to prevent. The education was complete on 5/16/17.	

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F 223	Continued From page 2 infections (UTI) and a history of pain to the right shoulder with increased confusion, poor memory and a decreased safety awareness (initiated 1/18/16). The care plan identified the resident ambulated around inside and outside of his/her room (initiated 1/19/16). Observation on 6/6/17 at 10:56 a.m. of a video recording from 5/13/17 revealed an altercation between the resident and Staff A, Certified Nursing Assistant (CNA) in the doorway of a resident's room in the SCU. The video showed what appeared as Staff A's gloved hand pushed Resident #2 away from the door entrance which resulted in Resident #2 stumbling backwards and losing his/her footing. The video shows Resident #2 taking several steps backwards and to the side almost falling before restoring his/her balance. During an interview 7/17/17 at 11:32 a.m., Staff A indicated Staff B, CNA took another resident into the restroom and noticed he/she had been incontinent and became combative with cares so Staff B called for assistance. Staff A grabbed blue gloves from the counter and entered the room where Staff B toileted the other resident who had been screaming and the bathroom door had been part way shut. Staff A stood in the bathroom doorway as Resident #2 attempted to open the door to the bathroom as he/she screamed and wanted to know what had been happening. At that point the other resident had also tried to exit the bathroom and yelled help me, help me, get me out of here. Resident #2 then poked his/her head through the bathroom door as the other resident said get him/her out of	F 223	Random audits of facility staff members on facility abuse and Neglect P&P will be completed. Audits will be assigned by QAPI and conducted weekly x 2 weeks, bi-weekly x1, then monthly x1 by designated staff. Findings will be brought to the QAPI committee. QAPI committee will review Findings and determine to continue or discontinue the audit.	

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here. Resident #2 stated, I needed to help him/her as he/she got closer to the other resident, almost face to face as Resident #2 screamed what had been happening, is the other resident OK. At one point Resident #2 used the door to hit Staff A as he/she grabbed the staff member's wrists. The staff member put her hands up beside her face with her palms out to show the resident they were not going to do anything. Staff A tried to get the other resident to back up and redirected Resident #2 and used her body to back the resident up and tried to shut the room door as a means to push Resident #2 out of the room as the resident grabbed both of the door knobs to the room door. The resident let go of the inside door knob and Staff A pried the resident's hand off of the outside door knob as the resident used his/her head as a means to push the door to get into the room. At one point the staff member stated she had been able to get the room door shut however the resident opened it right back up. The staff member told the resident you do not want to come in here again as she put her hands up with her palms out. The staff member said she did not think she pushed Resident #2 however the resident took a step back. The staff member then observed the resident look at someone as she shut the room door and the resident backed up against the wall.

During an interview 7/17/17 at 12:37 p.m., Staff B confirmed she took another resident to the restroom who became agitated and verbal so she called for the assistance of another staff member. During the process Resident #2 came into the bathroom but had been redirected by the staff member and that encounter had been the only time the 2 residents observed each other. Staff A arrived and again redirected Resident #2

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from the area at which time the resident became agitated. Staff B stated the other resident had been on the toilet during the entire situation and never attempted to get up and/or out of the bathroom. There had been one time Staff B looked up as Staff A stood in the doorway of the bathroom with the door half shut however the resident and Staff A never yelled at one another.

During an interview 7/6/17 at 2:40 p.m., Staff C, CNA/Certified Medication Aide (CMA) indicated on 5/13/17 before she passed her 4:30 p.m. medications Staff A came out of the SCU unit and asked for assistance. When Staff C entered the SCU unit she observed Staff A who stood in the doorway of the 2nd room on the left hand side of the hall and wore a pair of blue gloves as Resident #2 stood in the entryway of the room. Staff A tried to keep the resident out of the room as the resident had been concerned about the other resident in the room because that resident had been yelling in the bathroom. The staff member heard Staff A say you need to leave, this is someone else's room. Through the conversation between Staff A and the resident Staff C could hear the tone of Staff A's voice turn angry as the tone increased and her face became red. Staff C then went and tried to redirect the resident but he/she would not leave. Staff C could not recall why but she must have walked away or it happened when she walked to the room however she observed Staff A's hand made contact with the resident's upper torso area as she pushed the resident back. The resident stubble sideways and backwards as he/she continued to yell. Staff C stated her mouth then dropped as Staff D, Licensed Practical Nurse (LPN) walked into the SCU unit and walked down to the room. Staff A then told Staff D the resident

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F 223	Continued From page 5 had been being terrible at which time Staff D redirected the resident and Staff C walked up the hall together. As they walked Staff C noticed the resident's arms had been red and the resident cried because he/she had been pushed. The resident and Staff A remained separated. During an interview 7/6/17 at 12:10 p.m., Staff D confirmed on 5/13/17 at around 4 p.m. she had been walking up hallway 400 (outside of the SCU) and when she arrived at the lounge/dining area she heard screaming in the SCU unit. The staff member opened the door and observed Resident #2 flying backwards and almost fall as Staff C said it's not good and something needed to have been done. Staff D observed Staff A's arm with a gloved hand had pushed the resident. Staff D immediately went down the room and observed Staff A in the doorway wearing blue gloves so she asked her what had been going on as Resident #2 said she had been hurting him/her, and she shoved him/her and hurt him/her. Staff A said she had not pushed the resident rather she put her hands up to stop the resident (as she gestured her hands straight up and palms out). Staff D took the resident to the living room area and calmed the resident. The staff member then removed Staff A from the unit as an investigation was started. A Progress Note dated 5/13/17 at 5:10 p.m. documented the following: Vital signs obtained and recorded. A full body inspection had been completed with no outward signs of injury noted. The resident had full range of motion and had been able to demonstrate this on verbal request from the nurse. The resident denied pain when asked but rubbed his/her right buttock and stated you know this area here at	F 223		

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F 223	Continued From page 6 times bothers me. The resident smiled during the assessment and had been very cheerful during the conversation. The resident then went to the dining are in the SCU and assisted to set tables and had been very pleasant with the other residents in the SCU. Review of the facilities policy on Abuse Definitions revised 11/16 included the following definitions: a. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. b. Physical Abuse included hitting, slapping, pinching, kicking and etc. It also included controlling behavior through corporal punishment.	F 223		