LK 7/24/17

PRINTED: 06/27/2017
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0346	A. BUILDING: _____ B. WING _____	C 06/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MASONIC AL COMMUNITY	1300 28TH STREET PERRY, IA 50220

(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) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 12 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 13 TOTAL census of Assisted Living Program: 13 No regulatory insufficiencies were cited regarding the investigation of complaint #63414. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.	A 003	See attached Plan of Correcti DD — 7/24/17	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia Plum BSN	Assisted Living Coordinator	4/30/2017

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review staff failed to follow Program procedures regarding medication administration for 2 of 4 tenants reviewed (Tenant #1 and #2). Findings follow: During the med pass on 6-12-17 at 10:35 am Staff B went to Tenant #1's apartment to administer morning medications (meds). The staff placed the pills into a med cup and handed the cup to the tenant without checking the Electronic Medication Administration Record (EMAR) prior to administration. She then signed the EMAR that the meds were given prior to the tenant swallowing the pills. When asked if she had any more medications to pass, she stated she had already given medications to Tenant #2 earlier even though another staff passing medications at the same time was in possession of the EMAR. She stated she had not needed the EMAR when administering Tenant #2's meds because she knew what meds the tenant took and knew the routine as she had worked at the Program for a long time. Follow-up interview with Staff B on 6-13-17 at 9:14 am confirmed she understood she should have followed the procedure for administering medications which included having the computer with her at the time of administration. However she again stated she knew what medications Tenant #2 took and had not needed the EMAR with her at that time. She stated the Program was short staffed and she sometimes rushed to get things done even though it was not best practice. Regarding the	A 003		

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A 003	Continued From page 2 med pass with Tenant #1 on 6-12-17 she stated she was nervous which was why she did not follow correct procedures of checking meds with the EMAR and signing off after administering the meds instead of prior. She confirmed she had administered 8:00 am meds for Tenants #1 and #2 but did not log in under her name prior to administration. She should have made sure the other person was logged out and then logged in under her own name. Record review revealed the following: a. The EMAR dated 6-12-17 for Tenant #1 revealed that 8:00 am meds were documented as given by Staff E and not Staff B. Staff B did not ensure Staff E was logged out of the system and did not log in under her own credentials. b. The EMAR dated 6-12-17 for Tenant #2 revealed that 8:00 am meds were documented as given by Staff E and not Staff B. Staff B did not ensure Staff E was logged out of the system and did not log in under her own credentials. c. The Skills Checklist for Oral Medication documented staff were to compare each medication to the EMAR; review the 6 Rights of medication administration (Resident, Medication, Dose, Route, Time, and Documentation); remove meds from their container, check the EMAR with the medication labels 3 times; observe the tenant swallow medications, and then sign the EMAR immediately after administration. d. Delegation Forms dated 5-16-17 revealed Staff B signed off that she was trained on Administration of Oral Medications for Tenants #1 and #2. An interview with the Assisted Living Manager on 6-13-17 at 9:55 am revealed she expected staff to follow the procedures for administering	A 003		

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A 003	Continued From page 3 medications as they were trained. Staff were not to give meds without having the EMAR with them to refer to. In addition, staff were to sign off on medications they had administered and were to be logged in under their name on the computer and not another staff.	A 003		
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide staff with eight hours of dementia-specific education and training within 30 days of employment for 4 out of 4 staff reviewed (Staff A, B, C and D). Findings follow: Review of dementia training revealed the following: a. Staff A was hired on 5-3-17. Relias Learning transcripts revealed a total of 5.5 hours of dementia training was completed on 5-3-17, 5-5-17 and 5-24-17. b. Staff B was hired on 11-28-16. Relias Learning transcripts revealed a total of 3.25 hours of dementia training was completed on 10-26-17. c. Staff C was hired on 11-10-16. Relias	A 121		

