PRINTED: 08/25/2017 FORM APPROVED

OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Į.		CONSTRUCTION) DATE SURVEY COMPLETED	
		165325	B. WING				C	
	ROVIDER OR SUPPLIER OUSE CARE CENTER	188825		12	TREET ADDRESS, CITY, STATE, ZIP CODE 212 SOUTH STUART STREET IGOURNEY, IA 52591	<u> 08/</u>	01/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 000 F 223 SS=G	the investigation regal incidents 69054-M & incidents for facility will be sent to the facility will be sent t	rcies were identified during rding facility reported 68895-I. ent 68895 was not y reported incident 69054-M lity at a later date under Regulations (42 CFR), Part ROM RY SECLUSION right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to mptoms.		2223				
	abuse, corporal punis seclusion; This REQUIREMENT by:	is not met as evidenced			,			
	staff interviews a facil resident abuse/degrae	ord review, facility policy and ity staff failed to prevent dation for three of six on 5/29/17 Staff B witnessed	Addition or comment addition or comment					
•	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			Ministratol)	9.	(X6) DATE	

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.

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	A, BUILDING _		С
165325	B. WING		08/01/2017
IER		STREET ADDRESS, CITY, STATE, ZIP CODE	
MANOR HOUSE CARE CENTER		1212 SOUTH STUART STREET	
		SIGOURNEY, IA 52591	
FICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
picture of Resident #2 and told Staff are photo on any social media site. The photo on any social media site. The photo on 6/12/17 near the photo on 6/12/17 near the nuffe's death and reference to the ag soon. Staff A took a picture of the an unknown date and made tents. Staff A's failed to display idents and failed to maintain the and hurt by Staff A's actions; allure to notify the Administrator sibly prevented Staff A from taking picture since this occurred two areasonable person would value to time near Resident #6's death insult/or degrade someone in this facility reported a census of 53 deceived pictures of residents #4 and #6) taken by Staff A. The tasked for the pictures and texts the showed Staff A had taken sidents #2, #6 and #4. The ator notified the Department of did Appeals on 6/22/17 at 12:08 and investigation (on 6/21/17). The did the Administrator she had been the sidents with the control of the pictures of the pictures and texts and the Administrator she had been the first provided the Administrator she had been the sidents with the pictures of the pictures of the pictures and texts and the Administrator she had been the pictures of the pictures of the pictures and texts and the Administrator she had been the pictures of the pictures of the pictures of the pictures and texts and the pictures and texts the showed Staff A had taken sidents with the pictures and texts and the pictures and	F 223		
	IDENTIFICATION NUMBER: 165325 IER	IDENTIFICATION NUMBER: A BUILDING 165325 B. WING ARRY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) The page 1 Find the photo on any social media site, report what she had seen until the Administrator weeks later, other photo on 6/12/17 near the number of the number o	IER 165325 IER 165325 IER 17TER 165325 IER 17TER 18TEET ADDRESS, CITY, STATE, ZIP CODE 1212 SOUTH STUART STREET SIGOURNEY, IA 52591 ARRY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) Impage 1 Impage 2 Impage 2 Impage 2 Impage 2 Impage 2 Impage 3 Impage 2 Impage 4 Impage 2 Impage 3 Impage 4 Im

