Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **#8022**	**AMENDED 11/19/20**		**Date:** **March 17, 2020**
Facility Name: **Manilla Manor**		**Survey Dates:** **February 17-27, 2020**	
Facility Address/City/State/Zip **146 North 5th Street** **Manilla, IA 51454**			
	SB		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.19(2)i and j	**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: 58.19(2) *Medication and treatment.* i. Provision of emergency medical care, including arranging for transportation, in accordance with written policies and procedures of the facility; (I, II, III) j. Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III) **DESCRIPTION:** Based on clinical record review, staff interview, facility record review, and facility policy review, the facility failed to initiate CPR (cardiopulmonary resuscitation) or emergency measures, for a resident who expressed a desire for Full Code status, when staff witnessed a resident alert who then subsequently went limp ceasing respirations and heart beat on 12/24/19 (Resident #30); for 1 of 6 residents identified as wanting CPR at the time of survey. This failure posed an immediate	**I**	**$10,000 (Held in suspension)**	**UPON RECEIPT**

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	jeopardy situation to the residents which the facility abated on 12/26/19 when the facility re-educated all nursing staff. The facility reported a census of 30 residents. Findings include: The quarterly Minimum Data Set (MDS) assessment dated 11/5/19 for Resident #30 identified a Brief Interview for Mental Status (BIMS) score of 14 without signs/symptoms of delirium. A score of 14 indicated intact cognition. The MDS revealed the resident required the limited physical assistance of 1 person for transfers, walking in his room, and he utilized a walker and wheelchair for mobility devices. The MDS documented diagnoses that included: atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), pneumonia, hyperlipidemia (high blood cholesterol levels), Parkinson's disease, chronic obstructive pulmonary disease (COPD), cerebrovascular disease, and hypoxemia (low blood oxygen levels). The MDS recorded the resident did NOT have a condition or chronic disease that may result in a life expectancy of less than 6 months, he received oxygen therapy, and he was NOT on hospice level of care. The MDS documented a weight of 174 pounds.			

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	The Closet Care Plan dated 11/6/19 contained a section to record DNR (Do Not Resuscitate) or Full Code status; the section left blank with no indicators either way. The Admission Record (also known as the face sheet) printed 11/18/19 at 1:20 p.m. documented CPR under Advance Directives (indicating the resident wanted CPR in the event his heart stopped and breathing ceased). Care Plan: The Care Plan Conference Summary dated 11/26/19 documented Code Status discussed with no changes made. The summary recorded the resident remained cognitively intact oriented to person, place, and time. The summary recorded the resident present but too weak to sign the form. The care plan focus areas revised 8/20/19 identified an ADL (Activities of Daily Living) self-care performance deficit and limited physical mobility. The care plan instructed staff to provide assistance with dressing, transfers, ambulation, and locomotion. The care plan recorded the resident as able to transfer with SBA (stand by assistance) to limited assistance with wheeled walker.			

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	The care plan focus area revised 8/26/19 identified altered cardiovascular status related to atrial fibrillation. The care plan directed staff to monitor/document/report PRN (as needed) any signs/symptoms of CAD (coronary artery disease). The care plan focus area revised 11/27/19 identified the use of oxygen therapy related to COPD and increase in SOB (shortness of breath), wheezes, and decreased endurance. The care plan directed staff to monitor for signs/symptoms of respiratory distress and report to MD (doctor) PRN. The Progress Notes documented the following: a. On 11/26/19 at 11:20 a.m. the ADON (Assistant Director of Nursing) met with the resident and the resident's son for a care plan conference. The entry recorded code status discussed with the resident and the resident did not want to change; he wanted to remain FULL CODE status. b. On 11/28/19 at 2:11 p.m. the resident experienced an episode of being verbally unresponsive with family and staff but responded after a sternal rub completed. The nurse documented the resident cognitively intact and able to make his own decisions and refused to go			

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	to the hospital to get checked out. The nurse explained that full code meant if the resident found (unresponsive) it would mean being pulled off the bed, CPR would be started, and they would pound on his chest until the rescue squad got there then they would do the same thing all the way to the hospital in the ambulance; the resident still refused to go as he would not get to see his own doctor. The nurse recorded the resident's sons even tried talking to him and he wouldn't listen to them. c. On 11/29/19 at 8:22 a.m. discussion held with the resident asking him to go the the ER (Emergency Room) to get assessed. At 11.09 a.m. the notes recorded the resident admitted to the hospital for pneumonia. d. On 12/4/19 at 2:00 p.m. the resident returned from the hospital. e. On 12/20/19 at 3:22 p.m. the ARNP (Advanced Registered Nurse Practitioner) saw the resident on rounds and no new orders received. The Order Summary Report dated 12/20/19 at 2:31 p.m., signed by the ARNP on 12/20/19, contained an active order for CPR that originated on 8/9/19. The ARNP examination notes from 12/20/19 documented a current weight of 164 pounds.			

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	The Progress Notes dated 12/24/19 at 3:00 a.m. documented a visual check completed by Staff B, Licensed Practical Nurse (LPN), and the resident rested quietly with no signs/symptoms of respiratory distress. At 4:30 a.m. Staff B documented the resident up to the bathroom with assistance of 2 staff and wheeled walker; the resident did desat (decrease in blood oxygen level reading) to 80% with O2 (oxygen) in place. Staff B wrote she educated the resident to breath through the nose, out through the mouth, and to remain calm. At 4:40 a.m. Staff B documented the resident remained in the bathroom, O2 sat greater than 88%, and the resident stated he wasn't finished on the toilet. At 4:50 a.m. Staff B documented the resident continued to state he was not finished; no signs/symptoms of distress. At 4:55 a.m. Staff B documented the following: Call light on and (the resident) stated he finished. Assistance of 2 (persons) to ambulate to the bed with gait belt and wheeled walker. The resident ambulated approximately 5 feet and then stated he did not feel good. Staff placed the resident in the wheelchair and took him another 5 feet when the resident went limp with no pulse palpable. Staff documented they could not attempt CPR due to the resident's position and the staff present. Staff could not move the resident from			

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	wheelchair to bed until they received further assistance from a staff member in other department and then 4 staff assisted the resident to bed. At 5:10 a.m. the resident did not have a pulse or respirations. At 5:15 a.m. staff placed a call to the hospital and spoke with the ARNP. Staff updated the ARNP and received orders to release the body to the funeral home with diagnosis that caused death as: end stage COPD. At 5:20 a.m. staff attempted to reach the family and left messages left for sons. At 5:25 a.m. a son called back stating they would come to the nursing home. At 5:29 a.m. staff notified the funeral home. At 5:35 a.m. the other son called back and staff updated him. At 6:35 a.m. the funeral home attendant arrived at the facility. The death record dated 12/24/19 at 5:10 a.m. documented the cause of death as end stage COPD. The undated, typed summary of the facilities investigation conducted by the Administrator included the following: Regarding incident of charge nurse Staff B's failure to perform CPR on Resident #30 on 12/24/19. Staff B educated 12/24/19 by the Director of Nursing (DON) that the facility CPR policy did not give the charge nurse discretion to not perform			