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A 121	Continued From page 4 Learning transcripts revealed a total of 4.5 hours of dementia training was completed on 11-11-16 and 11-18-16. d. Staff D was hired on 9-26-16. Relias Learning transcripts revealed a total of 2 hours of dementia training was completed on 10-6-16 and 10-31-16. Interview with the Staff Development Coordinator confirmed that 8 hours of dementia training was not completed within 30 days of employment for these staff. She believed the requirement was 5 hours of training.	A 121		
A 125	481-69.30(5) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide staff with hands on dementia training for 4 out of 4 staff reviewed (Staff A, B, C, and D). Findings follow: Review of dementia training revealed the following: a. Staff A was hired on 5-3-17. Relias Learning transcripts revealed a total of 5.5 hours of dementia training was completed within 30 days. No hands-on dementia training was documented.	A 125		

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A 125	Continued From page 5 b. Staff B was hired on 11-28-16. Relias Learning transcripts revealed a total of 3.25 hours of dementia training was completed within 30 days. No hands-on dementia training was documented. c. Staff C was hired on 11-10-16. Relias Learning transcripts revealed a total of 4.5 hours of dementia training was completed within 30 days. No hands-on dementia training was documented. d. Staff D was hired on 9-26-16. Relias Learning transcripts revealed a total of 2 hours of dementia training was completed within 30 days. No hands-on dementia training was documented. Interview with the Staff Development Coordinator on (date) at 3:06 pm confirmed this finding as she unaware hands-on training was required.	A 125		
A 138	481-69.32(2) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation and interview the Program failed to have an operating alarm system connected to each exit door in a dementia-specific program. Findings follow: Observations throughout the recertification visit revealed the main door of the Program was not locked or alarmed and people were able to come	A 138		

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A 138	Continued From page 6 and go as needed. On 6-12-17 at 10 am during a tour of the Program, the door at the end of the hallway on the north side of the building was not locked and did not alarm when opened. On 6-13-17 at 3:09 pm the door in the dining room was not locked and when opened it did not sound an alarm. Both of these doors lead to an enclosed courtyard. Interview with Assisted Living Manager on 6-14-17 at 10:15 am confirmed none of the doors in the Program were locked or alarmed at all times. The Program utilized an Elpas security system which allowed doors to be unlocked unless an individual wearing a special bracelet was within the vicinity of the door. When that occurred the door would automatically lock and an alarm would sound. The Manager confirmed only 1 of the 13 tenants who resident at the Program utilized this type of bracelet. The other tenants were free to come and go through the unalarmed doors.	A 138		

A003

1. Staff B was required to complete an additional on-line medication administration education course and was suspended from med pass tasks until completed and skills demonstrated to nurse manager on 6/16/17.
2. Med pass delegation assignment was immediately changed to one staff member per shift completing entire med pass for all tenants on 6/14/17.
3. Policy and procedure on medication administration and documentation was reviewed and all AL staff re-educated by nurse manager on 6/21/17.
   Education included:
   a. Insuring that computer login and log out is done by each staff member before and after using the computer.
   b. If medication is not on the Medication Administration Record, staff cannot give a medication that tenant self-administers.
   c. 6 rights of medication administration and order to follow.
4. The nurse manager will monitor compliance by conducting bi-weekly observation of med pass for 1 month; then monthly for 3 months and then quarterly. Any concerns will be evaluated through the QAPI process and reported to the Administrator.

A121

1. The Policy and Procedure for new staff training was revised on 6/14/17 to include 8 hours dementia training for all new staff prior to starting to work with tenants.
2. Human Resources Director and AL Nurse manager will be responsible to monitor compliance with this regulation and document the completion of the required 8 hours of training. This record will be kept in each employee's personnel file for review by the department.

A125

1. The Policy and Procedure for new staff training was revised on 6/14/17 to include 8 hours dementia training with on-line and hands on training for all new staff prior to starting to work with tenants.
2. Human Resources Director and AL Nurse manager will be responsible to monitor compliance with this regulation and document the completion of the required 8 hours of training. This record will be kept in each employee's personnel file for review by the department.

7/24/17

7/24/17

A138

1. Administrator will obtain bids to change current alarm system and submit to Board of Trustees for approval by 7/24/17.

2. To insure safety of all tenants, the AL nurse manager will complete a nurse review on all tenants by 7/11/17 to review their wander risk and whether they are free to come and go from the program or need the wander function assigned to their wrist bracelet.

3. The AL nurse manager will update all service plans with each tenant to indicate the results of the nurse review by 7/11/17 to insure all tenants are safe.