Number 5776				Report June 27	
Facility name Corydon Specialt	y Care		Survey dates May 23, 202	5 2- June 16, 20	22
Facility address 745 East South S	treet				
City Corydon, IA 500	60	MW			
Rule or Code Section	N	lature of Violation	Class	Fine Amount	Correction Date
58.43(135C)	resident shall recent times and shall be and verbal abuse, injury. Each reside physical restraints in writing by a phy when necessary in from injury to the restraints may be a personnel who pro- physician; and in t individual when on authorized by a disabilities profess modification sessi normative situation	Resident abuse prohibited. Each ive kind and considerate care at all free from mental, physical, sexual, exploitation, neglect, and physical ent shall be free from chemical and except as follows: when authorized visician for a specified period of time; an emergency to protect the resident resident or to others, in which case uthorized by designated professional omptly report the action taken to the the case of an intellectually disabled redered in writing by a physician and designated qualified intellectual ssional for use during behavior ons. Mechanical supports used in ns to achieve proper body position ot be considered to be a restraint. (II)	Ι	\$500.00 Held in Suspension	Upon Receipt
	interviews, and f failed to ensure a considerate care restraints. A con #1 who was tied wheelchair to ke	l record review, staff facility investigation, the facility each resident received kind and and to be free from physical cern was identified for Resident with a sheet while in ep restrained for staff e facility reported census was			

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	Findings include	:				
	 (MDS) assessmed date of 10/28/21. Interview for Medindicating a sever Resident #1 requirements for the sever restraints included Non-All cerebrovascular and hemiplegia. Review of care provide for falls. There waddressing restle restraints. According to the Abuse Protocols 1) Abuse included unreasonably con 2) Mandatory Reprocedure include and Allegations up the chain of con b) The charge 	es the willful act to nfine a resident. eporting Abuse Investigation les: are to be reported immediately				

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	documentation re d) During the suspend or termi f) After the fac investigation, the return to work if investigation did e) If returned to separate the staff there is no invest department comp unfounded. According to Sta Staff C indicated restless and not r her back to the d nurses, Staff A a was in and out of point saw Staff Resident #1, say their work done a bed sheet. Staff minutes and upo Staff A and Staff with a bed sheet. they were doing, returned a few m observed in her v	shall collect any supporting elative to the incident. investigation, the facility shall nate the accused staff. cility completes their e staff member accused may the nursing facilities I not find founded abuse. to the facility, continue to f member from the victim until tigation determined or the olete the investigation and is off C's statement from 12/11/21, I that evening, Resident #1 was ready for bed, so they brought ining room and informed the nd Staff B. Staff C stated she f the dining room and at one A and Staff B standing next to ing they were not going to get and asking for a gait belt then a C left the dining room for a few n returning, witnessed both f B at Resident #1's wheelchair Staff C could not see what but after she left the area and ainutes later, Resident #1 was wheelchair with a sheet crossed and tied to the chair arms,			

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	immediately info contacted the DC investigation. The the sheet and the the resident was assisted to bed. According to Sta 12/12/2022, Staff reported that the and tied the reside room. Staff P we and could see the white bed sheet to it was also wrapp instructed to unti- to untie the bed sheet woven around the According to Sta Staff A indicated and restless that over her to provi- the bed sheet wa did not confirm of tying the bed sheet she was involved Staff A stated I her, but I didn't t	rom getting up. Staff C ormed another CNA who DN and initiated an he CNA was instructed to untie in took Resident #1 to room and no longer restless and was off P's statement from f P indicated after Staff C nurses had taken a bed sheet lent to wheelchair in the dining ent and observed Resident #1 e resident struggling against the that wrapped around chest and bed legs. Staff C and Staff were is the resident. Staff C struggled sheet especially how it was he resident. Aff A's statement from 12/12/21, a Resident #1 had been agitated evening and they placed a sheet de comfort. When informed s tied to the chair arms, Staff A or deny she was involved with het. On 12/15/21 when asked if d with restraining Resident #1, helped with getting a blanket on ie it on. When asked why they Staff A stated it was to keep			

