DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

8-25-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165444	A. BUILDING _____ B. WING _____	C 08/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BEND HEALTH AND REHABILITATION	203 FOURTH STREET NW WEST BEND, IA 50597

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F 000	INITIAL COMMENTS Correction date: 8/22/2017 The following deficiencies were identified during the investigation of Complaint #68722-C and Self Report Incident #68924-conducted July 26, to August 1, 2017. Complaint #68722-C was not substantiated, however deficiencies were identified during the investigation. Self Report Incident #68924-I was not substantiated, however deficiencies were identified. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000	*Involved staff were reeducated on the timely reporting of alleged abuse to the administrator of the facility and to the State Agency as well as the separation required after the facilities investigation is complete.* *All staff were reeducated on the timely reporting of alleged abuse and the separation needed after the facility investigation is completed will protect residents in similar situations.*	
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.	F 225	*A refresher presentation on timely reporting of alleged abuse and the separation needed after the facilities investigation is completed will take place at our yearly skills fair.* *The DNS or Designee will randomly question staff on their knowledge of abuse reporting requirements during facility huddles weekly for 4 weeks. If there are no concerns the random questioning will be reduced to monthly for one quarter. If there are no issues QA will monitor staff knowledge and understanding of abuse and abuse regulation quarterly to make sure that solutions are permanent.*	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pat Jay — TITLE: Administrator — (X6) DATE: 8/22/2017

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 225	Continued From page 1 (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: (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	F 225		

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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:
I. Based on observation, record review and staff interview, the facility failed to ensure that all alleged violations involving abuse were reported timely to the administrator of the facility and to other officials (including to the State Survey Agency in accordance with State law through established procedures for one resident incident of alleged abuse. Staff A RN (registered nurse) allegedly abused Resident #1 on 6/11/17. The facility failed to report the alleged abuse to the State agency until 6/13/17. In addition, the facility failed to implement written policies and procedures that prohibited and prevented alleged abuse for one resident (Resident #1). Staff A RN (registered nurse) allegedly abused Resident #1. The facility suspended Staff A until their investigation was complete and then Staff A returned to work. When Staff A returned to work, she worked with Resident #1. Facility census was thirty-one (31) residents.

Findings include:

1. A Minimum Data Set (MDS) with assessment reference date of 5/18/17, assessed Resident #1 with a brief interview for mental status (BIMS) score of "3" (severe cognitive impairment). The resident required extensive staff assistance with transfers and toileting. The resident was non-ambulatory and used a wheelchair for mobility. The resident was frequently incontinent of bowel and bladder. The resident had physical and verbal behaviors directed toward others 1 to 3 days out of 7. A clinic nursing home note, dated

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5/17/17 identified the resident with diagnoses that included: advanced age with dementia, deafness and depression with anxiety and agitation.

A facility investigation report form dated 6/14/17 to the State agency revealed 2 CNAs (certified nurse aides) alleged Staff A RN pulled Resident #1's hair in response to the resident pulling Staff A's hair. The report revealed the date of the incident as 6/11/17 and identified the facility became aware of the incident 6/12/17.

The Director of Nursing's (DON) "investigation of the incident involving Resident #1 on 6/11/17" revealed the DON became aware of the incident on 6/12/17 at 10 a.m. when Staff B (CNA) certified nurse aide told her to visit with Staff C CNA and Staff D CNA about an incident involving Staff A that occurred 6/11/17. Staff B stated she was not involved in the incident but Staff D CNA told her Resident #1 got upset with cares and pulled Staff A's hair and Staff A pulled Resident #1's hair back to get the resident to let go. The DON documented that Staff C worked on 6/12/17 so she summoned Staff C to her office and asked about the incident. Staff C said the resident got upset with toileting and Staff A came to assist. Resident #1 pulled Staff A's hair and Staff A responded by pulling the resident's hair. Staff C denied seeing Staff A pull the resident's hair but said Staff D did see it. The DON wanted to visit with Staff D about the incident before contacting Staff A. The resident did not sustain injury. Staff D worked 6/13/17 so the DON spoke to her about the incident. Staff D reported the same thing as Staff C and stated she actually saw Staff A pull the resident's hair. The DON then called Staff A and asked her about the incident. Staff A denied pulling the resident's hair. The DON had all

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F 225	Continued From page 4 involved staff write statements and suspended Staff A. She then completed the self report to the State agency on 6/13/17. On 7/31/17 at 12:35 p.m. the DON stated she counseled Staff C and Staff D for not reporting the incident in a timely manner. She stated they told her they did not think it was abuse. The DON informed them it was not their decision to make. She provided the surveyor with copies of the counseling both staff received. Progressive discipline for Staff C dated 6/15/17 for the 6/11/17 incident revealed the DON verbally counseled Staff C regarding failure to report the incident to Staff E (RN) who also worked 6/11/17 when the incident occurred. Staff C also failed to notify the Administrator or DON. Progressive discipline for Staff D dated 6/15/17 for the 6/11/17 incident revealed the DON counseled Staff D regarding failure to report the incident to the DON or Administrator or Staff E RN the other RN on duty. On 7/26/17 at 11:04 a.m. Staff D CNA stated she did not report the incident on 6/11/17 because she was "stunned" by the incident. On 8/1/17 at 2:14 p.m. Staff D stated she DID think the incident was abuse because it should not have happened. On 7/31/17 at 12:05 p.m. Staff C CNA stated she didn't think to report the incident. She didn't really see hair pulled so she didn't call it abuse. Facility Patient Abuse Policy identified any abuse will be reported to the State agency immediately. A policy for "reporting and investigating suspected	F 225		

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F 225	Continued From page 5 abuse" revealed the employee would immediately contact the State agency and then the direct supervisor to inform them of the situation. The direct supervisor will then contact the Administrator. In the absence of the Administrator, staff should contact the DON. Observation: On 7/31/17 at 9:22 a.m. observation showed the resident in a wheelchair. At that time, the surveyor communicated with the resident via dry erase board. The resident stated "yes" the workers at the facility treated him/her "good". The resident denied having his/her hair pulled. At that time, the surveyor tested the resident's cognitive ability. The surveyor asked the resident what month, year and town the resident was in. The resident answered "December" to questions asked. When asked how old the resident was, the resident also answered "December". 2 . On 8/1/17 at 11:50 a.m. the Director of Nursing (DON) stated the facility had the nurse return to work after the facility investigation determined no abuse occurred. She thought separation from Resident #1 was not required if the facility investigation determined no abuse occurred. On 7/26/17 at 10:15 a.m. Staff A stated after the incident, the CNAs brought the resident to the common area. Staff A wrote "I love you" on the resident's dry erase board and the resident smiled and said he/she loved Staff A then hugged the resident. On 8/1/17 at 12:43 p.m. the DON confirmed Staff A returned to work on 6/26/17.	F 225		

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F 225	Continued From page 6 Review of Resident #1's July 2017 medication administration record (MAR) showed Staff A administered medications to Resident #1 on 7/1, 2, 5, 6, 17, 19, 23, 24, 25, 29 and 30/17. Review of nursing progress notes revealed Staff A assessed the resident following a fall on 7/13/17. Facility policy procedure for "reporting and investigating abuse" revealed if abuse is suspected, the employee is immediately suspended pending a formal investigation. The policy also identified if abuse was seen heard or reported by a resident, employee or family, the resident will be moved to a place of safety.	F 225		