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	CPR on a resident wishing for CPR. Staff B stated she understood this. Staff B served with a discipline regarding her negligence of duty by failure to perform CPR on a resident desiring to be a full code on 12/31/19. The Discipline Record System for Employees Second Written Warning dated 12/24/19 for Staff B recorded: Failure to perform CPR on a Full Code resident due to Staff B's claims of incorrect resident position and staffing. Gross negligence of duty, failure to perform to standards, and in future will result in termination. Repeated failure to respond to supervisors attempted contacts. Staff Interviews On 2/18/20 at 1:18 p.m. Staff B, LPN, confirmed she worked 12/23/20 to 12/24/20 on the 10:00 p.m. to 6:00 a.m. shift and recalled working when Resident #30 expired. Staff B stated Staff F, Certified Nurse Aide (CNA), and Staff E, CNA, took Resident #30 to the bathroom then headed back to bed. Staff B stated they walked Resident #30 and placed him in the wheelchair as he went unresponsive. Staff B stated Resident #30 expired at that time. When asked if the time in the progress note of 4:55 a.m. reflected accurately when the resident went limp, Staff B responded she thought so- she at least knew it			

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	was after 4:00 a.m. Staff B reported Resident #30 as not responding when she entered the room. He went limp while the nurse aides tried to get the wheelchair under him and he was not breathing at that time. Staff B stated she could not palpate a pulse. Staff B said Staff F and Staff E got the resident about 3 foot from the bathroom to the wheelchair. Staff B commented they tried to get him back into bed but couldn't move him. Staff B voiced she knew they couldn't get the resident out of the wheelchair into the bed because she (Staff B) was too old and 1 of the aides pretty small. Staff B stated all she could think to do was get the person in laundry to come and help get the resident out of the wheelchair to the bed. Staff B identified the resident as so flaccid (a part of the body hanging loosely or limply) they could not get a hold of him. At that time Staff B stated she did not attempt CPR. Staff B said she then went and called the doctor because as far as she could tell Resident #30 expired. Staff B reported Staff D, Environmental Supervisor, helped get Resident #30 onto the bed where Staff B reassessed and still no heart rate, no respirations, nothing there. Staff B responded she did not attempt CPR on the bed. Staff B stated she physically froze up and couldn't think. Staff B stated she didn't think she knew at the time Resident #30's status as a full code but thought she knew it when the doctor said on the			

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	phone that the doctor tried to get Resident #30 changed to a DNR status several times in the past. Staff B said she told the doctor and the DON that she did not do CPR. Staff B responded it took at least 10 minutes or more to get the resident from the wheelchair where he went limp to the bed. Staff B again stated they could not get any kind of hold on the resident as he was so limp, so the smaller aide (Staff E) went to get the laundry person who started work at 5:00 a.m. Staff B stated staff knew the code status of a resident at the time of the interview by notation on the closet care plan, implemented after the incident. Staff B stated prior to the incident, a little green dot sticker on the spine of the chart indicated CPR/Full Code status. Staff B voiced there was a spot on the face sheet and on the electronic chart as well. After reviewing the progress note dated 12/24/19 at 4:55 a.m. word for word with Staff B, Staff B responded yes, 4:55 a.m. would have been the time Resident #30 went limp, 5:10 a.m. would indicate the time it took to get the resident into the bed as they physically could not get him transferred. Staff B again confirmed CPR not attempted by anyone. Staff B confirmed the 4 staff members assisting the resident to the bed were: Staff F, Staff E, Staff D, and herself. Staff B confirmed once Resident #30 was in the bed at 5:10 a.m., she re-assessed and again found no pulse, no respirations, then			

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	left the room to call the doctor. They reached the doctor by calling the hospital who transferred to the primary doctor covering the facility at the time of the call. Staff B confirmed again no CPR attempted once resident in the bed or after call to the doctor. Staff B confirmed the details of the rest of the progress note as accurate. Staff B responded there was enough staff, Resident #30 was in the wheelchair, and she didn't think to put him on the floor. Staff B responded she didn't know the reason why she couldn't put the resident on the floor, she just couldn't put him on the floor. Staff B stated it was during that time 8 years prior that her mom passed away. Staff B denied trying to do CPR in the wheelchair and stated the resident leaned to the right in the wheelchair. Staff B denied anyone else attempting to do CPR stating the aides were not certified at night to do CPR-only Staff B was. In a follow-up interview on 2/19/20 at 5:10 p.m., Staff B reviewed the interview from 2/18/20 at 1:18 p.m. and Staff B confirmed the information she said. Staff B responded she did not know at the time Resident #30 collapsed he was CPR status. Staff B stated if she would have ran up to look at the chart, then she would have known. Staff B said by the time she heard the doctor say that he was CPR his pupils were fixed. Staff B responded she knew she thought in her head she			

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	couldn't do the CPR while Resident #30 was in the wheelchair as she couldn't get her arms around his chest because he was falling out. Staff B commented, looking back, probably she would have just laid him out on the floor as he was already on his way. When asked if she sent another staff member to check the chart, Staff B responded that would have been the smart thing to do but at that moment, she did not think of it. When asked if she sent anyone to call 911, Staff B responded, no that didn't pop into her head. The only thing that popped into her head was her mother and having to tell the resident's family he passed away on Christmas Eve. Staff B responded she did not think his body was warm. When asked to clarify if the body just went limp, how was it not warm, Staff B stated, it wasn't to her when checking his pulse. Staff B clarified as she got to the resident's room, he was going down. Staff B described the resident's color as dark at that time, flaccid, with no signs of rigor mortis. Staff B responded her understanding for the facility policy on CPR, if they see the resident go then they do CPR but if they see someone cold with no pulse no respirations, and think some stiffness too, not positive, don't do CPR. Staff B responded at the time of the interview, she definitely believed she should have done CPR; Staff B commented Resident #30 was code, he wanted a code, the doctor didn't, the family			

