✓ 6/1/20

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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 03/02/2020

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

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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: 13 Number of tenants with cognitive disorder: 7 TOTAL Census of Assisted Living Program for People with Dementia: 20 The investigation of Complaint #88150-C resulted in the following regulatory insufficiencies:	A 000	See attached POC 6/12/20	
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 consistently follow established policy and procedures. Findings follow: 1. Record review revealed a Medication Incident	A 003		

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A 003	Continued From page 1 Report indicated on 12-23-19 Staff A asked if an as needed medication could be given to Tenant #2 for restlessness per request from Tenant #2's private caregiver. The Assistant Director of Health and Wellness (ADOHW) said a medication could be given for agitation; however, did not specify which medication. Staff A retrieved an as needed Lorazepam ordered for seizures only and gave to the private caregiver to administer. The medication was given at 1:01 p.m. and the reason listed was for seizure. Corrective action included to labels placed on the bag of syringes for Lorazepam for seizure only. Continued record review revealed Progress Notes dated 12-26-19 (late entry) for 12-23-19 at 4:00 p.m. reflected the Hospice Nurse made the ADOHW aware of a medication error at 3:50 p.m. An as needed medication was requested by staff and the ADOHW said an as needed medication could be given. Staff obtained Lorazepam 2 mg/ML which was listed for a seizure use only and not the medication listed for agitation (Quetiapine 25 mg). The ADOHW and the Hospice Nurse went to the apartment and Tenant #2 remained restless. Tenant #2's family and private caregiver were informed of the error and how it occurred. The caregiver was educated on signs of respiratory depression. The Hospice Nurse reported all vital signs were taken and were within normal limits. Medications (Olanzapine and Trazodone) were held until 8:00 p.m. Further record review revealed the Medication Management Agreement indicated if a medication error was found an incident report was to be completed and sent to the nurse immediately. The Medication Incident Report was dated and	A 003		

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A 003	Continued From page 2 timed at 12-24-19 at 3:54 p.m. completed by the ADOHW. The Program was aware of the medication error on 12-23-19 at 3:50 p.m. The Medication Incident Report was not completed when the medication error was noted. When interviewed on 3-2-20 the time of the exit meeting DOHW confirmed the incident report for the medication error (for Tenant #2) was completed the following day. 2. Continued record review revealed a Resident Incident Report indicated on 12-23-19 at 3:04 p.m. Staff B was asked to complete vitals by Tenant #2's private caregiver. When Staff B asked why, the private caregiver indicated because Tenant #2 had fallen. When Staff B went into the apartment Tenant #2 was in bed with a wash cloth over her forehead. Staff B noted there was "old" blood on her forehead but it was not bleeding when she took vitals. Tenant #2 had hit her head and there was a bump. The private caregiver said Tenant #2 got out of the chair fast and fell. Vitals were taken by Staff B. The ADOHW was told by Staff B on 12-24-19 at 10:05 a.m. that she was asked to do vitals. The Hospice Nurse was notified on 12-23-19 at 3:19 p.m. the physician was notified on 12-24-19 at 4:35 p.m. When interviewed on 2-26-20 at 3:36 p.m. Staff B revealed (regarding Tenant #2 fall) she had just come on shift and Tenant #2's private caregiver asked Staff B to do vitals. Staff B went into Tenant #2's apartment and the private caregiver was on the phone. Staff B was told by the person on the phone to do vitals and write them down and call back. Staff B asked the private caregiver if Tenant #2 had fallen and the private caregiver	A 003		

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A 003	Continued From page 3	A 003		

told Staff B that Tenant #2 had fallen and the chair had rocked forward too fast. Tenant #2 had a towel on her forehead and had a cut/bruise. Staff B called the person back and was told to write down vitals and Hospice was on the way. Tenant #2's vital signs were normal. A couple minutes later Hospice arrived. Staff B thought the fall had occurred before her shift as Tenant #2 was off of the floor, and was in bed asleep. The private caregiver did not report when the fall had occurred. Staff B thought everyone was already informed. An incident report was completed the next day and it was not completed by Staff B.

When interviewed on 2-26-20 at 1:38 p.m. the ADOHW revealed the day after Tenant #2's fall at 10:00 a.m. the ADOHW became aware of a fall. Staff B had been asked to do vitals for Tenant #2. Staff B said Tenant #2 was in bed and it did not appear a fall had just occurred. Staff B thought it had happened on a prior shift. The Program's nursing staff was not aware of the fall until the next day. The ADOHW completed on the incident report per Staff B's information.

