ASB ALP Complaint Intake

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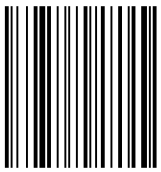

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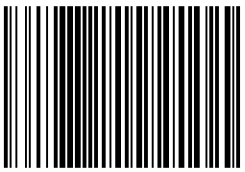

ALP 10-1

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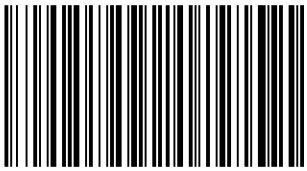

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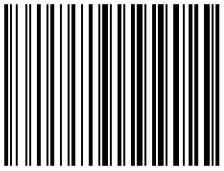

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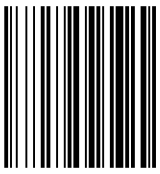

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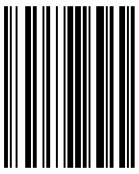

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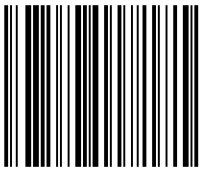

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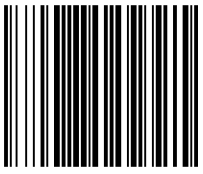

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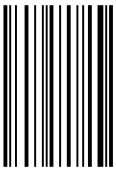

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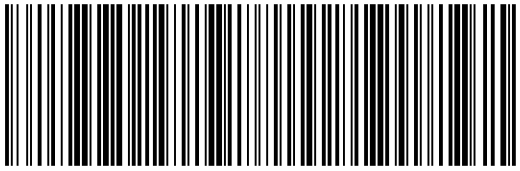
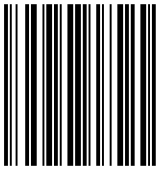


ADULT SERVICES BUREAU

Program



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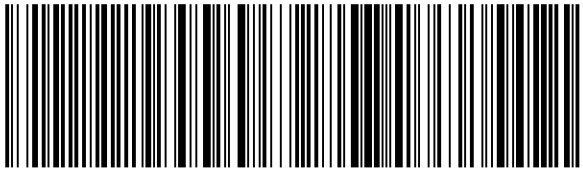
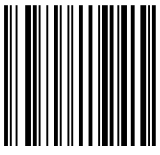


10 - Resolved Complaints

Exp. Date



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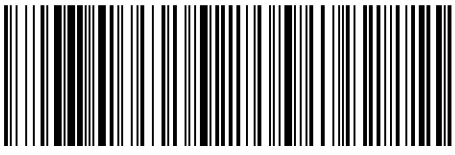

V5.1 ok 4/19/19

PRINTED: 04/02/2019
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
	S0375	A. BUILDING: _____ B. WING _____	C 03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT BRIDGEWATER ALP/D	3 RUSSELL SLADE BLVD CORALVILLE, IA 52241

(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	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 10 TOTAL Census of Assisted Living Program for People with Dementia: 14 The investigation of Complaint #81231-C resulted in the following regulatory insufficiencies:	A 000	POC 4/26/19 Please see attached Plan of Correction.	4.26.19
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the policy and procedure related to the completion of incident reports. This pertained to 2 of 3 tenants reviewed (Tenants #1 and #2). Findings follow:	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 4/15/19