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	didn't, but the decision was not up to them. After Staff B acknowledged she knew the family didn't want the resident to have CPR, she clarified she knew that approximately a week before the resident passed as he had been in the hospital and the other nurses told her. Staff B confirmed it was talked about that the family didn't want him to have CPR but the resident did want it. Staff B commented she knew in the back of her head all along Resident #30 was a full code resuscitation. She stated had no other excuse and it was obvious she would have done it differently if she would have thought and if she got the chance she would. Staff B responded she did remember the ARNP calling back after she had first talked to her. Staff B clarified the ARNP wanted to know if Staff B called an ambulance and Staff B said, no he was already gone. On 2/18/20 at 10:11 a.m. Staff F, CNA, recalled working the night Resident #30 passed away. Staff F reported Resident #30 activated his call light and wanted to go to the bathroom. Staff F identified Resident #30 as pretty weak. She offered the resident the walker and assisted him to stand. She did not know if he needed to have a bowel movement but she put the gait belt on him and got him onto the toilet. Staff F said the resident seemed weaker since he got back from the hospital. Staff F said the resident liked to sit a			

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	while and he "was with it" cognitively so she did not have to sit with him. Staff F stated she and Staff E hung around the room and told him to pull light when done. When the resident finished, they went in, put the gait belt on him , assisted him to stand, walked him back to the bed, when suddenly the resident looked over and "there was nothing". Staff F stated she hollered at Staff E to get the wheelchair as the resident was almost ready to go down. Staff F reported they made it out of the bathroom about foot to foot and half when the resident had no response. Staff F said she hollered for the resident to stand up and that's when she hollered at Staff E to get the wheelchair as Staff F couldn't hold him up. Staff F said Staff E hurried to get the wheelchair and the resident sat down not responding what-so-ever. Staff F told Staff E to run get Staff B, LPN, who was already down the hall and came back to check for pulse and heart rate. Staff F said the resident looked like he might have died right there when she saw him look at her and "there was nothing". Staff F stated she couldn't say for sure as she was not the nurse but the resident definitely appeared dead when he got into the wheelchair. Staff F stated the resident had a weird look and she had never seen it happen that quickly. It was tough to talk about and she remembered it well. Staff F reported it was the middle of night, overnight shift, although she			

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	couldn't remember the exact time. Staff F reported Staff B had to check for sure and the resident did not hold up his head. Staff F stated no one initiated CPR. When asked to clarify the time of the event, Staff F again said the middle of the shift, guessing something after 1:00 a.m. but she didn't know for a fact. When asked if the time was 4:55 a.m. as Staff B charted, Staff F responded it was possible and if Staff B charted that, it probably did happen at that time. Staff F responded after getting the resident into the wheelchair, they stayed with him for a time. Staff F said they were going to get him in the bed, but Staff B is old and Staff E is not very strong. Staff F stated they tried to think of how to get him into bed. Staff F stated it was not too long after when Staff D, Environmental Supervisor, got there and the 4 of them got the resident back into bed. Staff F said she didn't know if they could have lifted him before that as they tried a couple times but with dead weight, they couldn't get over there. Staff F reported Staff D grabbed the resident's feet, and they got him over to the bed. When asked how much time passed from when the resident went limp to getting into the bed, Staff F responded the time resident went limp he went to dead weight, then short time to the wheelchair, then from wheelchair to the bed, she thought maybe 20 minutes, something like that. Staff F responded she did not see anyone do CPR in the			

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	bed or attempts to get the resident to the floor for CPR. Staff F commented she used to have a CPR certification but it expired. When asked if Staff B made any comments about CPR, Staff F responded she thought Staff B said something like, maybe she should sit him down and do CPR but not sure; something like supposed to do CPR but said the resident already passed, she did not know the exact phrase. Staff F responded she did not think anyone called 911 as 911 responders never came. Staff F commented she was not positive on everything Staff B did as a nurse but Staff B said something about calling the family and it was tough to tell them as it was the holiday. Staff F stated they got the resident cleaned up and made him presentable as is done when someone dies. Staff F stated she ended her shift at 6:00 a.m. and the resident was still there so she did not know when funeral home came. On 2/19/20 at 6:18 p.m. Staff E, CNA, responded she was familiar with Resident #30 and confirmed she worked the day he passed. Staff E reported she had the resident in the bathroom and he was okay at that time. Staff E said as they put the resident in the wheelchair, all of a sudden he passed away in the wheelchair. Staff E clarified the approximate time towards the end of shift, probably 4:00 a.m., then said no actually later			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	than that as laundry lady was there so actually 5:30 a.m. Staff E's shift runs until 6:00 a.m. Staff E confirmed the date 12/24/19 and the event took place in Resident #30's room. Staff E reported Staff F, CNA, was in the room with her as well. Staff E stated Resident #30 activated his call light to go to bathroom then put call light on when he was done which was normal for him up to that point. Staff E stated when they entered bathroom Resident #30 appeared fine and talked to them. He said he needed a second, so they gave him a second before placing him in the wheelchair. Staff E reported they were almost to the bed, out the bathroom door, when he went limp. Staff E stated the resident was in his wheelchair, they were not ambulating him. When asked why Staff F might think they ambulated the resident, Staff E responded she swore they took him out of the bathroom in his wheelchair as he really didn't like to walk. Staff E reiterated the resident sat in his wheelchair almost to the bed when he went limp. Staff E said then she got Staff B as he didn't answer them and hunched over in his wheelchair. Staff E stated she went down the hall while Staff F stayed in the room and thought she found Staff B at the nurses station. Staff E commented she had a very bad short term memory, she had not been an aide a long time and not used to death, and so it was a shock. Staff E stated they tried to get the resident to come around and talk to them			

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Facility Administrator Date

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **#8022**	**AMENDED 11/19/20**		**Date:** **March 17, 2020**
Facility Name: **Manilla Manor**		**Survey Dates:** **February 17-27, 2020**	
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	and Staff B tried to listen for a heart beat while the resident sat in the wheelchair but Staff B didn't get a pulse. Staff E stated they then put the resident in his bed so people could come get him and he would not fall out of the wheelchair. Staff E reported she, Staff F, and Staff D, Environmental Supervisor, got the resident into bed. Staff E commented she was 5 foot 2 inches tall and weighed 120 pounds and no way she could help Staff F and Staff B lift Resident #30 into bed. Staff E stated no one initiated CPR. Staff E stated Staff B sent her for a stethoscope so Staff B could see if there was or wasn't a heartbeat. Staff E stated all 3 of them listened for a heartbeat just in case there was a heartbeat; Staff B couldn't hear and Staff B wanted to make sure there wasn't one. Staff E responded she thought Staff B was hard of hearing. Staff E responded she thought Staff B contacted 911 after that as Staff B made a couple of phone calls but Staff E had to finish her rounds and get everyone changed so she did not know for sure. Staff E clarified she witnessed Resident #30 go limp and it only took approximately 10 seconds if that for Staff B to arrive to the room. Staff E clarified it took maybe 5 to 10 minutes to get the resident from the wheelchair to the bed as Staff E had to go get Staff D. Staff E denied there being any discussion about trying to get the resident onto the floor at any point. When asked if there			