Further record review revealed The Program's Life Safety policy indicated the person in charge at the time of the incident would prepare and sign the report. The incident report would include statements from individuals who witnessed the incident.

The Resident Incident Report was dated and timed at 12-24-19 at 4:33 p.m. completed by the ADOHW. The incident report was not completed when the incident occurred on 12-23-19, when direct care staff had knowledge a fall had occurred.

When interviewed on 3-2-20 the time of the exit

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A 003	Continued From page 4 meeting the ADOHW confirmed the incident report was not completed on for the fall until 12-24-19 as she was not aware of the fall until 12-24-19. When interviewed on 3-2-20 at 1:30 p.m. the DOHW revealed incident reports should be completed as soon as it was recognized. When interviewed on 3-2-20 at 2:46 p.m. the Executive Director revealed the expectation for the completion of incident reports was that incident reports should be completed in the shift it occurred. 3. When interviewed on 3-2-20 at 4:08 p.m. the Executive Director revealed the DOHW reported three current tenants in the memory care had narcotics that were counted. Record review of the Program's policy regarding medication administration reflected the narcotic protocol would be determined by the Program's nurse. A Nurse Delegation for Narcotic Count document indicated two staff (current and oncoming shift) would complete the narcotic count. Staff was to initial with staff that was off going. If the count was not correct, staff was to recount and notify the nurse immediately. Staff was not allowed to leave until all medications were accounted for. Continued record review on 3-2-20 of the Shift Narcotic Count documents from 11-21-19 to 2-24-20 revealed the documents were not completed in accordance with the nurse delegation document regarding narcotic count. Entries lacked both offgoing and oncoming staff signatures and also lacked an indication if the	A 003		

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A 003	Continued From page 5 count was correct. There were also entries that did not reflect counts completed on each shift change, including on 1-1-20 there was one count at 10:30 a.m. There were no other counts documented as completed on 1-1-20. On 1-4-20 there was one count documented as completed at 11:00 a.m. and one staff signed. When interviewed on 3-2-20 at 1:30 p.m. the DOHW confirmed the narcotic count sheets had incompleteness and said there was on-going education provided to staff regarding the narcotic counts.	A 003		
A 061	481-67.9(4)d 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: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide nurse delegated training that included all tasks including the administration of liquid medications. This pertained 6 of 6 staff reviewed (Staff A, B, C, D, E	A 061		

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A 061	Continued From page 6 and F). Findings follow: 1. Observation on 2-26-20 at approximately 8:15 a.m. revealed Staff C administered medications to four tenants (Tenants #4, #5, #6 and #7). Staff C prepared to administer Tenant #7's Miralax (mix 17 grams in 4-8 ounces of water or juice and drink by mouth daily am shift). No measurement utilizing the cap or other form of measurement was observed in the preparation of the medication. The powder was put into a clear disposable water cup. When interviewed at the end of the medication pass on 2-26-20 Staff C said that she was taught to put it (powder) in the bottom of the cup, when asked how the powder medication was measured. 2. Record review of the February 2020 medication administration records (MARs) for Tenants #4, #5, #6 and #7 revealed the medications that were signed off as given or refused during the medication pass observed on 2-26-20 (morning medication pass) were documented with Staff G's initials despite the medication pass observed was completed by Staff C. The Program utilized an electronic MAR system. 3. Further record review revealed a Medication Incident Report indicated on 12-23-19 Staff A asked if an as needed medication could be given to Tenant #2 for restlessness per request from Tenant #2's private caregiver. The Assistant Director of Health and Wellness said a medication could be given for agitation; however, did not specify which medication. Staff A retrieved an as needed Lorazepam ordered for seizures only and gave to the private caregiver to	A 061		

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A 061	Continued From page 7	A 061		

administer. The medication was given at 1:01 p.m. and the reason listed was for seizure. Corrective action included to labels placed on the bag of syringes for Lorazepam for seizure only.

Continued record review revealed Tenant #2's December 2019 MAR reflected an order for Lorazepam concentrate 2 milligram/mililiters (ML), take 2 ML, by mouth every 15 minutes as needed for a seizure. Staff was to call Hospice if it was administered. Staff was to give it from pre-filled syringes in the narcotic box in the medication room refrigerator. A nurse pre-filled the syringes.

