STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165211	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - OTTUMWA	**2035 WEST CHESTER AVENUE OTTUMWA, IA 52501**

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 report an alleged violation involving abuse to the department for 2 of 4 sampled (Resident #2, #3). The facility reported a census of 124. Findings include: According the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairments. Resident #2 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #2 had [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], Resident #3 had a BIMS score of 5 indicating severe cognitive impairments. Resident #3 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #3 had [DIAGNOSES REDACTED]. During an interview on 7/14/20 at 5:24 p.m., Staff A (Nurse Aide) stated on the evening of 7/8/20, she and Staff B assisted Resident #2 to bed with a total mechanical lift. Resident #2 had combative and resistive behaviors during cares. Staff B was frustrated and stated she didn't want to work with another aide coming in at 6:00 p.m. Once in bed, Resident #2 started reaching and punching out at the staff. The staff pulled Resident #2's pants down and Resident #2 swung and grabbed at Staff B. Staff B grabbed Resident #2's wrists and shoved her hands into her stomach stating, my mother had a stroke and she didn't act like this. Resident #2 then started cussing and crying, which Staff A stated was not unusual for her. Later that same evening, while getting Resident #3 ready for bed, Staff B pulled Resident #3's sweater off roughly over her head, causing it to get tight around her neck, then Staff B yanked it off, ripping out her hearing aides. Staff A stated she did not report the incidents to the charge nurse that evening. Staff B stated she returned to work on the morning of 7/10/20 and reported her concerns to the Director of Nursing. During an interview on 7/14/20 at 5:55 p.m. the Director of Nursing (DON) stated on the morning of 7/10/20, Staff A approached her and reported on the evening of 7/8/20, Resident #2 was combative and Staff B held her arms down. The DON stated she spoke with Staff B who stated if you do not get your arm out of the way, Resident #2 will scratch and bite. Staff B denied forcefully grabbing Resident #2's wrists and pushing them into her stomach. The DON stated Staff A was counseled on reporting potential abuse situations immediately to a supervisor and Staff B was counseled regarding treating residents in a kind and considerate manner. The DON stated she consulted with her corporate office and determined that the incident described was not considered abuse and did not require reporting to the Department of Inspections and Appeals.

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.