Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number 10308			**Report date** **April 18, 2024**
Facility name Blackhawk Life Care Center		**Survey dates** **March 19, 2024 - April 2, 2024**	
Facility address 73 West 5th Street			
City Lake View	**JB**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
56.12	**481—56.12(135C) Class I violation as a result of multiple lesser violations.** The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.	I	**7750.00** **Held in Suspension**	**Upon Receipt**
58.43(2)	**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. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve			

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	proper body position and balance shall not be considered to be a restraint. (II) **58.43(2)** Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)			
58.43(9)	**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 observation, interviews, record, and policy review, the facility failed to immediately report allegations of abuse to the proper authorities for 2 of 5 residents reviewed (Residents #2 and #15). On 1/26/24, Staff G, Certified Nurse Aide (CNA), reported on the overnight shift of 1/25/24-1/26/24, Resident #2 hit, kicked, and spit at the staff. Staff F, CNA, took over for Staff G, and proceeded to slap Resident #2 on the face, step on her foot, and "manhandled" her into the wheelchair, sometime around 12:30-1:15 AM on 1/26/24. Staff G failed to report the alleged abuse to the Administration until later in the morning of 1/26/24. While investigating the situation between Staff F and Resident #2, Staff P, Registered Nurse (RN), reported approximately 3 months before, she			

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	had a similar situation with Staff F. Staff F told Staff P as Resident #15 became combative, he tapped her a little hard when he tried to get her dressed for bed. Staff P denied reporting the incident to the Administration or to the state authorities. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated 2/26/24, listed an admission date of 12/7/23. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive deficits. Resident #2 required total staff assistance for toilet use, showering and dressing. She required partial assistance with toilet transfers. The MDS described Resident #2 as frequently incontinent of urine and bowel. The MDS included diagnoses of Alzheimer's disease, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), malnutrition (inadequate intake of nutrients) and anxiety disorder. The Care Plan included the following Focuses: a. Revised 3/3/24: Resident #2 needed assistance with activities of daily living (ADLs) and had a history of falls. The Interventions indicated the following. - Resident #2 had anti-roll back brakes on her wheelchair			

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	- She could pivot transfer with the assistance of one. - The staff used a pull alarm attached to the wheelchair and to her clothing to alert them when she tried to self-transfer. b. Revised 1/31/24: Resident #2 cognitive decline made it difficult at times for the staff to manage her behaviors or health condition. The Interventions indicated the staff would assist her family to find a specialized memory unit for placement. c. Revised 2/3/24: Resident #2 had a behavioral problem related to her Alzheimer's dementia, mood disturbance, and agitation. The Interventions reflected - Resident #2 had a Wander Guard alarm for safety due to history of exit seeking. - Monitor Resident #2's behavior episodes and attempt to determine the underlying causes such as location, time of day, persons involved and situations. On 3/19/24 at 1:51 PM, observed Resident #2 in her wheelchair in the dining room area. She appeared calm but did occasionally attempt to get out of her chair. The observation revealed an alarm clipped to her shirt and hanging from her wheelchair. At 3:36 PM witnessed her sleeping in her wheelchair and at 4:00 she still appeared calm while sitting in her wheelchair in dining area.			

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	The Facility Investigation dated 1/26/24 reflected Staff G, CNA, voiced concerns to Staff T, RN DON, regarding the occurrences during the overnight shift. Staff G talked further with administration regarding her concerns. During discussion Staff G stated Resident #2 sat in the living area in the front of the facility. Staff G and Staff F tried different interventions to help Resident #2 calm down. Staff G expressed Resident #2 stated she would go to the bathroom, so they assisted her to the bathhouse. While in the bathhouse Staff G expressed Resident #2 went to spit on her and Staff F. Staff G stepped back. Resident #2 continued to hit and kick at them. At this time Staff F bent down to Resident #2's level and sternly asked her not to spit. Staff F then raised his hand and tapped Resident #2 on her left cheek. When asked to further explain, Staff G expressed, she wasn't sure if she should call it a tap or a smack or what. She was sure that his hand contacted Resident #2's face. Staff G felt like Staff F may have stepped on Resident #2's foot, but with her hitting and kicking, it was hard to explain everything that happened. The nursing staff completed a skin assessment on 1/26/24, that revealed no new skin areas on Resident #2's left cheek/and or face with no indication of injury to Resident #2's left cheek. When Resident #2 visited with the Administration the morning of 1/26/24, she explained she had a good night and described all the helpers as so nice. Resident #2 worked on a puzzle during that time			