Further record review revealed Progress Notes for Tenant #2 indicated the following: on 1-6-20 it was noted per a private caregiver that Tenant #2 had a suspected seizure from 1:59 to 2:02 p.m. as indicated by flailing arms and restless movements. The private caregiver had called Hospice and staff called Hospice at 2:10 p.m. It was noted Tenant #2 bit her upper lip and had a small laceration.

January 2020 MARs did not reflect a dose given of the Lorazepam take 2 ML, by mouth every 15 minutes as needed for a seizure on 1-6-20. Staff was to call Hospice if it was administered.

4. Continued record review of staff training documents on 2-26-20 for Staff A, B, C, D, E and F revealed nurse delegated training did not include training all medications staff provided assistance with including: powder medications and liquid medications.

5. When interviewed on 3-2-20 at 1:30 p.m. the Director of Health and Wellness revealed powder and liquid medications were not specifically

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A 061	Continued From page 8 included on the medication administration training records for staff. Staff A, B, C, D, E and F all administered medications.	A 061		
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record the Program failed to administer medications as prescribed by a tenant's physician. This pertained to 1 of 3 tenants reviewed (Tenant #2). Findings follow: 1. Record review revealed a Medication Incident Report indicated on 12-23-19 Staff A asked if an as needed medication could be given to Tenant #2 for restlessness per request from Tenant #2's private caregiver. The Assistant Director of Health and Wellness (ADOHW) said a medication could be given for agitation; however, did not specify which medication. Staff A retrieved an as needed Lorazepam ordered for seizures only and gave to the private caregiver to administer. The medication was given at 1:01 p.m. and the reason listed was for seizure. Corrective action included to labels placed on the bag of syringes for Lorazepam for seizure only.	A 147		

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A 147	Continued From page 9 When interviewed on 2-25-20 Staff A said Tenant #2 previously had a medication that was used for agitation and Hospice changed it to for seizures. Tenant #2's private caregiver requested an an needed medication for agitation. Staff A asked the ADOHW if an an needed medication could be used and the ADOHW said an as needed medication could be given. Lorazepam was given for Tenant #2. It was set up in a pre-drawn syringe. When interviewed on 3-2-20 at 9:57 a.m. the Hospice Nurse revealed Tenant #2 had Lorazepam ordered for seizures and it was a higher dose than prescribed for restlessness. When she visited Tenant #2 she checked the medications and became aware of the medication error. Lorazepam was given to Tenant #2 for restlessness. When interviewed on 2-26-20 at 1:38 p.m. the ADOHW revealed Staff A requested an as needed medication for agitation for Tenant #2. There were no specifics discussed as to the name of the as needed medication. Approximately two and a half to three hours later the Hospice Nurse came in and reviewed the medications and asked if Tenant #2 had a seizure. She noted Lorazepam had been given not for the indication provided. The Hospice Nurse and the ADOHW went to the apartment and Tenant #2 was still agitated. Tenant #2 was agitated and responsive and family and the private caregiver were present. Medications were held for later in the shift and no side effects were noted. Regarding the medication administered, licensed staff drew up the Lorazepam in syringes and the private caregivers administered the medication.	A 147		

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A 147	Continued From page 10 When interviewed on 3-2-20 at 1:30 p.m. the Director of Health and Wellness (DOHW) revealed a private caregiver for Tenant #2 asked Staff A for an as needed medication for agitation. Staff A asked the ADOHW and she said a medication could be given for agitation. There were no names provided of the medication. The ADOHW told her that Tenant #2 was given Lorazepam and she was supposed to have given Quetiapine. Record review on 2-25-20 and 2-26-20 of Tenant #2's file revealed diagnoses included: Alzheimer's disease and hydrocephalus. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #2 was discharged on 2-23-20. Continued record review revealed Tenant #2's December 2019 MAR reflected an order for Lorazepam concentrate 2 milligram/mililiters (ML), take 2 ML, by mouth every 15 minutes as needed for a seizure. Staff was to call Hospice if it was administered. Staff was to give it from pre-filled syringes in the narcotic box in the medication room refrigerator. A nurse pre-filled the syringes. The MAR reflected it was administered on 12-23-19 at 1:02 p.m. and the reason indicated was seizure. Tenant #2 had an order for Quetiapine tablet, 25 mg, take one tablet, orally, every four hours as needed for agitation. The MAR did not reflect Quetiapine 25 mg was given on 12-23-19. Further record review revealed Progress Notes indicated the following: -There were were no entries on 12-23-19 related to any seizure activity for Tenant #2.	A 147		

