STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(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 8/30/2017 The following deficiency relates to the investigation of facility reported incident 68786-M. The remainder of the findings for the facility reported incident will be sent to the facility at a later dater under separate cover. See Federal Code of Regulations (42-CFR) Part 483, Subpart B-C.	F 000		8/30/2017
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to care for Resident #1 with dignity and respect. The sample consisted of 4 residents and the facility reported a census of 54 residents. Findings include: Resident #1 had a Minimum Data Set (MDS) assessment with a reference date of 4/24/17. The MDS identified the resident had a Brief Interview for Mental Status (BIMS) score of 9. A score of 9 represented the resident had severely impaired cognitive status. The MDS indicated the resident depended upon staff to safely transfer and ambulate and needed extensive assistance	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathryn Dorcas	LNHA	8/30/2017

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.

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with dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included coronary artery disease, hypertension, gastroesophageal reflux disease, depression and adult failure to thrive.

In an interview on 7/31/17 at 10:15 a.m. the Director of Nursing (DON) stated on the morning of 6/14/17 she overheard Resident #1 speaking angrily to his/her tablemates during breakfast. The DON stated she asked what was wrong and Resident #1 stated the overnight aide had tried to take his/her pants and he/she wasn't having it. The DON reported the incident to the Administrator and together they spoke with Resident #1's roommate, Resident #2. Resident #2 stated last night he/she heard a commotion between Resident #1 and a blonde aide who had passed ice earlier. The aide was later identified as Staff A. The DON stated she noticed three bruises on Resident #1's left wrist where his/her watch band was located. The DON stated when initially interviewed, Resident #1 made no mention of being grabbed by Staff A.

In an interview on 7/31/17 at 10:30 a.m. the Administrator stated on the morning of 6/14/17 she was informed of an incident involving Resident #1 and Staff A. The Administrator stated she interviewed Resident #1, who stated he/she was getting ready for bed last evening and was sitting up on his/her bed folding his/her pants and the aide came in and wanted to take his/her pants to the laundry. Resident #1 stated he/she refused to allow the aide to take his/her pants and pulled his/her pants from the aide causing him/her to fall backwards onto his/her bed. The aide let go and left the room. The Administrator stated Resident #1 never alleged that he/she had

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been grabbed or abused by the aide. Later that same evening, Resident #1's family visited and were upset when they were not allowed access to Resident #1's medical information. The Administrator stated the next morning (6/15/17) a police officer arrived stating he was following up on a complaint made the previous evening involving Resident #1. The Administrator stated there had been an incident involving Resident #1 and Staff A on the evening of 6/13/17, but that no abuse had been alleged. Later that same day a Department of Human Services worker arrived at the facility to investigate a complaint. The Administrator stated Resident #1 had not made an allegation of abuse, but as time passed his/her story began to change and he/she was now alleging staff grabbed him/her. The Administrator stated she spoke with Staff A, who admitted there was an incident on the evening of 6/13/17 involving Resident #1. Staff A stated she gathered Resident #1's clothing, when Resident #1 grabbed his/her pants away from her. Staff A denied ever grabbing Resident #1 or forcing him/her onto the bed. The Administrator stated the bruising noted on Resident #1's wrist was likely due to his/her watch band. When the watch band was moved to his/her right wrist, similar bruising also developed. Resident #1 had stated the watch band pinches him/her, but he/she refused to take it off.

In an interview on 7/31/17 at 5:55 p.m. Resident #1 stated one evening an aide entered his/her room and wanted to take his/her pants to the laundry. Resident #1 told the aide he/she didn't want his/her pants taken to the laundry and grabbed a hold of the pants. The aide grabbed the pants and tried to pull them away from Resident #1 and at one point grabbed a hold of

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Resident #1's left forearm/wrist. Resident #1 stated that that hurt and the aide let go and left the room.

According to the Minimum Data Set (MDS) assessment with assessment reference date of 5/12/17, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13. A score of 3 identified the resident had no cognitive problems. Resident #2 required extensive assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #2's diagnosis included coronary artery disease, hypertension, gastroesophageal reflux disease, anemia and diabetes mellitus.

In an interview on 7/31/17 at 4:45 p.m. Resident #2 was questioned about an incident which involved his/her roommate and an aide. Resident #2 immediately recalled the event, stating his/her roommate was "attacked" by that girl from the staffing agency. Resident #2 stated the aide grabbed his/her roommates left wrist and pulled on it. Resident #2 stated his/her roommate said let me go, you're hurting me. Resident #2 stated he/she witnessed the altercation from his/her recliner and when asked, identified the privacy curtain as not drawn. Resident #2 stated the altercation was over the aide wanting to take his/her clothes to the laundry.

In an interview on 8/1/17 at 10:40 p.m. Staff B, certified nurse aide, stated on the evening of 6/13/17 she was approached by co-worker Staff A. Staff A stated that Resident #1 had become upset and combative when she tried to take his/her pants to the laundry. Staff A stated she grabbed the pants and Resident #1 grabbed them back and began pulling and became combative.

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Staff A stated his/her roommate, Resident #2, also started yelling at her. Staff B stated it was Staff A's first night and she was not familiar with the residents. Staff B stated Resident #1 is very protective of his/her pants and prefers to have them kept in his/her room.

In an interview on 7/31/17 at 4:00 p.m. Staff A, certified nurse aide, stated on the evening of 6/13/17 at around 9:00 p.m. she entered the room of Resident #1 to help him/her prepare for bed. Staff A assisted Resident #1 to the bathroom. Staff A then helped Resident #1 get undressed and in to a night gown. Resident #1 stated he/she did not want to lose his/her clothes, noting a lot were already missing. Staff A reassured Resident #1 that they would be washed and returned then sat the clothing on the counter. Staff A finished providing cares and escorted Resident #1 to his/her bed. While covering him/her up, Resident #1 again mentioned that he/she wanted his/her clothes and was told they were dirty and needed to go to the laundry. Resident #1 seemed upset, but laid down. Staff A stated she then assisted his/her roommate with preparing for bed and once finished, noticed Resident #1's pants were missing. Resident #1 stated he/she didn't want to lose his/her pants and Staff A tried again to reassure him/her that they would be brought back clean. Staff A noticed the pants sitting beside Resident #1 and as she grabbed the pants, Resident #1 grabbed them and yanked them from her hands. Resident #1 then began yelling that she was trying to steal her pants. Staff A stated she apologized for making him/her upset. Staff A then covered Resident #1 back up and left the room. Staff A denied ever touching Resident #1 during the pants altercation and stated Resident

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F 241	Continued From page 5 #1 never indicated being in any pain. Staff A stated Resident #2 asked what her name was and the name of the nurse.	F 241		

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This plan of correction constitutes our credible allegation of compliance. F 241 was corrected on the 30th of August 2017.

F 241 It continues to be the policy of Ridgewood Specialty Care to treat and care for residents in a manner to promote his/her quality of life and to protect and promote the rights of residents.

Resident #1 no longer resides in the facility. All other residents will be treated with dignity and respect.

Staff A has not worked at the facility since the incident occurred. Education was provided to all staff related to resident rights to be treated with dignity on August 30, 2017. Resident satisfaction surveys have been implemented with residents to ensure there are no concerns with meeting their rights and treating them with dignity. Family interviews will be initiated as well for those residents who cannot complete the survey, to ensure their residents are being treated with dignity. Follow up will be done during regular resident council meetings.

Monitoring will be a part of the facility's QA process.