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	but couldn't record any specific details of the night when asked. When interviewing Staff F, CNA, he validated he worked the night before. Staff F verbalized that Resident #2, spit, hit, and screamed at the staff. He expressed they had tried the interventions from her activity book, bathroom, snack, 1 on ls, but Resident #2 wouldn't calm down. Staff F stated he attempted to hold Resident #2's hands, when she expressed she would "kick him". Staff F stated when asked, "Yes, I tapped her (Resident #2) on the face and said to her, can you please stop?" Staff F described the tap as very soft with "no power behind it." Discussion throughout the conversation included utilizing his walkie for the charge nurse at the time, and Staff F verbalized understanding. At the end of the conversation Staff F stated, "I'm sorry - I wasn't trying to hurt her." Staff U, RN DON, and Staff T expressed they didn't have any specific resident concerns with Staff F. Staff U expressed that Staff F continued to need education regarding skills at times. On 3/21 at 3:52 PM. Staff G said the incident with Staff F and Resident #2 "happened so fast." Resident #2 was being difficult, hitting, and spitting which was not unusual for her. Staff G took her to the bathhouse to toilet her and she asked Staff F to assist. As Resident #2 sat on the toilet, she went to spit on Staff F. He got down to eye level with her and said "we do not spit." The resident told him to			

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	"go to hell." He went back to eye level with the resident again, said "fuck it," and slapped her on the check. When Resident #2 tried to kick him in the genitals, Staff F stepped on one of her feet to keep her from kicking him. Staff G got between the two of them and Resident #2 said "I'd rather deal with you, because I don't want to be black and blue." Staff G got Resident #2 up from the toilet, pulled her pants up, Staff F then grabbed the back of Resident #2's pants, "whipped" her around, and swung her into the wheelchair. The chair tipped back and if it hadn't had the anti-tip bar on the back, she could have fell backwards in her chair. Staff G said she got Resident #2 to the dining room and tended to her the rest of the night. About an hour after the incident, Resident #2 went to sleep in her room. Staff G said that hours went by before she saw the nurse. Staff F followed Staff G around throughout the rest of their shift and asked; "are you going to tell on me?" Staff G said she didn't get a chance to say anything to the nurse with Staff F always behind her. Staff G said the slap was not hard enough to leave a bruise, but it did leave a red mark on Resident #2's check that disappeared by morning. Staff G said she witnessed Staff F lose his temper at residents, as he would yell at them. She being afraid of Staff F that she could be retaliated against for reporting the incident.			

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	On 3/20/24 at 12:40 PM, Staff F said that Resident #2 was agitated the "majority of the time." He said that on the overnight shift from 1/25/24 - 1/26/24, he asked the nurse if she could give her some medication to help her calm down and the nurse responded she already gave her an Ativan (antianxiety medication) earlier in the evening and couldn't give her any more. Staff F said he went to help Staff G because she let Resident #2 hit and kick her. He told her to get out of the way and let him take over. Resident #2 spit in his face, clawed at him, and flailed her arms. While Resident #2 sat on the toilet, she threatened to kick him between the legs, so he put his foot on top of her foot and placed it down. She started to claw more and spit in his face so he tried to talk to her because "she can understand." Staff F said he "tapped" her on the face real soft, but it didn't work, so he told Staff G to take over. He said they put Resident #2 back into her wheelchair and wheeled her out to the nurse's station in front of the nurse. Staff F remembered being upset with the nurse because she didn't help them with Resident #2. He said the nurse saw them both scratched up pretty good, but the scratches happened when they cared for a different agitated resident earlier that evening. Staff F described Staff G as quiet and withdrawn, she just let Resident #2 beat her up and that's why he decided to take over, he said they shouldn't just stand there letting residents hit and kick them. Staff F said he grabbed			