			(X3) DATE SURVEY COMPLETED		
		165325	B. WING	-	08/01/2017
	ROVIDER OR SUPPLIER	,	121:	EET ADDRESS, CITY, STATE, ZIP CODE 2 SOUTH STUART STREET OURNEY, IA 52591	
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F 223	received a report from claiming he had recell (Residents #2, #4 and Administrator asked in messages which should pictures of Residents. The Administrator no Inspections and Apperature of the Administrator and Staff B informed the Administrator of the Administrator between the Administrator of the Administrator of Resident #2 with a cat face on a significant of the Administrator of the Administrator of Administrator of Mental indicating severely in indicated the resident of one staff for ambure extensive assistance activities of daily living resident with active of dementia, depression history of falling, unsweakness, and gastrator of the Administrator of the Administ	m., the Administrator m a non-facility person ived pictures of residents d #6) taken by Staff A. The for the pictures and texts wed Staff A had taken i #2, #6 and #4. tified the Department of eals on 6/22/17 at 12:08 investigation (on 6/21/17). Administrator she was aware icture of Resident #2 about did not report this to anyone. a.m. Staff A, LPN shared a that had been enhanced social media site to a The resident had been ff had taken a photo, until anced photo. The resident agitated per Staff B, LPN. Jum Data Sets (MDS) dated d Resident #2 with a Brief Status (BIMS) score of 3 Inpaired cognition. The MDS at required limited assistance lation and locomotion and a of one staff for other liagnoses of non-Alzheimer's In, cerebral infarction (stroke), teadiness, muscle	F 223		
	resident utilized an a	olan Instructed staff the llarm in bed/chair to alert staff uired assistance. The sic activities, would attend			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 165325 B. WING 08/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SOUTH STUART STREET MANOR HOUSE CARE CENTER SIGOURNEY, IA 52591 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION-(X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 3 F 223 activities as an observer. The care plan indicated the resident required staff assistance for transfers, ambulating, tolleting and meals. On 07/31/17 at 12:36 p.m. Staff B, LPN stated she had worked with Staff A on the 2-10 p.m. shift. She stated that she had seen Staff A with her cell phone on one occasion when not on break. Staff B stated that she had observed Staff A, LPN take a photo of a resident (Resident #2) with her cell phone and then added ears and whiskers onto the photo so that it appeared as a cat face. Staff B stated that she had explained to Staff A that taking photos of resident had been against the facility policy and she should not place the photo on any social media. Staff B stated she though Staff A had deleted the photo. Staff B stated that Staff A did show the photo to Resident #2 and the resident became a little agitated, pushed the phone away and said; "oh that is ridiculous". She stated that was the only photo that she had observed Staff A taken of a resident. On 08/01/17 at 4:35 p.m. Staff B stated that she had notified the facility Administrator of the incident when she came back for her next shift at the facility two weeks later after the incident. 2. The quarterly Minimum Data Sets (MDS) dated 05/16/17 documented Resident #6 with a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The assessment revealed Resident #6 had the ability The MDS indicated the resident required total assistance of two staff for ambulation and locomotion and extensive assistance of one staff for other activities of daily living. The MDS documented the resident with active diagnoses of

heart failure, generalized muscle weakness

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING _ С B. WING 165325 08/01/2017

		165325	B. WING_			08/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				12	12 SOUTH STUART STREET		
IANOR H	IOUSE CARE CENTER		İ	S	IGOURNEY, IA 52591		
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F 223	Continued From page	e 4	F	223			
		nypertension, iron deficiency nd pain in the thoracic spine.					
	date of 5/26/17 with the resident required two staff members for cares. The care plan	lan identified an admission ne resident receiving e care plan instructed staff extensive assistance with ransfers and personal indicated the resident apy per nasal cannula per					
	photo of Resident #6	6 a.m. Staff A had taken a and posted the photo with a probably going to go any redia site.	a file and a second production of the second p				
	approximately 3 (thre	ied Resident #6 expired e) hours later on 6/12/17 at 6's body had been sent to :15 a.m.					
	dated 05/6/17 docum Brief Interview for Me 15 indicating intact of the resident had been and locomotion. The required limited to no activities of daily livin resident with active d history of falls, history	mum Data Sets (MDS) ented Resident #4 with a ental Status (BIMS) score of egnition. The MDS indicated independent for ambulation MDS indicated the resident assistance of staff for other g. The MDS documented the lagnoses of hypertension, y of urinary tract infections, ophageal reflux and age					
	resident required ass	lan instructed staff the istance with activities of daily se process, hypertension, ir degeneration, impaired					

