STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165411	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHFIELD WELLNESS COMMUNITY	**2416 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to the State Agency for one of four residents (Resident#1). The facility reported a census of 67 residents. Findings Include: Resident #1's Minimum Data Set with assessment reference date of 7/03/20 revealed Resident #1's [DIAGNOSES REDACTED]. The MDS revealed the resident required extensive assistance with transfers and limited assistance with personal hygiene. The MDS revealed a Brief Interview for Mental Status not conducted due to severe cognitive impairment. A document titled Investigation Summary and Findings revealed on April 6th, 2020 the facility became aware of an incident involving Staff D contract RN (registered nurse). Staff D allegedly threatened Resident #1 by telling the resident she would cut off his penis with her scissors during the evening shift on April 4th, 2020 An interview on 9/02/20 at 3:00 PM with the Human Resources (HR) director revealed she knew of the incident involving Staff D on Monday April 6th, 2020. She stated Staff A CNA (certified nurse aide) heard Staff D tell Resident #1 she would cut his penis off while Staff D had scissors in her hands. Staff A informed Staff B RN on 4/6/20. The HR Director stated she obtained the information from Staff B and then immediately reported the incident to the present facility administrator. The HR Director stated the facility terminated Staff D's contract and the facility notified Department of Inspection and Appeals (DIA). On 9/3/20 at 11:34 a.m. the HR director identified the incident occurred over the weekend on 4/4/20 and not 4/1/20 as the submission to DIA indicated. She stated the previous Administrator filed the report date wrong. An interview on 9/2/20 at 3:23 PM with the present facility administrator stated he received a call from the HR Director related to the weekend incident with Resident #1 and Staff D. The Administrator stated that Staff A should have reported the incident right away instead of waiting until 4/6/20 (Monday). All staff previously received dependent adult abuse training and knew of reporting requirements. The facility separated staff after the HR and Administrator were made aware of incident and terminated Staff D's contract. (Staff D was a contracted travel agency nurse) On 9/2/20 at 4:15 PM Staff D RN said she told Resident #1 if his penis got stuck in his pants then the hospital would have to cut his pants off. She denied telling the resident she would cut his penis off and could not remember if she had scissors in her hands, but might have because she was sitting by the treatment cart. She stated she had no idea if anyone else heard this statement and could not remember if any other residents were around the area. Staff D stated the facility investigated on the following Monday and then they called her agency and she was laid off. Staff D stated she worked on 4/4/20 beginning at 5:00 PM. The surveyor verified this per a schedule provided by the facility. On 9/2/20 at 5:00 PM Staff B stated Staff A informed her that Staff D told Resident #1 she would cut his penis off. Staff B stated she reported this information to the HR Director the next day when she came back to work for the evening shift. Staff B identified the timeline for reporting abuse is 24 hours. Staff B stated if she would have heard or seen the incident she would have called the on call nurse. Staff B stated she believed the incident happened over the weekend but did not know for sure because she was not present. Staff B informed Staff A that the incident needed to be reported during their conversation. On 9/3/20 at 11:24 AM Staff A stated about 2 days prior to her telling Staff B about the incident, she witnessed Staff D threaten to cut Resident #1's penis off. Staff A stated Staff D called over the radio to come get Resident #1 and Staff A responded to the radio call. She went to the back nurses' station and stood directly beside Resident #1 who sat in a recliner. Staff D told the resident told the resident she would cut his penis off. Staff A then took Resident #1 to the bathroom to get him out of the situation. Staff A stated she didn't feel she could say anything to Staff D as Staff D is a registered nurse. Staff A stated there was no other staff or competent residents around to hear the incident. Staff A admitted she did not tell anyone about the incident right away and confirmed she told Staff B about the incident two days later. Staff A stated she should have told the other charge nurse right away and she did not. During review of document titled Course Completion History revealed that Staff A completed ABCM Dependent Adult Abuse and Elder Just Act Annual review on 11/5/19.