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ty Care	*	-	Survey dates May 23, 2022- June 16, 2022		
treet					
60	MW				
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out of the chair". According to Sta Staff B indicated a sheet over Residisrobing and the up because she helot. On 12/12/21 suspended and re- were not restrain When told the she wheelchair arms but asked if she finish her schedu Observation of a Resident #1 was bed sheet wrappe and around the less sheet was tied to In an interview of Director of Nurs evening of 12/11	aff B's statement from 12/11/21, I she was involved with putting ident #1 because she had been e sheet may have gotten tangled had been restless and moving a I Staff B was informed of being esponded by saying "her hands hed". heet had been tied to the , Staff B did not respond to this would be able to come back to hed shifts. I photo taken at the time tied in the wheelchair showed a ed between the resident's legs egs. The the ends of the bed the back rest of the wheelchair. on 5/23/22 at 3:55 p.m. the ing (DON) stated on the /21 she received a call				
,	treet 60 her from sliding dycem and one w out of the chair". According to Sta Staff B indicated a sheet over Rest disrobing and the up because she h lot. On 12/12/21 suspended and re were not restrain When told the sh wheelchair arms but asked if she finish her schedu Observation of a Resident #1 was bed sheet wrappe and around the la sheet was tied to In an interview of Director of Nurs evening of 12/11 informing her th	treet 60 MW Nature of Violation her from sliding out of her chair. Even with the dycem and one way glide, she was still sliding out of the chair". According to Staff B's statement from 12/11/21, Staff B indicated she was involved with putting a sheet over Resident #1 because she had been disrobing and the sheet may have gotten tangled up because she had been restless and moving a lot. On 12/12/21 Staff B was informed of being suspended and responded by saying "her hands were not restrained". When told the sheet had been tied to the wheelchair arms, Staff B did not respond to this but asked if she would be able to come back to finish her scheduled shifts. Observation of a photo taken at the time Resident #1 was tied in the wheelchair showed a bed sheet wrapped between the resident's legs and around the legs. The the ends of the bed sheet was tied to the back rest of the wheelchair. In an interview on 5/23/22 at 3:55 p.m. the Director of Nursing (DON) stated on the evening of 12/11/21 she received a call informing her there was an allegation of abuse	treetMay 23, 20treet60MW60Nature of ViolationClassher from sliding out of her chair. Even with the dycem and one way glide, she was still sliding out of the chair".ClassAccording to Staff B's statement from 12/11/21, Staff B indicated she was involved with putting a sheet over Resident #1 because she had been disrobing and the sheet may have gotten tangled up because she had been restless and moving a lot. On 12/12/21 Staff B was informed of being suspended and responded by saying "her hands were not restrained".When told the sheet had been tied to the wheelchair arms, Staff B did not respond to this but asked if she would be able to come back to finish her scheduled shifts.Observation of a photo taken at the time Resident #1 was tied in the wheelchair showed a bed sheet wrapped between the resident's legs and around the legs. The the ends of the bed sheet was tied to the back rest of the wheelchair.In an interview on 5/23/22 at 3:55 p.m. the Director of Nursing (DON) stated on the evening of 12/11/21 she received a call informing her there was an allegation of abuse	June sy Care Survey dates May 23, 2022- June 16, 7 foo MW 60 MW According out of her chair. Even with the dycem and one way glide, she was still sliding out of the chair". According to Staff B's statement from 12/11/21, Staff B indicated she was involved with putting a sheet over Resident #1 because she had been disrobing and the sheet may have gotten tangled up because she had been restless and moving a lot. On 12/12/21 Staff B was informed of being suspended and responded by saying "her hands were not restrained". When told the sheet had been tied to the wheelchair arms, Staff B did not respond to this but asked if she would be able to come back to finish her scheduled shifts. Observation of a photo taken at the time Resident #1 was tied in the wheelchair showed a bed sheet wrapped between the resident's legs and around the legs. The the ends of the bed sheet was tied to the back rest of the wheelchair. In an interview on 5/23/22 at 3:55 p.m. the Director of Nursing (DON) stated on the evening of 12/11/21 she received a call	

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	investigation, tw were identified a two nurses were outcome of the fa A and Staff B ad over Resident #1 denied tying the The DON stated she concluded R in her wheelchair wheelchair arms was hesitant to id Staff B or both in DON stated the i with their corpor team determined under conditions supervision. Sta her contract was In an interview of Administrator sta contacted by her allegation of abu two nurses. It w been restrained in sheet. The DON	ring the course of her o nurses, Staff A and Staff B, s the alleged perpetrators. The suspended pending the acility investigation. Both Staff mitted to placing the bed sheet and both Staff A and Staff B bed sheet to the wheelchair. following her investigation, esident #1 had been restrained r with a bed sheet tied to the and that it was abuse, however dentify whether it was Staff A, nvolved as the perpetrator. The nvestigation was discussed rate management team and the Staff A could return to work which provided better ff B was an agency nurse and up and not renewed. on 5/24/22 at 2:50 p.m. The ated on 12/11/21 she was DON and informed of an se involving Resident #1 and as alleged that Resident #1 had n her wheelchair using a bed interviewed staff present that n finishing the interviews, she eident with their Human ement team. It was determined			