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	Resident #2's hands and held them down to get her to stop hitting but she didn't care. Staff F said the nurse took Resident #2 back to her room until she went to sleep while he and Staff G answered call lights the rest of the night. 2. Resident #15's MDS assessment dated 2/27/24 identified a BIMS score of 1, indicating severely impaired cognition. Resident #15 required total assistance from staff for lower body dressing, toilet hygiene, and putting on footwear. She displayed verbal behavioral symptoms directed toward others such as screaming and cursing 1-3 days a week. She did not exhibit physical behavioral symptoms such as hitting, kicking and scratching during the week-long look-back period. The MDS included diagnoses of Alzheimer's Disease, muscle wasting (loss of muscle mass and strength), and chronic obstructive pulmonary disease (long-term lung issues). The Care Plan Focus revised 1/23/24, indicated Resident #15 would at times refuse or resist care. At times, she cussed at the staff or said unpleasant words or statements to the staff. The Interventions directed the staff to monitor and record occurrence of target symptoms. On 3/27/24 at 5:50 PM, Staff P, RN, said that she worked the 6p-6a shift and she worked with Staff F several times. She didn't personally hear Staff F			

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	raise his voice or get angry at residents, but heard from other staff that he would "get in their face." She said one night, Staff F came to her and told her that he may have tapped a little hard on a resident's shoulder. He told her as he tried to get a resident changed for the night, she swung at him. He said he tried to distract her to get her attention and "tapped" her shoulder. Staff P immediately assessed the resident's shoulder and didn't see any marks. She said he got frustrated sometimes and she would separate him from the residents. She didn't remember a date but thought it happened within the past 3 months and with Resident #15. Staff P did not remember if she had reported this incident to the administration. On 4/1/24 at 4:30 PM, Staff G said she worked with Staff F one night when he came out Resident #15's room and told the nurse that he "tapped" Resident #15 while getting her ready for bed. She didn't know if the nurse assessed Resident #15 or what happened afterwards. According to the Daily Assignment Sheets on the 10 PM - 6 AM shift on 12/19/23, Staff P, Staff G, and Staff F all worked that shift together. The Nurses Note dated 12/20/23 at 2:32 AM, Staff P documented about Resident #15 being combative with care, hitting, and scratching staff that evening.			

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	On 4/1/24 at 10:04 AM the Administrator said she expected Staff G to report the alleged abuse immediately. She added she addressed that concern as soon as she learned about it on the morning of 1/26/24. She educated all the staff that day that they must report alleged abuse immediately so the alleged abuser could be separated from the residents. She said that she had no knowledge of anger issues with Staff F towards residents before this incident. She denied knowing about any incident between Resident #15 and Staff F. On 3/27/24 at 12:33 PM, Staff T, Registered Nurse (RN) and Director of Nursing (DON), said Staff G went home after she finished her shift at 6:00 AM on 1/26/24 and then later that morning, she sent Staff T a text. The note said she needed to talk to her about the incident. She asked Staff G to come back in to the facility and write up a statement. She said she didn't know what time of night the incident happened but "it was early enough in the shift" that Staff G should have let them know right away so they could have separated Staff F from the residents. During a confidential interview, Staff Z said they went to the DON and the Administrator with concerns about Staff F's anger issues and how he			

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	would yell at the residents. Staff Z said that they didn't take the concerns seriously and didn't investigate. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy revised October 2023, All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. In addition, all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and/or misappropriation of property 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 would be reported to the Iowa Department of Inspections and Appeals no later than two (2) hours after the allegation was made. **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. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a			