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 1 1. Record review on 3-4-19 and 3-5-19 of Tenant #1's file revealed progress notes documented the following: a. On 1-15-19 Tenant #1 required assistance of three staff, as he slid off the bed and sat on the floor. Staff used a gait belt and assisted him to stand. Staff tried multiple times before getting him up. No injuries were reported. b. On 1-26-19 (late entry for 1-25-19) it was noted staff called the Nurse overnight and reported staff checked on Tenant #1 and found him laying on the floor near the apartment door. There were no complaints of pain. Three staff assisted Tenant #1 to a chair with the use of a gait belt. When interviewed on 3-5-19 at 11:42 a.m. Staff A reported Tenant #1 slid out of bed. She contacted the staff in the general population to assist. On two occasions staff waited for first shift staff to arrive to assist him up on the floor, including one time in early February. On the two occasions Tenant #1 had to wait, seated on the floor for 1 to 1/2 hours and the longest of 3 hours. When interviewed on 3-6-19 at 9:31 a.m. Staff J reported two to three weeks ago she worked in the general population and staff in memory care called her to assist with Tenant #1 who was on the floor. The two staff were unable to get Tenant #1 up and had to wait for first shift staff to arrive to assist. Tenant #1 waited greater than two hours. When interviewed on 3-6-19 at approximately 3:35 p.m. the Nurse reported Tenant #1 slid to the floor approximately one to three times per week.	A 003		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 2 An incident report for Tenant #1 dated 1-25-19 at 12:30 a.m. indicated it appeared Tenant #1 was found on the floor, he had scooted himself to his walker and then used the walker to guide him to the apartment door. Tenant #1 was observed scooting further to the door, to the exit of his apartment. It indicated Tenant #1 needed assistance of three staff and a gait belt to assist Tenant #1. The incident report indicated there was a history of that type of incident and Tenant #1 previously slid off the side of the bed and had been found on the floor. Continued record review of incident reports did not reveal incident reports related to the incident with Tenant #1 on 1-15-19 noted above. 2. Record review of Tenant #2's file on 3-4-19 and 3-5-19 revealed progress notes documented the following: a. On 1-14-19 Tenant #2 was found sleeping in another tenant's apartment. Tenant #2 did not cooperative when asked to move to her own apartment and hit and yelled at staff. b. On 2-15-19 staff tried to assist Tenant #2 to the bathroom and she hit staff in the face. Continued record review revealed there were no incident reports completed related to the incidents noted above for Tenant #2. 3. Further record review revealed the Program's policy and procedure for incident reports indicated all accidents or unusual occurrences in the building or on the property that affected	A 003		

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A 003	Continued From page 3 tenants should be reported as incidents. The person in charge at the time of the incident would prepare and sign the report. The incident report would include statements from witnesses. 4. When interviewed on 3-6-19 at approximately 3:35 p.m. the Nurse revealed all incident reports for the tenants indicated above were provided.	A 003		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate. This pertained to 1 of 3 tenants reviewed (Tenants #1). Finding follows: 1. Record review on 3-4-19 and 3-5-19 of Tenant #1's file revealed progress notes documented the following: a. On 1-15-19 Tenant #1 required assistance of three staff, as he slid off the bed and sat on the floor. Staff used a gait belt and assisted him to stand. Staff tried multiple times before getting him up. No injuries were reported. b. On 1-26-19 (late entry for 1-25-19) it was	A 013		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 013	Continued From page 4 noted staff called the Nurse overnight and reported staff checked on him and found him lying on the floor near the apartment door. There were no complaints of pain. Three staff assisted Tenant #1 to a chair with the use of a gait belt. Continued record review revealed an incident report for Tenant #1 dated 1-25-19 at 12:30 a.m. indicated it appeared Tenant #1 was found on the floor, he had scooted himself to his walker and used the walker to guide him to the apartment door. Tenant #1 was observed scooting further to the door, to the exit of his apartment. The report documented Tenant #1 needed assistance of three staff and a gait belt to get up from the floor. The incident report indicated a history of similar incidents and noted Tenant #1 had previously slid off the side of the bed and had been found on the floor. When interviewed on 3-5-19 at 11:42 a.m. Staff A reported Tenant #1 slid out of bed. She contacted the staff in the general population to assist. On two occasions staff waited for first shift staff to arrive to assist Tenant #1 up from the floor, including one time in early February. On the two occasions Tenant #1 had to wait, seated on the floor for one to one and half hours and the longest of three hours. Staff A reported the nurse on-call was notified. When interviewed on 3-6-19 at 9:31 a.m. Staff J reported two to three weeks ago she worked in the general population and staff in memory care called her to assist with Tenant #1 who was on the floor. The two staff were unable to get Tenant #1 up and had to wait for first shift staff to arrive to assist him. The Nurse was made aware. Tenant #1 waited greater than two hours and it took four staff to assist him up.	A 013		

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A 013	Continued From page 5 When interviewed on 3-5-19 at 1:55 p.m. Tenant #1's family member reported Tenant #1 had no falls when asked if she was made aware of any incidents with Tenant #1 including falls. When interviewed on 3-6-19 at approximately 3:35 p.m. the Nurse reported staff called regarding Tenant #1 found on the floor. When memory care staff and general population staff assisted the tenant they used a gait belt, let him rest for a bit, used a chair instead of a walker and provided encouragement. She had not heard of those interventions not being successful. She reported Tenant #1 slid to the floor approximately one to three times per week. Continued record review of the ALP Monitoring Entrance Form and staff schedules for January and February 2019 revealed there was one staff in the memory care unit on third shift and one staff on third shift assigned to the general population program (certified separately). There were occasions when a third staff was assigned on third shift for training. Further record review revealed Tenant #1's service plan dated 12-28-18 did not reflect the incidents of Tenant #1 sliding off of the bed and interventions. In summary, Tenant #1 did not receive care, services and treatment that were adequate and appropriate as he was not assisted from the floor for an extended period of time on at least two occasions as staff were unable to lift him and waited for the next shift to arrive to assist.	A 013		