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	had been any discussion about attempting CPR or why not, Staff E responded because the resident had no pulse or heartbeat. When asked if Staff B said that, Staff E stated, no as they were both tiny if they put the resident on the floor they wouldn't be able to get him up and wanted to get him out of the wheelchair and to the bed before he fell out of the chair. Staff E responded she wasn't sure if Staff B attempted CPR once the resident transferred into the bed as Staff E went to do rounds as it was 5:30 a.m. and Staff E needed to clock out by 6:07 a.m. On 2/19/19 at 10:03 a.m. Staff D, Environmental Supervisor, recalled the morning Resident #30 passed away. Staff D reported she was doing laundry when Staff E, CNA, asked if she could help put the resident into bed. Staff D recalled the time to be shortly after she got to the facility around 5:00 a.m.; right after she punched in or few minutes after that when Staff E asked for help as they needed muscle. Staff D recalled when she got to the room the resident passed away. Staff D clarified Staff B, LPN, said the resident passed away. Staff D stated when she walked in the room she observed the resident not breathing and slumped over in the wheelchair. Staff D helped provide assistance of 4 persons to get the resident into the bed. Staff D reported she stood there for a little while then she left the room. Staff			

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	D responded she did not see anyone perform CPR and Staff E did not get her until the resident already passed away. Staff D reported she was told the resident had to go to the bathroom and then event happened after that. Staff D was unsure exactly who else had been in the room that morning. On 2/19/20 at 11:00 a.m. the surveyor questioned the ARNP if she would have expected CPR to performed on Resident #30. The ARNP responded it was hard to say. The ARNP commented she was not made aware of the circumstances around Resident #30's death when Staff B first called her, Staff B just called and said Resident #30 was definitely gone. The ARNP stated she just examined Resident #30 a few days prior and identified the resident with serious health issues. The ARNP stated she had a conversation with Resident #30 regarding his code status. The ARNP reported she educated the resident that CPR could actually worsen his health and may not even be successful given his serious health status; but Resident #30 continued to say he didn't care, he wanted CPR if he coded. The ARNP stated she had in fact called Staff B back that morning to inquire if any CPR had been performed and was told no as the resident definitely gone when Staff B assessed him.			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	On 2/19/20 at 11:20 a.m. the Director of Nursing, (DON), recalled the circumstances surrounding Resident #30 expiring. The DON reported Staff B, LPN, called that morning and said he passed away. The DON stated informed Staff B that Resident #30 requested a full code CPR status. The DON asked Staff B if she performed CPR, and Staff B said no Resident #30 was in the wheelchair. The DON then informed Staff B she should take the resident out of the chair and put him on the floor and do CPR. The DON reported Staff B said she called the ARNP and the son who said it was okay. The DON commented she did not have any words for the statement. The DON stated she would expect Staff B to initiate CPR. When asked if she talked anymore to Staff B, the DON responded she left several messages and emails then finally caught Staff B at 6:00 a.m. one morning and brought her into the Administrator's office to chat. She did not recall what day. The DON reported Staff B got quiet and then said she knew she really screwed up. The DON responded Staff B did go over the circumstances, they read the progress notes and Staff B said she was the only nurse. The DON stated other staff could have called 911 to which Staff B said, "yeah". The DON confirmed no one called 911. The DON commented when she came to work and read Staff B's charting she wasn't happy and all the DON could say was Staff			

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	B knew she screwed up. The DON responded she spoke with the ARNP about the resident. The DON identified the ARNP at the facility the day before and tried to talk Resident #30 into changing his code status to DNR but the ARNP "talked till blue in the face and Resident #30 still wanted CPR". The DON reported the resident's family also wanted a DNR code status but couldn't get the resident to change his mind. The DON responded staff knew to do CPR from a sticker placed on the closet care plans which was a new intervention after the event; otherwise staff placed a green dot on the outside of the hard chart to identify residents who wanted CPR. When asked if Staff B ever indicated she thought Resident #30 was a DNR, the DON responded when Staff B first called she told Staff B she knew he was a CPR and Staff B agreed. The DON stated she asked Staff B why she did not put the resident on the floor and perform CPR as she would have expected Staff B to. The DON responded she was unsure if the facility policy stated anything about staff determining when to perform CPR. When asked if the DON ever observed anything to indicate Staff B couldn't perform the job duties, the DON responded no the facility expected Staff B to perform the same job duties as other nurses. The DON described Staff B as more of a turtle not a rabbit, good with the residents, good on the graveyard shift, she			

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	didn't think Staff B could do another shift as Staff B seemed stuck in her ways. The DON stated she thought of Staff B as capable nurse who had never played the age card with her. The DON responded she thought Staff B told them in the meeting she just went blank and froze up and she screwed up. Additional Staff Interviews On 2/19/20 at 12:52 p.m. Staff C, LPN, stated if she walked into a room where staff reported a resident limp and already passed away, she would get the resident onto the floor and start CPR while she sent a CNA to call 911. Staff C stated she would continue CPR until the ambulance arrived. Staff C responded she would check code status on the outside of the hard chart where a green circle or green sticker is placed to identify if a resident is a full code. Staff C commented that the facility had so few residents with full code status she really already knew who required initiation of CPR. On 2/19/20 at 12:55 p.m. Staff A, LPN, stated if she walked into a room where staff reported a resident limp and already passed away, she would check the resident's code status, which most times she already knew, but listed on the closet care plan on the closet door and the dot on the outside of the hard chart. Staff A stated if a			

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	resident DNR code status then she would get the resident up on the bed and comfortable. Staff A said if a resident Full Code status then she would tell staff to call 911 and she would initiate CPR. When asked what she would do if staff said the resident already died, Staff A responded she would do CPR anyway unless rigor mortis set in with signs the resident cold and stiff. Staff A responded prior to the facility initiating closet care plans, she checked the sticker on the spine of the chart. Staff A commented she usually made a habit of checking the spines of the chart at the beginning of every shift. On 2/19/20 at 12:57 p.m. the Assistant Director of Nursing (ADON) responded if she walked into a room where staff reported a resident limp and already passed away, she would check the closet care plan for code status. The ADON stated if the closet care plan not up to date she would look on the outside of the hard chart for green full code sticker. The ADON commented if she were in doubt, she would do CPR. When asked what she would do if staff said the resident already died, the ADON responded she wouldn't care, she would continue to ask someone to call 911 and she would initiate CPR. The ADON responded prior to the facility putting code status on the closet care plan, the system was a sticker on the outside of the hard chart.			