				X3) DATE SURVEY COMPLETED			
		165325	B. WING				C
	ROVIDER OR SUPPLIER			1212 5	T ADDRESS, CITY, STATE, ZIP CODE SOUTH STUART STREET URNEY, IA 52591	_19	8/01/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	posted a photo of Respective to comments on it; such a minute" and "Crazy had been using a memberson. During investigation of 07/31/17 several of the noted that Staff A had often during the shift of the during the shift stated Staff A had here either talking or playing had never seen Staff with the cell phone. So check on the resident pass medications at 4 their paperwork done only times they saw the condition of the stated of the	at 1:08 P.M. Staff A had sident #4, in which the be sleeping. The photos had as "In the AL"; "I'll explain in mother***** [Expletive] and ssaging site with an outside of the above issues, on the night shift (10 p-6a) staff been on her phone quite as follows: a.m. Staff I, CNA stated she is A on the night shift. Staff I is cell phone out all the time the gon it. Staff I stated she is A take photos of residents taff I stated the nurse would so one time during the night, 1:00 a.m. if needed and get is She stated that was the the nurses at night. b.m. Staff C, CNA stated she p.m. or 3-11p.m. shift with that Staff A had been ohone a lot during the shift. The so on the night shift. Staff seen Staff A take resident	F2	223			