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A 058	Continued From page 6	A 058		
A 058	481-67.9(4)a Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document a review to ensure staff were sufficiently trained within 60 days of the new nurse beginning employment. This pertained to 8 of 9 staff reviewed (Staff A, B, D, E, F, G, H and I). Findings follow: Record review of the ALP Monitoring Entrance Form revealed the Nurse was hired on 12-3-18. Record review of Staff A's file revealed a hire date of 11-19-18. The Nurse documented training of some aspects of activities of daily living (ADLs) and treatments, dated 1-8-19; however, training on ADLs and treatments was not complete. Record review of Staff B's file revealed a hire date of 10-31-18. The Nurse completed training	A 058		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 058	Continued From page 7 on nurse delegated tasks; however, it was documented on 2-13-19 and 2-14-19, greater than 60 days from the Nurse's hire date. Record review of Staff D's file revealed a hire date of 11-29-18. The Nurse completed training on ADLs and treatments on 1-11-19; however, training on medication administration was not provided. Record review of Staff E's file revealed a hire date of 7-16-18. The Nurse completed training on ADLs, treatments and some aspects of medication administration on 1-26-19; however, the training on medication administration was not complete. Record review of Staff F's file revealed a hire date of 8-22-18. The Nurse completed training on ADLs and treatments on 2-16-19, which was greater than 60 days from the Nurse's hire date. The training on medication administration was not reviewed with the current Nurse. Record review of Staff G's file revealed a hire date of 12-19-18. The Nurse completed training on ADLs and treatments on 1-11-19; however, training on medication administration was documented on 2-13-19, which was greater than 60 days from the Nurse's hire date. Record review of Staff H's file revealed a hire date of 7-31-18. The Nurse completed training on ADLs, treatments and some aspects of medication administration on 1-26-19; however, the training on medication administration was not complete. Record review of Staff I's file revealed a hire date of 12-17-18 and a termination date of 2-8-19.	A 058		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 058	Continued From page 8 Staff I did not have any documented nurse delegated training during the time of employment. When interviewed on 3-6-19 at approximately 3:35 p.m. the Nurse revealed all nurse delegated documented were provided for the staff indicated above. The Nurse reported medication training was completed for Staff D on the date of the other training; however, it could not be located.	A 058		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to reflect identified needs of tenants. This pertained to 1of 3 tenants reviewed (Tenants #1). Findings follow: Record review on 3-4-19 and 3-5-19 of Tenant #1's file revealed progress notes documented the following: a. On 12-30-18 Tenant #1 had leg pain to the point he could not move his leg. b. On 12-31-18Tenant #1 complained of left leg pain and as needed Tylenol was administered. c. On 1-1-19 (late entry for 12-31-18) Tenant #1	A 089		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 089	Continued From page 9 grimaced with ambulation when he tried to sit down and elevate his legs. Tenant #1 complained of left thigh pain. d. On 1-15-19 Tenant #1 required assistance of three staff as he had slid off the bed and was seated on the floor. Staff used a gait belt and assisted him to stand. Staff tried multiple times before getting him up. No injuries were reported. e. On 1-17-19 it was noted Tenant #1's family called and requested Tenant #1 avoid Vitamin K enriched foods as his International Normalized Ratio (INR) had dropped. Family also requested staff check his tubigrips when they assisted with toileting as they easily fell down. f. On 1-26-19 (late entry for 1-25-19) it was noted staff called the Nurse overnight and reported staff checked on him and found him lying on the floor near the apartment door. There were no complaints of pain. Three staff assisted Tenant #1 to a chair with the use of a gait belt. g. On 2-19-19 it was noted there was a skin condition change and Tenant #1's scrotum was very red. h. On 3-4-19 it was noted an order was received for Calmoseptine ointment, apply to reddened irritated area four times per days as needed. When interviewed on 3-5-19 at 10:40 a.m. Staff E reported Tenant #1's bedding was soaked with urine every morning and it took two to three staff at times to transfer Tenant #1 out of bed. When interviewed on 3-5-19 Staff H reported staff changed Tenant #1's bedding almost daily (due to urinary incontinence).	A 089		