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	On 2/19/20 at 4:05 p.m., Staff J, Registered Nurse (RN), responded to the scenario if he walked into a room where staff reported a resident limp and already passed away, what he would do. Staff J commented he only worked at the facility for a week. Staff J stated he would verify code status by the sticker on the outside of the hard chart but he could also look in 2 other places that included in the chart under Advanced Directives and on the closet care plan. Staff J stated if he verified the resident needed CPR , he would then follow the normal steps for CPR which is start CPR, call 911, report symptoms to 911 of rigor mortis or different color setting in, and could only stop CPR if 911 response team confirmed he could. When asked what he would do if staff said the resident already died, Staff J responded he was not allowed to take their word for that and still needed to initiate CPR. On 2/19/20 at 11:58 a.m. the ADON provided a Chart Audit dated 1st Quarter Year 2020. The ADON confirmed the list reflected 5 current residents listed as full code status: CPR. Facility Policy Review The facility policy effective 2/2/17 titled Resuscitation Policy included the following documentation:			

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	Purpose - Determine the circumstances when cardiopulmonary resuscitation must be initiated, pursuant to federal law requirement to carry out a resident's advanced directives. Definitions - Cardiopulmonary Resuscitation (CPR) refers to a range of procedures used to attempt to restore heartbeat and breathing following a cardiopulmonary arrest. Basic CPR refers to a means of opening and maintaining an airway, providing ventilation through rescue breathing and providing artificial circulation through the use of external cardiac compression. Cardiopulmonary arrest is a physiologic state wherein the resident actually has no palpable pulse and no spontaneous respirations. Respiratory arrest is a physiologic state wherein the resident has absence of adequate respiratory effort without loss of pulse. Dependent lividity means clear demarcation of pooled blood within the body, seen in a dependent part of the body, occurring as a sign of irreversible death. Rigor mortis means that major joints such as the jaw, shoulders, elbows, hips, or knees are immovable; this is a sign of irreversible death. Do Not Resuscitate (DNR) Order is a written order issued by the resident's treating physician which directs that, in the event of cardiac or			

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	respiratory arrest, no CPR measures will be initiated. Policy - Point 1. Upon determination that a resident is in cardiopulmonary or respiratory arrest (note the time), CPR will be immediately initiated by nursing staff and 911 called for advanced cardiac life support unless one of the exceptions applies: a. when the resident or surrogate has indicated that resuscitation is not desired and the attending physician has issued a written do not resuscitate (DNR) order that is maintained in the facility's clinical record; or b. when there is the presence of obvious clinical signs of irreversible death (defined as rigor mortis or dependent lividity); or c. no physiologic benefit can be expected because the vital functions have deteriorated despite maximal therapy for such conditions such as progressive septic shock or cardiogenic shock; or d. when attempts to perform CPR would place the rescuer at risk of personal injury. Point 2. Each resident's resuscitation status will be maintained in the clinical record as follows: Any and all residents opting to have CPR performed in the event of cardiopulmonary arrest or respiratory arrest will have their chart labeled on the spine of the chart with a FULL CODE sticker. All others absent of a sticker will be DNR.			

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	Point 3. If CPR is required, it will be immediately initiated by any staff member currently certified to perform CPR, pursuant to current American Heart Association guidelines. Point 4. If CPR is initiated, it will be continued until a physician directs staff to stop, the paramedics arrive and take over the CPR, or staff becomes too exhausted to continue. Point 5. The facility will maintain readily available and functioning emergency equipment which may include: a. barrier mask b. bag valve mask (BVM) c. suctioning equipment d. backboard e. flashlight f. stethoscope Point 6. If a nurse's assessment concludes that the resident exhibits signs or irreversible death leading to nursing judgement not to initiate CPR, complete and contemporaneous documentation of the nursing assessment shall be documented in the clinical record. Abatement: Following the incident on 12/24/19 involving Resident #30 not receiving CPR the facility completed the following: a. on 12/24/19 the facility reeducated Staff B on the facility CPR policy.			

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	b. all licensed nursing staff educated on the CPR policy prior to their next shift scheduled to work beginning on 12/24/19 and completed 12/26/19. c. on 12/26/19 the facility implemented a sticker process showing the residents choice of CPR or DNR to be put on the residents' closet care plan. The MDS coordinator/ADON the one who visits with the residents at the time of their care plans about their choice of CPR or DNR and would update their care plans in the medical record software as well as on the closet care plan to ensure that those are up to date. d. on 12/31/19 Staff B presented with a written discipline. e. all staff educated on the CPR policy at the 1/15/20 all staff in-service and reviewed again at the 2/19/20 all staff in-service. The deficient practice detailed above resulted in an immediate jeopardy situation for the facility. This abatement resulted in past noncompliance for the facility. **FACILITY RESPONSE:**			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.43(9)	**481—58.43(135C) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. 58.43(9) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III) **DESCRIPTION:** Based on clinical record review, staff interview, facility record review, and facility policy review, the facility failed to report 1 allegation of neglect (Resident #30), and 3 separate instances of abuse (assault/unreasonable punishment) regarding Staff G CNA (certified nurse aide) mistreatment of Resident #30, #80, #90, to the Iowa Department of Inspections & Appeals (DIA) within the required timeframe; for 3 out of 3 residents reviewed for abuse. The facility reported a census of 30 residents.	**II**	**$500 (Held In Suspension)**	**UPON RECEIPT**

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	Findings include: 1. The quarterly MDS assessment dated 11/5/19 for Resident #30 identified a BIMS score of 14 (no cognitive impairment) without signs/symptoms of delirium. The MDS recorded the resident did NOT have a condition or chronic disease that may result in a life expectancy of less than 6 months, he received oxygen therapy, and he was NOT on hospice level of care. The Admission Record (also known as the face sheet) printed 11/18/19 at 1:20 p.m. documented CPR (cardiopulmonary resuscitation) under Advance Directives, which identified the resident requested CPR if his heart and breathing stopped. The Care Plan Conference Summary dated 11/26/19 documented Code Status discussed with no changes made. The summary recorded the resident remained cognitively intact oriented to person, place, and time. The summary recorded the resident present but too weak to sign the form. The Order Summary Report dated 12/20/19 at 2:31 p.m., signed by the ARNP (advanced registered nurse practitioner) on 12/20/19,			