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	specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II) **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) **481—52.6(235E) Separation of victim and alleged abuser.** Upon receiving a claim of dependent adult abuse of a dependent adult in a facility or program, the facility or program shall separate the victim and the alleged abuser immediately and shall maintain that separation until the department's abuse investigation is completed and the abuse determination is made. NOTE: Facilities that participate in the federal Medicare or Medicaid program may be subject to			

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	additional federal requirements regarding separation. Based on observation, interviews, record and policy review, the facility failed to immediately separate an alleged abuser from residents for 2 of 5 residents reviewed (Residents #2 and #15). On 1/26/24, when Staff G, Certified Nurse Aide (CNA), reported Staff F, CNA (alleged abuser), slapped Resident #2 because she hit, kicked, and spit at the staff. Staff G failed to intervened at the time of incident to prevent further emotional or physical damage to Resident #2. In addition, Staff G failed to report the incident until a few hours after Staff F and her shift. This allowed Staff F to work with other venerable residents until the end of their shift at 6:00 AM. During the investigation of the incident with Resident #2 and Staff F, Staff P reported a similar situation with Staff F. One night approximately 3 months before, Staff F reported he may have tapped Resident #15 a little hard when he tried to get her dressed for bed, when she was combative. When Staff P failed to notify the Administration or separate Staff F from the residents, this allowed him to tap another resident. Staff P reported she didn't remember reporting the incident to the Administration. Findings include:			

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	1. Resident #2's Minimum Data Set (MDS) assessment dated 2/26/24, listed an admission date of 12/7/23. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive deficits. Resident #2 required total staff assistance for toilet use, showering and dressing. She required partial assistance with toilet transfers. The MDS described Resident #2 as frequently incontinent of urine and bowel. The MDS included diagnoses of Alzheimer's disease, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), malnutrition (inadequate intake of nutrients) and anxiety disorder. The Care Plan included the following Focuses: a. Revised 3/3/24: Resident #2 needed assistance with activities of daily living (ADLs) and had a history of falls. The Interventions indicated the following. - Resident #2 had anti-roll back brakes on her wheelchair - She could pivot transfer with the assistance of one. - The staff used a pull alarm attached to the wheelchair and to her clothing to alert them when she tried to self-transfer. b. Revised 1/31/24: Resident #2 cognitive decline made it difficult at times for the staff to manage her behaviors or health condition. The Interventions			

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	indicated the staff would assist her family to find a specialized memory unit for placement. c. Revised 2/3/24: Resident #2 had a behavioral problem related to her Alzheimer's dementia, mood disturbance, and agitation. The Interventions reflected - Resident #2 had a Wander Guard alarm for safety due to history of exit seeking. - Monitor Resident #2's behavior episodes and attempt to determine the underlying causes such as location, time of day, persons involved and situations. On 3/19/24 at 1:51 PM, observed Resident #2 in her wheelchair in the dining room area. She appeared calm but did occasionally attempt to get out of her chair. The observation revealed an alarm clipped to her shirt and hanging from her wheelchair. At 3:36 PM witnessed her sleeping in her wheelchair and at 4:00 she still appeared calm while sitting in her wheelchair in dining area. The Facility Investigation dated 1/26/24 reflected Staff G, CNA, voiced concerns to Staff T, Registered Nurse (RN) Director of Nursing (DON), regarding the occurrences during the overnight shift. Staff G talked further with administration regarding her concerns. During discussion Staff G stated Resident #2 sat in the living area in the front of the facility. Staff G and Staff F tried different interventions to			