NAME OF PROVIDER OR SUPPLIER MANOR HOUSE CARE CENTER CAJID PRECINT A 2239 THE PROVIDERS CRAFF CENTER THE PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES CRAFF CENTER TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED			
MANDE OF PROVIDER OR SUPPLIER MANDR HOUSE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 223 Continued From page 6 Cn 07/31/17 at 3:35 p.m. Staff E, CNA stated she worked with Staff A on the regil phone almost every shift she worked with Part A take photos of residents. On 07/31/17 at 3:54 p.m. Staff F, CNA stated that she had worked with Staff A on the regil phone quite a lot at the end of her (Staff Fe) shift around 10 p.m. Staff F stated she video chatted a lot. She stated she had not seen Staff A take any photos of the residents. On 07/31/17 at 10:30 a.m. Staff F, cNA stated she did work with Staff A on the regil phone out every night off and on. Staff F stated she had never seen Staff A take any photos of the residents. On 07/31/17 at 10:30 a.m. Staff F, stated she had never seen Staff A take she had never seen Staff A take any photos of the residents. On 07/31/17 at 10:30 a.m. Staff F, cNA stated she worked with Staff A on the regil phone out every night off and on. Staff F stated she had never seen Staff A take photos of residents with the real phone. On 07/31/17 at 19:55 a.m. Staff H, CNA stated she worked with Staff A to her working the shift that stated she had seen Staff H with her cell phone out most of the time unless she had been passing medications. Staff H stated she had not seen Staff A take any photos of residents with the cell			165325	B. WING			1	
PREFIX TAG PREFICENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 223 Continued From page 6 On 07/31/17 at 3:35 p.m. Staff E, CNA stated she worked with Staff A on the 3-11 p.m. shift. Staff E stated she had never seen Staff A take photos of residents. On 07/31/17 at 3:54 p.m. Staff F, CNA stated that she had worked with Staff A a few times. She stated she had never seen Staff A take any photos of the residents. On 07/31/17 at 3:54 p.m. Staff F, CNA stated that she had worked with Staff A a few times. She stated she had not seen Staff A take any photos of the residents. On 07/31/17 at 10:30 a.m. Staff G, CNA stated she idid work with Staff A on the night shift (11p-7a). She stated Staff A had her cell phone out every night off and on. Staff F stafed she had never seen Staff A take photos of residents with her cell phone. On 07/31/17 at 9:55 a.m. Staff H, CNA stated she worked with Staff A on the overnight shift. Staff H stated she had never seen Staff A take she had one seen Staff H with her cell phone out most of the time unless she had been passing medications. Staff H stated she had not seen Staff H take any photos of residents with the cell Staff H take any photos of residents with the cell					1212	SOUTH STUART STREET	1 000	0112011
On 07/31/17 at 3:35 p.m. Staff E, CNA stated she worked with Staff A on the 3-11 p.m. shift. Staff E stated she had seen Staff A on her cell phone almost every shift she worked with her. Staff E stated she had never seen Staff A take photos of residents. On 07/31/17 at 3:54 p.m. Staff F, CNA stated that she had worked with Staff A a few times. She stated she did see Staff A on her cell phone quite a lot at the end of her (Staff F's) shift around 10 p.m. Staff F stated she video chatted a lot. She stated she had not seen Staff A take any photos of the residents. On 07/31/17 at 10:30 a.m. Staff G, CNA stated she did work with Staff A on the night shift (11p-7a). She stated Staff A had her cell phone out every night off and on. Staff F stated she had never seen Staff A take photos of residents with her cell phone. On 07/31/17 at 9:55 a.m. Staff H, CNA stated she worked with Staff A on the overnight shift. Staff H stated she had seen Staff H with her cell phone out most of the time unless she had been passing medications. Staff H stated she ad not seen Staff A take any photos of residents with the cell	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	COMPLETION
Staff A's personnel file identified she had been hired to work at the facility as a temporary [agency] nurse and completed Mandatory Reporter training for Dependent Adult Abuse through a staffing agency which she worked for known as GrapeTree Medical Staffing, Inc. on 4/17/17.	F 223	On 07/31/17 at 3:35 worked with Staff A c stated she had seen almost every shift sh stated she had never residents. On 07/31/17 at 3:54 she had worked with stated she did see S a lot at the end of he p.m. Staff F stated si stated she had not s of the residents. On 07/31/17 at 10:30 she did work with Sta (11p-7a). She stated out every night off ar never seen Staff A ta her cell phone. On 07/31/17 at 9:55 worked with Staff A c stated she had seen out most of the time medications. Staff H Staff A take any phot phone. Staff A's personnel fi hired to work at the f [agency] nurse and Reporter training for through a staffing ag known as GrapeTree	p.m. Staff E, CNA stated she in the 3-11 p.m. shift. Staff E Staff A on her cell phone is worked with her. Staff E is seen Staff A take photos of p.m. Staff F, CNA stated that Staff A a few times. She taff A on her cell phone quite in (Staff F's) shift around 10 in evideo chatted a lot. She seen Staff A take any photos of a.m. Staff G, CNA stated aff A on the night shift. Staff A had her cell phone and on. Staff F stated she had alke photos of residents with staff H with her cell phone unless she had been passing stated she had not seen accility as a temporary completed Mandatory. Dependent Adult Abuse ency which she worked for	F	223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		EDCENTIFICATION AND ADED.		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165325	B. WING			C 08/01/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SOUTH STUART STREET SIGOURNEY, IA 52591			
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F 223	Continued From pag	e 7	F 22	3			
	comprehensive syster procedures designed mistreatment, abuse misappropriation of ridentify any allegation c) insure that reason to the appropriate ago The abuse policy sor is defined as any indiby the health care fact temporary agency, p. Medicare/Medicaid of to provide direct or into residents in the fact The abuse policy traitime of hire and annual contractors will rexplains their obligat under the federal Eld (section b) revealed make a special effort each resident person physical body and his including accommod. The policy stated that prohibiting the use of cameras, smart phorequipment) to take, ke photographs and recidemeaning or humilicity for prevention Mandatory reporter reviewed at staff mean mandatory reporter, it	revealed the facility had a am of practices and a to prevent occurrence of a neglect and/or esident property; b) monitor, as of suspected abuse; and able suspicions are reported encies. een revealed an "employee" ividual who is paid by either cility or any entity (i.e. rivate duty, or independent contractors) adirect treatment or services cility. Ining section revealed at the easily thereafter, employees eccive information that ion as Mandatory Reports ier Justice Act. The training staff would be trained to to promote the rights of all privacy of his/her own sher personal space ations and personal care. It Abuse training includes any equipment (e.g., nes, and other electronic					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		165325	B, WING_			08/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR H	MANOR HOUSE CARE CENTER 1212 SOUTH STUART STREET SIGOURNEY, IA 52591						
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 223	Continued From page		F:	223		:	:
		ed to report allegations of nd without hesitation directly					
F 225 SS=D	ALLEGATIONS/INDI\		F:	225			
	483.12(a) The facility	must-					
	(3) Not employ or other who-	erwise engage individuals		****			
		uilty of abuse, neglect, opriation of property, or art of law;					
	or her professional lic			j			
·	licensing authorities a actions by a court of I	e nurse aide registry or iny knowledge it has of aw against an employee, unfitness for service as a cility staff.					
		egations of abuse, neglect, atment, the facility must:					
		eged violations involving itation or mistreatment,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ B. WING 165325 08/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SOUTH STUART STREET MANOR HOUSE CARE CENTER SIGOURNEY, IA 52591 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 9 F 225 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 clinical record review, Interviews, and facility policy review, the facility failed to report an allegation of abuse for Resident #2 immediately to the Department of Inspections and Appels (DIA). The facility reported a census of 53

