STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165405	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAPPY SIESTA NURSING HOME	**PO BOX 80 REMSEN, IA 51050**

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 interviews and record reviews, the facility failed to report an altercation between two residents (Resident #37 and #15) of 15 residents reviewed. The facility reported a census of 57. Findings include: 1. The Minimum Data Set (MDS) completed for Resident #37 with an Assessment Reference Date (ARD) of 1/20/20, showed the resident had long-term and short-term memory problems. The resident had [DIAGNOSES REDACTED]. The resident showed physical and behavioral symptoms directed towards others for one to three days out of the seven days of the lookback period. The Provider Notification, dated 1/28/20, stated the resident was seen at the breakfast table that morning. During that time, the resident noted to grab another resident she was sitting by, and then also slapped the peer's right arm. The peer noted to have an abrasion to their right arm. The Incident Note, dated 1/28/20 at 8:45 AM, documented the resident had resident to resident contact with a peer at the breakfast table. The Certified Nurses' Aide (CNA) intervened immediately and separated the residents. An intervention put into place and the care plan updated. The Care Plan, dated 9/24/18, showed the problem of behaviors with the intervention dated 9/24/18 of aggression towards peers and staff. Staff to observe and intervene as necessary. The Care Plan, dated 10/25/19, showed the problem of communication with the intervention dated 1/28/20, the resident was to sit at a bedside table in the dining room. 2. The MDS completed for Resident #15 with an ARD of 12/9/19, showed the resident had short-term and long-term memory problems. The resident had [DIAGNOSES REDACTED]. The resident had physical and behavioral symptoms directed toward others for one to three in the seven day lookback period. The Provider Notification, dated 1/28/20, stated the resident was noted at the breakfast table that morning. A peer sitting by the resident grabbed the resident's right wrist and slapped the resident's right arm. An abrasion noted to the right wrist following the incident. An assessment of the resident's arm with no signs or symptoms of pain from the resident. The resident's Power of Attorney (POA) notified and interventions put into place. The Incident Note, dated 1/28/20 at 8:45 AM, stated the CNA reported the resident had resident to resident contact with another peer at the breakfast table. The CNA intervened immediately and separated the residents. The notification to the provider and POA completed with an intervention put into place. An abrasion noted to the right wrist-the information reported to the Director of Nursing (DON) and Administrator. The investigation completed by the DON, dated 1/28/20, stated Staff B, CNA, was with Resident #37 and Resident #15 in the Assisted Dining Room. Staff B observed Resident #37 reach and touched Resident #15's right arm. Resident #15 pulled her arm away from Resident #37, resulting in a small skin tear to the right wrist. Staff B responded by separating the two residents and alerting the nurse. The determination of the incident was that due to their dementia and Resident #37 having a tendency for mood fluctuation, an appropriate intervention was for Resident #37 to be seated at a tray side table away from peers at meals. During an interview on 3/11/20 at 8:58 AM, Staff B, CNA stated she remembered the situation but did not witness the incident. She stated all she saw was Staff A, CNA, telling the residents, oh no, don't do that. During an interview on 3/11/20 at 9:02 AM, Staff A, CNA stated she couldn't remember the situation too well as it was two months ago. Staff A said Resident #15 likes to take other resident's plates. Staff A believed Resident #15 had her fork on Resident #37's plate. Staff A remembered seeing Resident #37 squeezing Resident #15's arm aggressively and then slapped her arm. During an interview on 3/11/20 at 1:34 PM, the DON reported she lacked notification the resident had slapped the other resident. She stated if she had received the information that the other resident had slapped the other resident, she would have reported it. The DON then said she did not make the ultimate decision on reporting the incident. The Administrator decided about notifying DIA, and due to her surgery, she would not be able to comment on the situation. During an interview on 3/12/20 at 8:45 AM, the Director of Clinical Coordination stated the facility was submitting a rapid improvement process for the failure to report. The policy, Resident Safety, dated 2020, reported residents would not be subject to abuse by anyone, including but not limited to: facility staff, other residents, consultants, volunteers, the staff of other agencies, family members, legal guardians, friends, or other individuals. Any such incidents will be investigated, and any findings will be reported to the Iowa Department of Inspections and Appeals (DIA) for such data in the Abuse Registry. All allegations of resident abuse shall be reported to the DIA not later than two hours after the allegations made. The document, Resident/System: Reporting Protocol, dated 3/11/20, stated the problem was on 1/28/20; an incident between two residents of the facility resulted in one resident receiving a small abrasion to her forearm. After an interview with the charge nurse, management did not feel that this was a reportable incident. During the annual survey, documentation reviewed and determination made that this should have reported to the DIA.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, review of policy and staff interview the facility failed to ensure food was stored under sanitary conditions by not dating food when opened. The facility reported a census of 57 residents. Findings include: During the initial tour of the kitchen at 9:43 AM on 3/9/20, observed two packages of opened diced green peppers in the walk-in freezer not dated when opened. In the stand-up refrigerator unit, observed 2 bottles of chocolate syrup, 1 bottle of strawberry syrup, 1 bottle of thickened juice, 1 bottle of thickened water, and 3 opened 1 liters of soda that were not dated when opened. In the dry storage room, observed 3 opened packages of dry noodles not dated when opened. Review of the document titled, Food storage, dated 2018, stated: beverages must be dated when opened and discarded after 24 hours, other opened containers must be dated and sealed and covered during storage. During an interview with the Dietary Manager at 9:43 AM on 3/9/20, she stated she would expect all items to be dated when opened.

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.