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	help Resident #2 calm down. Staff G expressed Resident #2 stated she would go to the bathroom, so they assisted her to the bathhouse. While in the bathhouse Staff G expressed Resident #2 went to spit on her and Staff F. Staff G stepped back. Resident #2 continued to hit and kick at them. At this time Staff F bent down to Resident #2's level and sternly asked her not to spit. Staff F then raised his hand and tapped Resident #2 on her left cheek. When asked to further explain, Staff G expressed, she wasn't sure if she should call it a tap or a smack or what. She was sure that his hand contacted Resident #2's face. Staff G felt like Staff F may have stepped on Resident #2's foot, but with her hitting and kicking, it was hard to explain everything that happened. The nursing staff completed a skin assessment on 1/26/24, that revealed no new skin areas on Resident #2's left cheek/and or face with no indication of injury to Resident #2's left cheek. When interviewing Staff F, CNA, he validated he worked the night before. Staff F verbalized that Resident #2, spit, hit, and screamed at the staff. He expressed they had tried the interventions from her activity book, bathroom, snack, 1 on ls, but Resident #2 wouldn't calm down. Staff F stated he attempted to hold Resident #2's hands, when she expressed she would "kick him". Staff F stated when asked, "Yes, I tapped her (Resident #2) on the face and said to her, can you please stop?" Staff F			

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Facility Administrator Date

Citation Number 10308			**Report date** **April 18, 2024**
Facility name Blackhawk Life Care Center		**Survey dates** **March 19, 2024 - April 2, 2024**	
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City Lake View	**JB**		

Rule or Code Section	Nature of Violation	**Class**	**Fine Amount**	**Correction Date**
	described the tap as very soft with "no power behind it." On 3/21 at 3:52 PM. Staff G said the incident with Staff F and Resident #2 "happened so fast." Resident #2 was being difficult, hitting, and spitting which was not unusual for her. Staff G took her to the bathhouse to toilet her and she asked Staff F to assist. As Resident #2 sat on the toilet, she went to spit on Staff F. He got down to eye level with her and said "we do not spit." The resident told him to "go to hell." He went back to eye level with the resident again, said "fuck it," and slapped her on the check. When Resident #2 tried to kick him in the genitals, Staff F stepped on one of her feet to keep her from kicking him. Staff G got between the two of them and Resident #2 said "I'd rather deal with you, because I don't want to be black and blue." Staff G got Resident #2 up from the toilet and pulled her pants up. Then Staff F grabbed the back of Resident #2's pants, "whipped" her around, and swung her into the wheelchair. The chair tipped back and if it hadn't had the anti-tip bar on the back, she could have fell backwards in her chair. Staff G said she got Resident #2 to the dining room and tended to her the rest of the night. About an hour after the incident, Resident #2 went to sleep in her room. Staff G said that hours went by before she saw the nurse. Staff F followed Staff G around throughout the rest of their shift and asked; "are			

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	you going to tell on me?" Staff G said she didn't get a chance to say anything to the nurse with Staff F always behind her. Staff G said the slap was not hard enough to leave a bruise, but it did leave a red mark on Resident #2's face but it disappeared by morning. Staff G said she witnessed Staff F lose his temper at residents, as he would yell at them. She being afraid of Staff F that she could be retaliated against for reporting the incident. On 3/20/24 at 12:40 PM, Staff F described Resident #2 as agitated the "majority of the time." He said that on the overnight shift from 1/25/24 - 1/26/24, he asked the nurse if she could give her some medication to help her calm down and the nurse responded she already gave her an Ativan (antianxiety medication) earlier in the evening and couldn't give her any more. Staff F said he went to help Staff G because she let Resident #2 hit and kick her. He told her to get out of the way and let him take over. Resident #2 spit in his face, clawed at him, and flailed her arms. While Resident #2 sat on the toilet, she threatened to kick him between the legs, so he put his foot on top of her foot and placed it down. She started to claw more and spit in his face so he tried to talk to her because "she can understand." Staff F said he "tapped" her on the face real soft, but it didn't work, so he told Staff G to take over. He said they put Resident #2 back into her wheelchair and wheeled her out to the nurse's			