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	contained an active order for CPR that originated on 8/9/19. The Progress Notes dated 12/24/19 at 4:55 a.m. documented 2 staff ambulated the resident to the bed with a gait belt and wheeled walker. The resident stated he did not feel good. Staff placed in wheelchair and took him another 5 foot, when the resident) went limp with no pulse palpable. Staff did not attempt CPR and identified they were unable due to the resident's position and the staff present. Staff could not move the resident from wheelchair to bed until they received further assistance from a staff member in other department and then 4 staff assisted the resident to bed. At 5:10 a.m. staff could not obtain a pulse or respirations. At 5:15 a.m. staff placed a call to the hospital and spoke with the ARNP. Staff updated the ARNP and received orders to release the body to the funeral home with diagnosis: end stage COPD (chronic obstructive pulmonary disease). On 2/18/20 at 1:18 p.m. Staff B, LPN (licensed practical nurse), confirmed she worked 12/23/20 to 12/24/20 on the 10:00 p.m. to 6:00 a.m. shift and recalled working when Resident #30 expired. Staff B stated Staff F, Certified Nurse Aide (CNA), and Staff E, CNA, took Resident #30 to the bathroom then headed back to bed. Staff B			

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	stated they walked Resident #30 and placed him in the wheelchair as he went unresponsive. Staff B stated Resident #30 had expired. Staff B reported Resident #30 did not respond when she entered the room. He went limp when the nurse aides got the wheelchair under him and he was not breathing at that time. Staff B stated she could not palpate a pulse. Staff B commented they tried to get him back into bed but couldn't move him. Staff B voiced she knew they couldn't get the resident out of the wheelchair into the bed because Staff B was too old and 1 of the aides was pretty small. Staff B stated all she could think to do was get the person in laundry to come and help get the resident out of the wheelchair to the bed. Staff B commented the resident was so flaccid (a part of the body hanging loosely or limply) that they could not get a hold of him. At that time Staff B stated she did not attempt CPR. Staff B reported Staff D, Environmental Supervisor, helped get Resident #30 onto the bed where Staff B reassessed and still found no heart rate, no respirations, nothing there. Staff B responded she did not attempt CPR on the bed. Staff B commented, like she told the doctor she "physically froze up and couldn't think". After reviewing the progress note dated 12/24/19 at 4:55 a.m. word for word, Staff B responded yes, 4:55 a.m. would have been the time Resident #30 went limp, 5:10 a.m. would indicate the time it			

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Facility Administrator Date

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: #8022	AMENDED 11/19/20	Date: March 17, 2020
Facility Name: Manilla Manor		Survey Dates: February 17-27, 2020
Facility Address/City/State/Zip 146 North 5th Street Manilla, IA 51454	SB	

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	took to get the resident into the bed as they physically could not get him transferred. Staff B again confirmed no one attempted CPR. Staff B confirmed the 4 staff members that assisted the resident to the bed were: Staff F, Staff E, Staff D, and herself. Staff B confirmed once they got Resident #30 in the bed at 5:10 a.m., she re-assessed and again found no pulse, no respirations, then left the room to call the doctor. Staff B denied trying to do CPR in wheelchair and stated, no he was leaning over the wheelchair towards the right. Staff B denied anyone else attempting to do CPR stating the aides did not have CPR certification. On 2/18/20 at 10:11 a.m. Staff F, CNA, recalled working the night Resident #30 passed away. Staff F reported no one initiated CPR. Staff F responded she did not see anyone do CPR in the bed or attempts to get the resident to the floor for CPR. Staff F responded she did not think anyone called 911 as 911 responders never came. On 2/19/20 at 6:18 p.m. Staff E, CNA, responded she was familiar with Resident #30 and confirmed she worked the day he passed. Staff E reported no one initiated CPR. Staff E stated Staff B sent her for a stethoscope so Staff B could see if there was or wasn't a heartbeat. Staff E stated all 3 of them listened for a heartbeat just in case there			

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	was a heartbeat. Staff B couldn't hear and Staff B wanted to make sure there wasn't one. Staff E clarified she witnessed Resident #30 go limp and it only took approximately 10 seconds, if that for Staff B to arrive to the room. When asked if they discussed attempting CPR or why not, Staff E responded because the resident did not have a pulse or heartbeat. When asked if Staff B said that, Staff E responded, no as they were both tiny if they put the resident on the floor they wouldn't be able to get him up and wanted to get him out of the wheelchair and to the bed before he fell out of the chair. Staff E responded she wasn't sure if Staff B attempted CPR once the resident transferred into the bed as Staff E went to do rounds. On 2/19/19 at 10:03 a.m. Staff D, Environmental Supervisor, recalled the morning Resident #30 passed away. Staff D reported when she walked in the room the resident was not breathing and appeared slumped over in the wheelchair. She didn't recall which way he slumped. She stated she knew the resident for a long time so it was kind of hard to take in. Staff D helped to provide assistance of 4 persons to get the resident into the bed. Staff D responded she did not see anyone perform CPR and Staff E did not get her until the resident already expired.			

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	On 2/19/20 at 11:00 a.m. the ARNP stated she examined Resident #30 a few days prior to passing and the resident had serious health issues. The ARNP stated she had a conversation with Resident #30 regarding his code status during that visit. The ARNP reported she educated the resident that CPR could actually worsen his health and may not even be successful given his serious health status but Resident #30 continued to say he didn't care, he wanted CPR if he coded. The ARNP stated she called Staff B back that morning to inquire if staff performed CPR and staff told her no as the resident was definitely gone (expired) when Staff B assessed him. On 2/19/20 at 11:20 a.m. the Director of Nursing, (DON), recalled the circumstances surrounding Resident #30 expiring. The DON reported Staff B, LPN, called that morning and said the resident passed away. The DON stated she told Staff B the resident wanted CPR and asked Staff B if she performed CPR and Staff B said no due to the resident sitting in the wheelchair. The DON informed Staff B she could take the resident out of the wheelchair and perform CPR. The DON stated she expected Staff B to initiate CPR. Staff B informed the DON she was the only nurse working when the resident expired. The DON stated other staff could have called 911 and Staff			