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	 and Staff B was The Administrate they had to support responded Staff. suitable to return was asked if a beter resident in her words staff, would shaff, would shaff, would shaff, would shaff, would shaff, would shaff, would shaff a witness that ever restrained in her stated she was average picture, but had a ninstructed to delea Administrator state as evidence. According to the summary, an allear restrained in her was made on the p.m. The DON con Resident #1 was Staff A, who acter #1 was restrained. Staff restless and discontration of the state of the DON stating restrained. Staff restless and discontration of the state o	aurn to work with conditions believed to be the perpetrator. or was asked what evidence ort that conclusion and she A was not cruel and was a to work. The Administrator ed sheet was used to restrain a heelchair for the convenience he consider that abuse. The ated yes. The Administrator was aware of a picture taken by ening, showing the resident wheelchair. The Administrator ware Staff C had taken a not seen it. Staff C was ete the photo. The ated she did not keep the photo e facilities investigative egation that Resident #1 was wheelchair with a bed sheet evening of 12/11/21 at 8:45 ontacted the facility to ensure not restrained. She spoke with ed unaware of whether Resident d or not. Then Staff B called Resident #1 had not been B stated Resident #1 had been obing and a sheet was placed reason. The following day			

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	 Resident #1 rest untied the sheet had Staff A and investigation. T Staff A and Staff regarding care a Written offense Staff B employn staff regarding the constitutes a rest Staff A and Staff but does not pro- investigation. According to an Administrator free Human Resource determined Staff suspension under *Staff A will mo- receive more sug *Staff A will mo- at this time until *Additional Rel- will be assigned 1/4/22. 	een the one who noticed rained with a bed sheet and from the wheelchair. The DON Staff B suspended pending the he summary indicated both f B would be reeducated nd treatment of residents. were added to the Staff A and nent file. Reeducation for all he use of restraints and what traint. The summary implies f B are suspected perpetrators, vide a conclusion to their email addressed to the facility om the Regional Director of es dated 12/16/21, it was f A would be removed from er the following conditions: ove to day shifts where she will pervision. t work in the memory care unit approved by the Administrator. ias courses on resident abuse to Staff A to be completed by ghly encouraged.			

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	HR will have we A. *The Administra check on Staff A days. *The Administra	ator and Regional Director of beekly conversations with Staff ator and DON will visually a throughout her shift for 30 ator will check with residents in ice weekly for 30 days. SE:			

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58.28(3)	supervision to prote or elements in the of DESCRIPTION: Based on record refacility failed to president who was getting up frequent room and failed to were physically ag for 3 of 4 incident #4 & #5) The fact Findings include: According to Resi (MDS) assessment of 10/5/21, Reside mental status (BIN severely impaired required extensive transfers, dressing needs. Resident #6 Non Alzheimer's of	sident shall receive adequate ect against hazards from self, others, environment. (I, II, III) eview and staff interviews, the rovide adequate supervision of a at high risk for falls and who was itly unassisted while in the dining oproperly supervise residents who ggressive towards other residents s reviewed. (Residents #2, #6, #9, ility reported census was 59. dent #6's Minimum Data Set t with assessment reference date ent #6 had a brief interview for <i>MS</i>) score of 5 indicating a cognitive status. Resident #6 e assistance with bed mobility, t, toilet use and personal hygiene 6's diagnosis included Alzheimer's, dementia, congestive heart failure, y and chronic obstructive	1	\$8750.00 Held in Suspension	Upon Receipt

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	risk for falls with a making sure Resid footwear, provided clutter, provided g of recliner, provid wheelchair and pla decrease risk for in According to incid 11/27/21, Residen occurred in Nover dated 11/27/21 at dinner time and th several visitors en doorbell. Residen several occasions redirected back to Resident #6 was d #6 had a hematom hip appeared out of pain when touched Resident #6 was s evaluation. According to the H Assessment dated an acute fracture of also diagnosed wir bacterial pneumor and end stage lung made for Resident	of care indicated a focus area on interventions which included lent #6 was wearing proper d a safe environment without grippy strips at bedside and in front ed dycem for her recliner ace a black mat at bedside to njury. dent reports from 7/1/21 through t #6 had 17 recorded falls. 5 falls nber alone. The incident report 4:20 p.m. indicated it was near e dining room was noisy with tering the building and using the t #6 had got up unassisted on to answer the doorbell and was her chair each time. At 4:20 p.m. discovered on the floor. Resident a above her right eye and her left of socket. Resident #6 screamed in d. The physician was notified and ent out to the emergency room for Emergency Room Note: 11/27/21, Resident #6 sustained of the pubic ramus (pelvis) and was th pulmonary edema, possible hia, end stage Alzheimer's disease g disease. The family decision was t #6 to return to the facility with a care. The emergency room				