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
	S0375	A. BUILDING: _____ B. WING _____	C 03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT BRIDGEWATER ALP/D	3 RUSSELL SLADE BLVD CORALVILLE, IA 52241

(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 089	Continued From page 10 When interviewed on 3-5-19 at 1:55 p.m. Tenant #1's family reported Tenant #1 was soaked at night and he did not have that problem until recently. She also indicated family provided rubber coasters for under the bed to prevent it from moving and twice recently the bed was not on the coasters. Continued record review revealed the service plan dated 12-28-18 did not reflect the leg pain and treatment, transfer assistance needed, rubber coasters under the bed and that at times Tenant #1 slid out of bed and interventions. It also did not reflect Tenant #1's anti-coagulant use and to avoid Vitamin K enriched foods, the level of urinary incontinence and interventions, the reddened area and Calmoseptine treatment and to check the tubigrips for appropriate placement with toileting. When interviewed on 3-6-19 at approximately 3:35 p.m. the Nurse confirmed current service plans for the tenants indicated above were provided.	A 089		

5/1/19

Plan of Correction
Grand Living at Bridgewater

A003 -Program Policies and Procedures

Regulatory Insufficiency: The Program failed to follow the policy and procedure related to the completion of incident reports.

Plan of Correction:
The insufficiencies will be corrected as follows:

- With any tenant incident, a report will be completed per policy (Attachment A).

The following measures will be taken to ensure the problem does not recur:

- Review and re-education of *Incident Reporting Policy and Procedure* provided to healthcare staff, including step-by-step instructions of completing the report within EMR (Attachment B) will be provided to all healthcare staff at the April 19, 2019 scheduled in-service.

The program will monitor performance to ensure compliance as follows:

- Program nurse or designee will monitor completion of incident reports for all reported tenant incidents.

Date insufficiencies corrected by: April 26, 2019.

A013 -Tenant Rights

Regulatory Insufficiency: The Program failed to provide care, treatment and services that were adequate and appropriate.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Healthcare staff were re-educated to notify non-emergent personnel to assist tenant off floor when unable to do so.
- Tenant #1 will have an updated assessment and service plan completed by 4.26.19 which will include interventions for healthcare staff to follow.

The following measures will be taken to ensure the problem does not recur:

- Review and re-education of *Resident Right's Policy and Procedure* (Attachment C) will be provided to all healthcare staff at the April 19, 2019 scheduled in-service.
- Appropriate interventions will be added to all tenant's service plans as indicated based on assessment.

The program will monitor performance to ensure compliance as follows:

- Program nurse or designee will ensure compliance by review of incident reports as they occur.

Date insufficiencies corrected by: April 26, 2019

A058 -Staffing

Regulatory Insufficiency: The Program failed to document a review to ensure staff were sufficiently trained within 60 days of the new nurse beginning employment.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Delegations for Staff A, B, D, E, F, G, H and I have been completed by the Program Nurse.

The following measures will be taken to ensure the problem does not recur:

- All healthcare staff will be delegated by Program Nurse within 30-days of hire per *Staffing Policy and Procedure* (Attachment D).

The program will monitor performance to ensure compliance as follows:

- Process to be audited periodically and no less than monthly for six months for compliance by Executive Director of designee.

Date insufficiencies corrected by: April 26, 2019.

A089 -Service Plans

Regulatory Insufficiency: The Program failed to develop service plans to reflect identified needs of tenants.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Updated assessment will be completed for Tenant #1 to include appropriate interventions for identified needs.

The following measures will be taken to ensure the problem does not recur:

- *Resident Service Plan Policy and Procedure* (Attachment E) will be reviewed with healthcare staff at the April 19, 2019 scheduled in-service.
- Healthcare staff instructed to notify Program Nurse or designee of any tenant needs not being met by current service plan so appropriate follow-up and assessment can be completed.
- All evaluations and service plans, for all tenants, will be completed prior to move-in, within 30 days, with significant change, and minimally annually thereafter to ensure accuracy to meet the needs of each tenant.

The program will monitor performance to ensure compliance as follows:

- Program Nurse or designee will be notified by healthcare staff of any tenant needs not being met by their service plan through the EMR communication tool.
- Program Nurse or designee will follow-up on concerns with nursing assessment and potential interventions.

Date insufficiencies corrected by: April 26, 2019