Findings Included:

residents.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165325	B. WING			}	C 01/2017
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
				121	2 SOUTH STUART STREET		
MANOR HOUSE CARE CENTER				SIC	GOURNEY, IA 52591		
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F 225	Continued From pa	ge 10	F	225			
		p.m., the Administrator om a non-facility person					
	claiming he had rec	eived pictures of residents and #6) taken by Staff A. The					
	Administrator asked	I for the pictures and texts nowed Staff A had taken					
	pictures of Residen	ts #2, #6 and #4.					
	Inspections and App	otified the Department of peals on 6/22/17 at 12:08					
	1 '	investigation (on 6/21/17).	İ				
	+	Administrator she was aware					
		picture of Resident #2 about did not report this to anyone.					
	l .	a.m. Staff A, LPN shared a that had been enhanced					
	·	social media site to a					
	1	r. The resident had been		1			
		aff had taken a photo, until					
		hanced photo. The resident					1
		y agitated per Staff B, LPN.					
		36 p.m. Staff B, LPN stated					
)	h Staff A on the 2-10 p.m. at she had seen Staff A with		-			
	1	ne occasion when not on					
		she had observed Staff A,					
	†	f Resident #2 with her cell					į
		ded ears and whiskers onto					
	1 '	appeared as a cat face. Staff					
		ad explained to Staff A that		1			
		sident had been against the					
	- ,	ne should not place the photo		1			
		a. Staff B stated she though					
	Staff A had deleted						
		Staff A did show the photo to		-			
	1	e resident became a little					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		165325	B. WING		C	147
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SOUTH STUART STREET SIGOURNEY, IA 52591	08/01/20	ri r
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		сом	(X5) IPLETION DATE
F 225	agitated, pushed the part that is ridiculous". She photo that she had obresident. On 08/01/17 that she had notified the incident when she shift at the facility two incident. The quarterly Minimum 05/16/17 documented Interview for Mental Sindicating severely imindicated the resident of one staff for ambula extensive assistance activities of daily living resident with active didementia, depression history of falling, unstewakness, and gastro. The Abuse Prevention Investigations policy or reasonable suspicions appropriate agencies. Item 13 stated that Preminders of the Manarequirements are roumeetings, including a reporter, b) what are rabuse, and c) procedum the section under Ide Employees are requirements and the occurrence of the occurrence incidents-anything untime of the occurrence.	chone away and said; "oh e stated that was the only be stated that was the only be served Staff A taken of a at 4:35 p.m. Staff B stated the facility Administrator of a came back for her next weeks later after the a mean part of a came back for her next weeks later after the a mean part of a came back for her next weeks later after the a mean part of a mean part o	F	225		
	person in charge of the investigation, regardle	ess of whether the incident				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/25/2017 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 165325 08/01/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1212 SOUTH STUART STREET MANOR HOUSE CARE CENTER SIGOURNEY, IA 52591 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) F 225 Continued From page 12 F 225 results in obvious or visible injury. (The policy stated that Abuse training includes prohibiting the use of any equipment (e.g., cameras, smart phones, and other electronic equipment) to take. keep, or distribute photographs and recordings of residents that are demeaning or humiliating.) Item 13 of the Abuse policy for prevention revealed reminders of the Mandatory reporter requirements are routinely reviewed at staff meetings, including a) who is a mandatory reporter, b) what are reportable types of alleged abuse, and c) procedures for filing reports. The abuse policy for protection revealed employees are required to report allegations of abuse immediately and without hesitation directly to the person in charge. (The abuse policy screen revealed an "employee" is defined as any individual who is paid by either by the health care facility or any entity (i.e. temporary agency. private duty, Medicare/Medicaid or independent contractors) to provide direct or indirect treatment or services to residents in the facility.) The abuse policy training section revealed at the time of hire and annually thereafter, employees and contractors will receive information that explains their obligation as Mandatory Reports under the federal Elder Justice Act.