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	B replied "yes". The DON confirmed no one called 911. The DON stated she spoke to the ARNP about the resident. The DON identified the ARNP at the facility the day before spoke with the resident about changing his code status from CPR to DNR (do not resuscitate). Resident #30 still wanted CPR. When asked about reviewing the incident for neglect, the DON stated she and the Administrator discussed the time frame and reporting. On 2/19/20 at 4:30 p.m. the Administrator reported all the actions the facility took after Staff B failed to initiate CPR on 12/24/19. The Administrator could not recall the exact date as she forgot to date the discipline, but reported it as a few days after the incident when she and the DON arrived to the facility at 6:00 a.m. to speak to Staff B and provided her disciplinary action. The undated, typed summary of the facilities investigation conducted by the Administrator included the following: Regarding incident of charge nurse, Staff B's failure to perform CPR on Resident #30 on 12/24/19. Staff B educated on 12/24/19 by the DON. The facility CPR policy did not give the charge nurse discretion to not perform CPR on a resident			

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	wishing for CPR. Staff B stated she understood this. Staff B served with a discipline regarding her negligence of duty by failure to perform CPR on a resident desiring full code status on 12/31/19. The Discipline Record System for Employees Second Written Warning dated 12/24/19 for Staff B recorded: Failure to perform CPR on a Full Code resident claiming incorrect position and staffing. Gross negligence of duty, failure to perform to standards, and in future will result in termination. Repeated failure to respond to supervisors attempted contacts. On 2/19/20 at 4:45 p.m., the Administrator identified Staff B as coming to the facility to sign an education form and the Administrator would inform Staff B of suspension pending investigation of abuse/neglect. The Online Abuse Reporting for the Facility revealed the facility did not report the failure to provide CPR incident to DIA (Department of Inspections and Appeals). 2. The Online Abuse or Incident Reporting dated 10/16/19 recorded a report of allegation of abuse with approximate date/time occurred on 10/5/19			

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	at 10:00 a.m. and date aware as 10/16/19 at 12:00 p.m. The report documented the following under Incident Summary: CNA came in after all staff in-service to visit regarding a situation that she was very upset about. She reported one of the overnight CNA's (Staff G) was very disrespectful of the residents and even mildly physically abusive. An example- she told a resident who yells out to "shut the f*** up" and calling her a cunt and an old cow. Another resident was combative and the CNA told her to "hit her again bitch" and then squeezed her hand to make her stop. The CNA told another resident she did not want to see his call light on again. The CNA told another staff person when a call light comes on to "just wait a while and they will go back to sleep and then you can go tip toe in and shut it off". They visited with the resident who the CNA told not to put his call light on and he confirmed the allegations. Corrective Action Taken - The CNA, Staff G, put on suspension pending the investigation of the allegations. A message out to the two charge nurses and another CNA who worked with Staff G to get their report. The residents named in the allegation: Resident #30, #80, #90.			

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	Review of the facility's investigation file included the following: An undated hand written witness statement signed by Staff H, CNA, recorded the following: In the few weeks that Staff H worked with Staff G, CNA, Staff H witnessed and learned how Staff G talked and treated the residents. Point 1. Staff G said it's a good thing the security cameras didn't have sound because she would've been fired a long time ago. Point 2. Heard Staff G telling Staff H, awe they wanted her to talk nice to the residents yeah f*** that, then laughed. Point 3. Staff G never answers any of the call lights and actually called herself fat and lazy. Staff G told Staff H if she just let the call lights go for a while eventually the resident would fall asleep and she could just sneak in their room and shut the call light off. Point 4. Staff G sat at the nurses station filling out the vital sheet. Staff H asked Staff G if she went and got their vitals and Staff G said, no sometimes she just wrote something down so it showed that she did it as she was just too lazy to walk down there. Point 5. Resident #30's call light on so Staff H went down and the resident wanted ice water so Staff H walked back and got him his ice water. Staff H left his room and he turned his light back			

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	on, Staff H went back down there, and he apologized and said he forgot to have Staff H turn the heat down 1 degree. Staff H informed him it was on 67 degrees and he said thank you so Staff H then left the resident's room. Staff H walked down to the nurses station and the resident's call light back on so Staff G said she would go find out what the old bastard needed. When Staff G returned she said she walked in the resident's room and Resident #30 said, "oh it's you". Staff G said, "yes it was her what did the resident need as Staff H had already been down there twice". Resident #30 asked what the thermostat was on and Staff G said he already knew what it was on and they better not have to go back down there again so don't turn his call light on again while Staff G was still on her shift. Staff H was pretty sure Resident #30 wanted ice cream but didn't want to ask Staff G for it because he told Staff H before that anything he asked Staff G to do Staff G didn't do it. Staff H did go back down to check on Resident #30 and just visited for a while. Point 6. Staff H walked past Resident #80's room and seen her pants wet and needed changed. Staff H grabbed Staff G because it was Staff H's first time down that hall and never helped Resident #80 so unsure how to go about it. Staff H got everything ready and Resident #80 tried to kick her while lying in bed, so Staff G went around			

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	the bed. Staff G got in Resident #80's face and said, "let's act like adults here and quit trying to kick her". That only made Resident #80 get mad and frustrated so Resident #80 started to slap and hit Staff G on her chest and arms. Staff G let Resident #80 hit her for a while instead of just stepping back. Staff G then got down in Resident #80's face egging it on saying, "hit her again bitch hit her again". Resident #80 kept hitting Staff G until Staff G had enough. Staff G grabbed Resident #80's hand and squeezed it really hard telling Resident #80 to act like an adult and to knock it off! Staff G finally left Resident #80 alone and went back around to the other side of the bed. Staff G and Staff H pulled Resident #80's pants up and left her be. Staff H felt of that could have been avoided had Staff G not walked around and got in Resident #80's face. Point 7. Resident #90, like they all knew, liked to repeat herself and say, hurry up hurry, and like Staff H said before, it was her first time down that hallway. Staff G went in Resident #90's room with Staff H. They changed Resident #90 in bed when Resident #90 said, "hurry up hurry up". Staff G then told Resident #90 to, "shut the f*** up". Resident #90 repeated herself and Staff G called Resident #90 a "cunt and to shut up". After they got Resident #90 changed, she said she wanted to go to her chair because her neck hurt and the time was maybe 3 a.m. Staff G said, no			

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	and told Resident #90 she would lay in bed until the morning shift got there at 6 a.m.. Resident #90 kept repeatedly saying she wanted to go to her chair and Staff G started to walk out saying, "shut up old cow and to lick her". Staff H stayed back and helped Resident #90 and Resident #90 grabbed her hand and said, thank you, you are a very nice lady. The Administrator attested to her unsigned hand written note dated 10/16/19 which documented an interview conducted with Staff K, LPN, who reported Staff G not quick to answer call lights but did go and he did not hear Staff G speak abusively to residents. In email dated 10/16/19 at 3:44 p.m. from Staff B, LPN, to the DON, Staff B responded to the DON's question if Staff B heard Staff G use abusive language towards any of the residents or any kind of abuse. Staff B responded she did not. The typed statement signed by the Administrator documented the following: 10/16/19 - Visited with Resident #30 and questioned him regarding the information received from Staff H. Resident #30 confirmed Staff G not very nice and Staff G told the resident his heat temperature reading did not change since the last time staff			