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews the facility failed to provide adequate supervision to ensure the safety of residents. Resident #2 was physically aggressive to to other residents. The care plan did not identify updated interventions following the first 3 incidents and failed to identify increased supervision needs for the resident resulting in 4 separate incidents. Resident #3 reported the 11/15/19 and 11/21/20 incidents and Resident #4 reported the 4/15/20 incidents as no staff witnessed them indicating a lack of supervision. The facility reported a census of 67 residents. Findings Include: A Minimum Data Set (MDS) assessment dated [DATE], revealed [DIAGNOSES REDACTED]. The MDS documented the Brief Interview for Mental Status (BIMS) not conducted due to severe cognitive impairment. 11/15/19 Incident: Resident #2's late entry progress note effective 11/15/19 at 4:15 p.m. revealed the resident's wheelchair got locked into Resident #3's wheelchair and the wheels got caught. Resident #2 hit the other resident 4 times in the back. The assessment stated: self propels in wheelchair and ambulates. No injuries observed. An entry dated 11/16/19 at 4:15 p.m. identified the new intervention as keep residents away from each other. Review of the care plan did not identify this intervention in place. A narrative summary report regarding the incident revealed camera footage identify Resident #3 ambulated with her wheelchair side by side with Resident #2 in the front lobby on 11/15/19 at 4 p.m. when the wheels became entangled. Before Resident #3 could untangle the wheels, Resident #2 open handed slapped Resident #3 on the back between the shoulder blades. After Resident #3 untangled her wheelchair and went to a table, Resident #2 self propelled herself to the table where Resident #3 sat and open hand slapped her a second time between the shoulder blades. Resident #3 left the front lobby and reported the incidents to Staff G (activity assistant). The online report to the State agency regarding the 11/15/19 incident revealed the facility would ensure increased staff supervision of Resident #2 when in close proximity of other residents in common areas. The care plan failed to contain the interventions documented to the State agency. 11/21/20 Incident: An online report to the State Agency dated 11/21/19 at 9:30 a.m. revealed the facility reported another incident occurred on that date at 9:30 a.m. The report identified Resident #2 struck Resident #3 in the back when the 2 residents were in A hall that moirning. No injuries occurred. The facility wrote on the online report they would keep residents separated and increase staff supervision of Resident #2 when residents were in close proximity in common areas. The care plan failed to contain

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the interventions documented to the State agency. On 9/10/20 at 11:00 AM with Staff G stated she recalled the incident with Resident #3. Staff G stated she was called on the radio to come and redirect the resident. Staff G stated she received other calls when Resident #2 yelled out. Staff G stated she did not recall a directive to specifically keep Resident #2 separated from others. She stated Resident #2 wheels around independently but there is usually staff around. On 9/10/20 at 9:17 a.m. Staff E RN (registered nurse) verified Resident #3 reported Resident #2 hit her. Staff E stated she maintained separation of the residents and kept a visual of Resident #2 from the nurses' station. Staff E could not remember if monitoring of the residents was documented and would have to ask. On 9/10/20 at 9:00 am the former Administrator stated he recalled Resident #3 struck by Resident #2. He stated staff separated the residents and the former Director of Nursing instructed staff to keep an eye on Resident #2. He stated it was a standard of practice to put triggers and interventions on care plans. The former Administrator stated that the Director of Nursing at the time would follow-up verbally at with staff. 2/7/2020 Incident: A late entry dated 2/7/20 at 6:30 p.m. revealed the resident self propelled her wheelchair in the front lobby and bumped the back of another resident and then tapped the other resident's left arm. Staff separated the residents. 4/21/20 Incident: The facility did not document the 4/21/20 incident in Resident #4's record or incident report. Review of a facility reported incident information to the State Agency submitted 4/22/20 revealed an incident involving Resident #2 and Resident #4 occurred on 4/21/20. The information submitted revealed camera footage showed Resident #2 entered the front lobby and then Resident #4 entered the lobby in her electric wheelchair and passed Resident #2. Resident #2 then wheeled up to Resident #4 and gave her 2 open hand slaps on her forearm over her sweater and wheeled back from Resident #4. Resident #4 then talked to Resident #2. Resident #2 then approached Resident #4 a second time and gave her one more open hand slap on her forearm over the sweater. Resident #4 then talked to the resident and waved her finger at her. Resident #2 wheeled down the hallway a short ways, returned and slapped the resident again on the arm over the resident's sweater. No injuries occurred. The surveyor could not interview the charge nurse as she no longer works at the facility. The report information revealed the charge nurse monitored Resident #2 