Manor House Care Center

Ph: (641) 622-2142 • Fax: (641) 622-2181

Manor House Care Center 1212 South Stuart, Sigourney, IA 52591

Preparation and execution of this plan of Correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under Federal or State law.

F 000 August 25, 2017

F223 483.12(a)(1) FREE FROM ABUSE /INVOLUNTARY SECLUSION

The facility will ensure that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation; and will not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

- On 6/22/17, the contract with Grapetree Staffing Agency was terminated for Staff A. Ongoing investigation was turned over to the local police department upon notification from Administrator.
- The facility will continue to ensure that the contracted staffing agency will thoroughly screen employees through criminal background screening and licensure checks; and require employees are educated and current on Abuse Policy and Mandatory Reporter training for Dependent Adult Abuse.
- Facility will continue to do orientation with new temporary staffing at the time of initial employment. Facility will review verbally and in writing the policies on abuse and no use of cell phones while on duty. Informational binder will be available for review at the nurses' station outlining this information.
- 4. Administrator and Director of Nursing or designee will be responsible to monitor temporary staff and perform random audits on knowledge of resident rights and abuse policy and facility orientation process. Random audits will be done monthly for three months and periodically thereafter for one year.
- 5.
 The results of the audits will be reviewed as part of our on-going quality assurance process and the frequency of the audits thereafter will be based on outcomes and the subsequent recommendations of the committee.

24-hour Skilled Nursing • Physical, Occupational & Speech Therapy • Independent & Assisted Living Restorative Program • Adult Day Services • Hospice Suites • Medicare/Medicald







F225 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or 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 a resident property; and 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.

Facility will 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 in accordance with State law through established procedures, have evidence that the alleged violations are thoroughly investigated, prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress, and report the results of all investigations to the administrator or his/her designee representative and to other officials in accordance with state law, including the state Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken.

- On 6/23/17, one-on-one counseling was conducted with staff B by administrator of facility regarding mandatory reporting and Dependent Adult Abuse, and responsibility to notify the administrator immediately with any suspected concerns. Staff B verbalized understanding of these policies.
- Facility re-educated staff on 8/4/17 via in-service on the abuse policy and mandatory reporting policy and assigned an additional course for employees to complete by 9/30/17 on Preventing, Recognizing and Reporting via on-line educational training site.

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- The facility will continue to thoroughly screen new employees through criminal background screening, reference checks, and licensure checks. Facility will also continue to require employees have a course on abuse policy training and Mandatory Reporting at the time of hire and annually thereafter.
- 4. Administrator and Director of Nursing or designee will be responsible to monitor staff and perform random audits on knowledge of resident rights, mandatory reporting, and abuse policy, and facility orientation process. Random audits will be done monthly for three months and periodically thereafter for one year.
- The results of the audits will be reviewed as part of our on-going quality assurance process and the frequency of the audits thereafter will be based on outcomes and the subsequent recommendations of the committee.

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