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	checked it. Resident #30 also said that Staff G would refuse to get him a refill on his water. Resident #80 not interviewed due to inability to cognitively understand; nor was Resident #90. The Administrator did visit with Resident #90's son, made him aware of the situation, informed that the staff person no longer worked at the facility, and apologized for the incident. Resident #80's son made aware of the incident. No injuries were sustained by any of the residents. The typed facility investigation summary, signed by the Administrator and the Director of Nursing, documented the following: 10/16/19 - After receiving a complaint from an employee regarding Staff G and Staff G's abusive behavior to the residents, the Administrator and DON placed a phone call to Staff G informing Staff G of the allegations against her. After reading her the list of complaints, there was a very long silence. The Administrator asked Staff G if she was still on the phone line. Again, after a somewhat shorter time Staff G answered yes, she was there. The Administrator asked Staff G what she had to say regarding the allegations. Again, silence and finally Staff G stated that the allegations were untrue. The Administrator asked Staff G why someone would make such dramatic allegations			

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	up. All Staff G could say was that they may be very immature. Staff G was informed at that moment she was on suspension pending the result of the investigation. Staff G then asked what happened if the facility determined the allegations were false. The Administrator told Staff G they would pay her for the days missed due to the investigation. The call ended. 10/17/19 - After contacting all staff that worked recently with Staff G, none other than Staff H stated they heard Staff G mistreat residents. In fact, Staff H stated she was present when Staff G said the things to Resident #90 and Resident #80. Staff H stated Staff G told her what she said to Resident #30 except for stating to Staff H that she would go down to see what the resident wanted. Also, Staff G told Staff H the items about the security cameras and the management wanting Staff G to talk sweet to the residents. When visited with Resident #30, he confirmed Staff H's account of what Staff G stated to him about he better not put his call light on again that shift and that she would not get him ice water. The DON and Administrator called Staff G again that day to inform her that at least one of the allegations had been confirmed and Staff G would not be allowed back in the facility and she was released from her employment.			

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	The Statement of In-Service Training for Employees dated 10/16/19 recorded areas of instructions covered that included self-report of resident-to-resident (abuse). Staff H signed attendance to that meeting. Staff Interviews On 2/26/20 at 11:05 a.m. Staff H verified employed at the facility 9/5/19 to 12/31/19. Staff H recalled her undated, hand written statement regarding an allegation of abuse. After reviewing the statement, Staff H verified accuracy of the statement as to what happened. Staff H could not recall the exact date, but guessed she worked with Staff G for the first time in October 2019. Staff H reported Staff G seemed scary and intimidating and Staff H a very quiet person, new there, and had not worked as a CNA for so long. Staff H commented that was why she went to the DON and the Administrator, she didn't know how to go about dealing with Staff G. Staff H responded she was not sure exactly when she went to the DON and Administrator, but it was 2 days or so after Staff G got fired. Staff H stated she only worked with Staff G twice and within those 2 days Staff H observed the things she wrote about. Staff H reported the events happened on the overnight shift, not the 2 p.m. to			

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	10 p.m. shift. Staff H reported when she came at 6:00 p.m. to 10:00 p.m. it was busy with people running back and forth with supper and bedtime and no time to talk or observe anything with Staff G. When she verified the schedule, it showed Staff H only worked overnights 2 days in a row with Staff G on 10/4/19 and 10/5/19, Staff H responded those were likely the 2 days the events occurred on, as the other days Staff H worked 2 p.m. to 10 p.m. shift. Staff H responded the nurse who worked was Staff K, LPN, who since quit with no other staff present on those nights who witnessed anything. Staff H clarified she notified the facility after an in-service meeting when they described if staff observed something like abuse they needed to tell. Staff H stated she went in right after the in-service and told as that in-service training gave her the understanding and courage to do so. Staff H could not recall specifically, but she thought the Resident #30 situation happened the first night of 10/4/19 right around midnight or 1:00 a.m. Staff H recalled the situation with Resident #30 more laid back but then the next night she remembered thinking she couldn't do it anymore and needed to say something. Staff H reported she thought the situations with Resident #80 and #90 occurred on the same night after the night with Resident #30, (10/5/19). Staff H stated it was a bad night. Staff H reported both Resident #80's and Resident			

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	#90's events occurred late in the shift around 3:00 to 4:00 a.m. Staff H responded she did not report her concerns to the charge nurse, Staff K as he was laid back, extremely quiet, and Staff H thought he would just tell her to go to the DON or the Administrator. Staff K responded she did not report her concerns to the day shift workers either. On 2/26/20 at 2:05 p.m. the Administrator responded she first became aware of the allegation of abuse from Staff H regarding Staff G after the October 2019 in-service (10/16/19). The Administrator stated she spoke with Staff H via phone and made notes from the call then asked Staff H to write out what she was reporting. The Administrator stated Staff H brought the written statement in the next day. Resident Record Review At the time of survey 2/17/20, all 3 residents named in the allegation of abuse 10/16/19 (Resident #30, #80, #90) had since passed away. Review of the clinical records for Resident #30, Resident #80, and Resident #90 revealed the records contained no documentation pertaining to the allegations of abuse made or the investigations conducted.			

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	The Online Abuse Reporting for the Facility revealed no reports made 10/4/19 or 10/5/19 when Staff H first identified a concern related to Staff G's care of Residents #30, #80, #90. Facility Policy Review The facility policy revised 4/1/17 titled Abuse Prevention, Identification, Investigation, and Reporting Policy included the following documentation: Identification, Investigation, and Reporting of Abuse - - Dependent adult abuse is defined under Iowa law as: Point 1. Any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances. d. Neglect of a dependent adult means deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or physical or mental health. - Resident Abuse under the Federal Certification Guideline is defined as: Point 1. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a			

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	caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Point 9. Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or mental illness. - Reporting: All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections & Appeals not later than two (2) hours after the allegation is made. All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections & Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation			

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Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **#8022**	**AMENDED 11/19/20**			**Date:** **March 17, 2020**
Facility Name: **Manilla Manor**		**Survey Dates:** **February 17-27, 2020**		
Facility Address/City/State/Zip **146 North 5th Street** **Manilla, IA 51454**				
	SB			
Rule or Code Section	**Nature of Violation**	**Class**	**Fine Amount**	**Correction date**
	result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury. **FACILITY RESPONSE:**			

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Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).