STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. BUILDING ______ B. WING ______	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW CARE CENTER	**1200 WEST NISHNA ROAD SHENANDOAH, IA 51601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date___________ Investigation of mandatory report # 59836-M resulted in deficiency. See Code of Federal Regulations (42CFR) Part 483, subpart B-C.)	F 000		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and review of a personnel file, the facility failed to treat Resident #1 with kind and considerate care and free from mental abuse, humiliation, harassment and threats of punishment or deprivation. The sample consisted of 4 residents and the facility reported a census of 50 residents. Findings include: 1. Resident #1 had an annual MDS (Minimum Data Set) assessment with a reference date of 2/15/16. The MDS reflected the resident had a Brief Interview of Mental Status (BIMS) score of 12. A score of 12 identified the resident with moderately impaired cognition. The resident exhibited verbal behaviors that significantly	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1	F 223		

interfered with care. The resident depended upon staff for the completion of bed mobility, transfers, dressing and toileting, extensive assistance for completion of personal hygiene, limited functional range of motion in both lower extremities and received dialysis treatments. The resident received anti-anxiety and antidepressant medications and had diagnoses including renal (kidney) disease, anxiety and depression.

The Care Plan identified a problem initiated on 3/26/14 and revised on 3/6/15. The problem identified the resident had alterations in mood and behavior related to sadness, crying, isolating self to room, loss of independence, recent health changes, problems sleeping and having increased agitation and aggression with threats of verbal harm to staff related to smoking.

The Care Plan directed staff to anticipate disease and do not ignore him/her when he comes to the nursing station for cigarettes. If the resident is physically/verbally aggressive/disruptive related to smoking, encourage the resident to return to his room.

The Care Plan directed staff that the resident required the assistance of 2 staff members for bed mobility and transfer with a mechanical lift.

On 5/19/16 at 9:55 AM, Staff A, certified nursing assistant (CNA), was interviewed and stated she and Staff B, CNA were taking care of another resident across the hall from Resident #1. They observed the Director of Nursing (DON) in the hallway passing medications. Staff A stated she heard the DON tell Resident #1 several times she/he could not get out of bed to go smoke until

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F 223	Continued From page 2	F 223		

the resident took his/her medication.

Staff A stated she and B then went into a resident room next door to Resident #1. Prior to the entry of this room, the DON told her Resident #1 could not get out of bed until the resident took the medication. Staff A stated she heard Resident #1 say "Give me the damn things then". When she finished with the resident next door she saw the DON had placed Resident #1 in the mechanical lift sling and asked her to help get the resident out of bed. Resident #1 called the DON a "dumb bitch". The DON replied she was and "was damn proud of it ".

Staff A stated she pushed Resident#1 into the hallway after the transfer from the bed to the wheel chair. At that time, the DON told Resident #1, "I have worked hard to earn that title" and continued to antagonize Resident #1. Staff A stated the resident exhibits behaviors and the DON kept antagonizing the resident. Staff A stated she reported the incident immediately to the charge nurse, who directed her to the Administrator. Staff A stated she had never heard the DON talk like that to any other resident and felt it had been really inappropriate.

The facility document titled Timeline identified the incident occurred on 4/28/16 and Staff A reported the incident to the charge nurse at 1:15 p.m. The Administrator arrived to the facility and spoke with Staff A at 1:25 p.m. about the incident with Resident #1.

On 6/9/16 at 10:50 AM Staff B was interviewed and stated she and Staff A observed the DON in the hallway outside Resident #1's room at the medication cart. The DON stated Resident #1

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could get up after he/she took medication and she would assist Staff B in getting the resident up. Staff B stated she left to go get the mechanical lift; and when she came back down the hall she heard Resident #1 screaming " Fu-[expletive] you " ! and yelled did not want to take medication. She overheard the DON tell Resident #1 that if she/he did not take the medication then he/she could not go out to smoke. Resident #1 continued to yell " Fu-[expletive] you! " Staff B instructed Staff A to close the resident's door because other residents did not need to hear all the bad language. Staff B stated she could hear a pill hit the floor when she stood outside Resident #1's door.

Staff B stated she and Staff A entered another resident ' s room. When they came out into the hallway, the DON told them Resident #1 could get up because she/he took medication. Staff A went in to help the DON get the resident out of bed. Staff B stated she entered a bit later and helped Staff A and the DON left the room. Resident #1 kept cursing at the DON. Staff B stated she knew residents have the right to refuse medication and has never been instructed not to get a resident up or not let them smoke.

Review of the personnel file and the Timeline form, the Administrator suspended the DON from work on 4/28/16 and terminated on 5/3/16.