and no further resident to resident contacts occurred. Resident #4 reported she was not hurt, more surprised. Resident #4 no longer resided in facility. On 9/10/20 at 11:47 AM the Social Worker verified she had conversation with Resident #4 regarding the incident with Resident #2. The Social Worker identified Resident #4 as not upset over the incident, just surprised. The Social worker stated they were roommates and did not want to switch rooms. Observation: Observation showed on 9/9/20 at 11:52 AM the resident up in hall until 12:00 p.m. with no other residents around. At 12:04 p.m. observation showed the resident moving in the wheelchair independently from her room to the far end of the(NAME)hall. The resident then wheeled back to the front nurses station lobby area. Observation showed staff approach the resident at that time and tried to get her to go to lunch with resident observed in dining room at 12:08 PM. The resident ate very minimal for lunch and then proceeded leave the dining room independently to go back out into the hallway by the back nurses station. Observation at 12:30 p.m. revealed the resident sat by front nurses station with two staff present. The resident continued to sit in front hallway with staff present at 1:45 PM. Other interviews: On 9/9/20 at 3:05 p.m. Staff H RN (registered nurse) stated if Resident #2 got agitated they keep a close eye on her and try activities to redirect her. Staff H stated when Resident #2 is up in her wheelchair they try very closely to watch Resident #2. Staff H stated they do not usually document, they are just used to observing. Staff H stated she would document an incident. On 9/9/20 with Staff I CNA (certified nurse aide) stated staff are told to keep Resident #2 separated and make sure they watch. She did not know of any documentation regarding monitoring or separation of residents. Staff I identified no formal plan related to keeping residents separated. Staff I identified Resident #2 as not out of bed much. Care Plan: Resident #2's care plan revealed a focus area created on 1/31/19, initiated and revised on 5/18/19 that identified the resident with a history of hitting, kicking, pushing, grabbing when scared. The goal was - will not harm anyone else during times of physical aggression. Interventions dated 5/18/19 included: *Please intervene if you notice me hitting kicking, pushing, scratching, grabbing. Ensure she is safe and remove from situation if possible. *Please do not have male givers take care of the resident *Report any physical injuries that the resident may receive/and or inflict upon others as a result of physical aggression to the Administrator, DON, physician and family. Interventions dated 4/23/20 (after the 4/21/20 incident) included: *Resident likes to playfully play tag with other residents, please redirect to prevent ALL injuries. * During increased time of agitation, obtain order for minicath. The care plan failed to contain any updated interventions following the 11/15/19, 11/21/19 and 2/7/20 incidents. The care plan failed to contain interventions that identified staff supervision of the resident.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on record review and staff interview, the facility failed to document an incident in the resident's medical record for 1 of 2 residents reviewed for accurate records (Resident #4). The facility reported a census of 67 residents. Findings include: Resident #4's Minimum Data Set with assessment reference date 8/6/20 revealed a Brief interview for Mental Status (BIMS) score of 15 (no cognitive impairment). Review of a facility reported incident information to the State Agency submitted 4/22/20 revealed an incident involving Resident #2 and Resident #4 occurred on 4/21/20. The information submitted revealed camera footage showed Resident #2 entered the front lobby and then Resident #4 entered the lobby in her electric wheelchair and passed Resident #2. Resident #2 then wheeled up to Resident #4 and gave her 2 open hand slaps on her forearm over her sweater and wheeled back from Resident #4. Resident #4 then talked to Resident #2. Resident #2 then approached Resident #4 a second time and gave her one more open hand slap on her forearm over the sweater. Resident #4 then talked to the resident and waved her finger at her. Resident #2 wheeled down the hallway a short ways, returned and slapped the resident again on the arm over the resident's sweater. Resident #4 Progress Notes from 4/20/20 to 4/22/20 revealed no documentation of the resident to resident incident or assessment for injuries. On 9/10/20 at 11:15 AM the Director of Nursing (DON) stated she found report charting but no documentation in the clinical record related to Resident #4 incident of slapped on the forearm. She verified that report charting as not legal documentation. She stated she was not the DON at the time, and that the nurses dropped the ball. The DON stated that she made everyone aware now that they must document in the record. On 9/10/20 at 12:00 PM the Administrator confirmed there was no incident report or documentation in the chart related to the incident.