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	U	center given this new fracture. ually expired on 12/5/21.			
	at the nurse's stati- unassisted in the c one moment Resid turned around she Resident #6 had b answering the doc Staff L stated she were at the time o aides that evening probably needed a staff and other res have suffered.	nurse, stated on 11/27/21 she was on when Resident #6 stood up lining room and fell. Staff L stated dent #6 was sitting and when she was on the floor. Staff L stated een up unassisted multiple times or bell, which was near her table. was uncertain where the aides f the fall, noting they only had 2-3 . Staff L stated Resident #6 a 1:1. but there was not enough idents care and supervision would a 6/16/22 at 1:07 p.m. Staff M,			
	certified nurse aid beyond 2:00 p.m., because she recall the dining room at had just fallen. St aides working wh	e, stated she usually does not work but on 11/27/21 she must have, s walking down hall three towards nd coming upon Resident #6, who aff M stated there were only three ich is usual, but not adequate to ds, noting it takes at least four.			
	certified nurse aid 11/27/21 she recal the dining room w N stated there wer	a 6/16/22 at 12:55 p.m. Staff N, e, stated on the afternoon of lled walking down hall 4 towards when Resident #6 had fallen. Staff re only three aides working that stated she was assigned hall 4 and ot on that hall.			

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	According to Resident #2's Minimum Data Set (MDS) assessment with assessment reference date of 8/17/21, Resident #2 had a brief interview for mental status (BIMS) score of 4 indicating a severely impaired cognitive status. Resident #2 was independent with bed mobility and transfers and required limited assistance with dressing, toilet use and personal hygiene needs. Resident #2's diagnosis included Alzheimer's and Non Alzheimer's dementia and she resided on a memory care unit. Resident #2's plan of care indicates a focus area of impaired cognitive function/dementia or impaired thought process related to dementia, noting Resident #2 may strike out at staff, use profanity and on 12/11/20 and 7/1/21 was hit in the face by Resident #9. Interventions 12/11/20 included keep Resident #2 and Resident #9 separated. According to Resident #9's Minimum Data Set (MDS) assessment with assessment reference date of 9/14/21, Resident #9 had a brief interview for mental status (BIMS) score of 3 indicating a severely impaired cognitive status. Resident #9 was independent with bed mobility and transfers and required minimal assistance with dressing, toilet use and personal hygiene needs. Resident #9's diagnosis included Alzheimer's and Non Alzheimer's dementia				

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	impaired cognitive disease noting Rest the face on 12/11// Interventions 12/1 and Resident #9 set sundowning and s and may need som In an interview on certified nurse aid working on the me was sitting at a tabrambling. Resider her to shut up and the face. Staff H se and informed the face staff H se and informed the face of the his of the care plan in from one another. According to Resi (MDS) assessmen of 12/30/21, Resider mental status (BIN severely impaired independent with required limited as extensive assistant.	dent #4's Minimum Data Set t with assessment reference date left with das strick Resident #4's diagnosis included keep the second consistence with dressing and cognitive status. Resident #4' was bed mobility and transfers, ssistance with dressing and ce with toilet use and personal estident #4's diagnosis included				

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		MW				
			-			
Rule or Code Section	N	lature of Violation	Class	Fine Amount	Correction Date	
	Alzheimer's and N resided on a memo	Ion Alzheimer's dementia and he ory care unit.				
	According to Resident #5's Minimum Data Set (MDS) assessment with assessment reference date of 11/25/21, Resident #5 had a brief interview for mental status (BIMS) score of 3 indicating a severely impaired cognitive status. Resident #5 required limited assistance with bed mobility, transfers and dressing and required extensive assistance with toilet use and personal hygiene needs. Resident #5's diagnosis included Alzheimer's and Non Alzheimer's dementia and she resided on a memory care unit. Resident #5's plan of care indicates a focus area on potential for physical aggression related to dementia with an intervention including when Resident #5 is agitated with another resident, intervene and redirect resident to another activity. In an interview on 6/1/22 at 12:10 p.m. Staff I, certified nurse aide, stated she and another aide were working on the memory care unit on 1/29/22. Resident #5 had just returned after being out with family for a week. At 4:10 p.m. Resident #4 was standing in the hallway near the dining room, when without notice, Resident #5 approached him and struck him in his abdomen. Staff I immediately					
	back to her room a room. Staff I state charge nurse. A f	residents, sending Resident #5 and Resident #4 to a chair near his ed she reported the incident to the ew minutes later, at 4:18 p.m., lated out of her room with her				

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	Nature of Violation wheel walker and rammed the walker into Resident #4. Staff I stated she was standing next to Resident #4 at the time. The residents were again separated and Resident #4 was moved to a chair closer to the dining room. Resident #5 returned to her room. Minutes later at 4:25 p.m. Resident #5 returned to the hallway and as Resident #4 stood, Resident #5 struck Resident #4's arm. Residents were separated and the nurse notified. At that time they added an intervention for staff to remain with Resident #4 when in the dining room and to keep Resident #4 away from Resident #5 and for staff to provide stand by supervision of Resident #5 when she is in the dining room. Staff I stated there were no further incidents that afternoon. FACILITY RESPONSE:				