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	station in front of the nurse. Staff F remembered being upset with the nurse because she didn't help them with Resident #2. He said the nurse saw them both scratched up pretty good, but the scratches happened when they cared for a different agitated resident earlier that evening. Staff F described Staff G as quiet and withdrawn, she just let Resident #2 beat her up and that's why he decided to take over, he said they shouldn't just stand there letting residents hit and kick them. Staff F said he grabbed Resident #2's hands and held them down to get her to stop hitting but she didn't care. Staff F said the nurse took Resident #2 back to her room until she went to sleep while he and Staff G answered call lights the rest of the night. 2. Resident #15's MDS assessment dated 2/27/24 identified a BIMS score of 1, indicating severely impaired cognition. Resident #15 required total assistance from staff for lower body dressing, toilet hygiene, and putting on footwear. She displayed verbal behavioral symptoms directed toward others such as screaming and cursing 1-3 days a week. She did not exhibit physical behavioral symptoms such as hitting, kicking and scratching during the week-long look-back period. The MDS included diagnoses of Alzheimer's Disease, muscle wasting (loss of muscle mass and strength), and chronic obstructive pulmonary disease (long-term lung issues).			

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	The Care Plan Focus revised 1/23/24, indicated Resident #15 would at times refuse or resist care. At times, she cussed at the staff or said unpleasant words or statements to the staff. The Interventions directed the staff to monitor and record occurrence of target symptoms. On 3/27/24 at 5:50 PM, Staff P, RN, said she worked the 6 PM – 6 AM shift and she worked with Staff F several times. She didn't personally hear Staff F raise his voice or get angry at residents, but heard from other staff that he would "get in their face." She said one night, Staff F came to her and told her that he may have tapped a little hard on a resident's shoulder. He told her as he tried to get a resident changed for the night, she swung at him. He said he tried to distract her to get her attention and "tapped" her shoulder. Staff P immediately assessed the resident's shoulder and didn't see any marks. She said he got frustrated sometimes and she would separate him from the residents. She didn't remember a date but thought it happened within the past 3 months and with Resident #15. Staff P did not remember if she had reported this incident to the administration. On 4/1/24 at 4:30 PM, Staff G said she worked with Staff F one night when he came out Resident #15's room and told the nurse that he "tapped" Resident #15 while getting her ready for bed. She didn't			

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	know if the nurse assessed Resident #15 or what happened afterwards. According to the Daily Assignment Sheets on the 10 PM - 6 AM shift on 12/19/23, Staff P, Staff G, and Staff F all worked that shift together. The Nurses Note dated 12/20/23 at 2:32 AM, Staff P documented about Resident #15 being combative with care, hitting, and scratching staff that evening. On 4/1/24 at 10:04 AM the Administrator said she expected Staff G to report the alleged abuse immediately. She added she addressed that concern as soon as she learned about it on the morning of 1/26/24. She educated all the staff that day that they must report alleged abuse immediately so the alleged abuser could be separated from the residents. She said that she had no knowledge of anger issues with Staff F towards residents before this incident. She denied knowing about any incident between Resident #15 and Staff F. On 3/27/24 at 12:33 PM, Staff T said Staff G went home after she finished her shift at 6:00 AM on 1/26/24 and then later that morning, she sent Staff T a text. The note said she needed to talk to her about the incident. She asked Staff G to come back in to the facility and write up a statement. She said			

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	she didn't know what time of night the incident happened but "it was early enough in the shift" that Staff G should have let them know right away so they could have separated Staff F from the residents. During a confidential interview, Staff Z said they went to the DON and the Administrator with concerns about Staff F's anger issues and how he yelled at the residents. Staff Z said that they didn't take the concerns seriously and didn't investigate. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy revised October 2023, All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. In addition, all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and/or misappropriation of property 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 would be reported to the Iowa Department of Inspections and Appeals no later than two (2) hours after the allegation was made.			

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	FACILITY RESPONSE			

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