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A 147	Continued From page 11 -On 12-26-19 it was noted (late entry) for 12-23-19 at 4:00 p.m. reflected the Hospice Nurse made the ADOHW aware of a medication error at 3:50 p.m. An an needed medication was requested by staff and the ADOHW said an as needed medication could be given. Staff obtained Lorazepam 2 mg/ML which was listed for a seizure use only and not the medication listed for agitation (Quetiapine 25 mg). The ADOHW and the Hospice Nurse went to the apartment and Tenant #2 remained restless. Tenant #2's family and private caregiver were informed of the error and how it occurred. The caregiver was educated on signs of respiratory depression. The Hospice Nurse reported all vital signs were taken and were within normal limits. Medications (Olanzapine and Trazodone) were held until 8:00 p.m. -On 1-6-20 it was noted per the private caregiver Tenant #2 had a suspected seizure from 1:59 to 2:02 p.m. as indicated by flailing arms and restless movements. The private caregiver had called Hospice and staff called Hospice at 2:10 p.m. It was noted Tenant #2 bit her upper lip and had a small laceration. January 2020 MARs did not reflect a dose given of the Lorazepam take 2 ML, by mouth every 15 minutes as needed for a seizure on 1-6-20. Staff was to call Hospice if it was administered. Staff was to give it from pre-filled syringes in the narcotic box in the medication room refrigerator. Continued record review revealed the Service Plan Agreement dated 7-16-19 reflected medication was to be brought in whole form to the apartment. Staff told the private caregivers what medications were to be taken at the scheduled	A 147		

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A 147	Continued From page 12 time and to asked if they wanted any medications crushed. The Program was responsible for ordering, storage and administration of medications. Further record review revealed the a Program document dated 12-23-19 revealed DOHW discussed with the ADOHW regarding as needed medications and orders to state the specific as needed medication name for staff to administer when requested. Continued record review revealed the Program's policy and procedure for medication administration indicated medications would be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.	A 147		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change.	A 037		

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 03/02/2020

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 037	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days and annually. This pertained to 2 of 3 tenants reviewed (Tenants #1 and #2). Findings follow: 1. Record review on 2-25-20 and 2-26-20 of Tenant #1's file revealed Tenant #1 was admitted on 9-6-19 and discharged on 1-5-20. Evaluations were completed dated 9-6-19. Cognitive, health and functional evaluations were not completed within 30 days of taking occupancy. 2. Record review on 2-25-20 and 2-26-20 of Tenant #2's file revealed Tenant #2 was discharged on 2-23-20. An annual evaluation was completed on 10-20-19; however, it lacked a cognitive evaluation. Functional and health evaluations were completed. 3. When interviewed on 3-2-20 at 1:30 p.m. the Director of Health and Wellness revealed evaluations were not completed within 30 days for Tenant #1. A health and functional evaluation was completed on 10-20-19 (annual review); however, a cognitive evaluation was not completed at that time for Tenant #2.	A 037		
A 085	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy	A 085		

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 03/02/2020

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 085	Continued From page 14 and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days of taking occupancy, as needed with significant change or annually. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2, #3). Findings follow: 1. Record review on 2-25-20 and 2-26-20 of Tenant #1's file revealed Tenant #1 was admitted on 9-6-19 and was discharged on 1-5-20. A service plan was dated 9-6-19. A service plan was not developed within 30 days of taking occupancy. 2. Record review on 2-25-20 and 2-26-20 of Tenant #2's file revealed diagnoses included: Alzheimer's disease and hydrocephalus. Tenant #2 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #2 was discharged on 2-23-20. Evaluations were completed annually on 10-20-19; however, a service plan was not developed at that time. Continued record review revealed Tenant #2's December 2019 MAR reflected an order for Lorazepam concentrate 2 milligram/mililiters (ML), take 2 ML, by mouth every 15 minutes as needed for a seizure. Staff was to call Hospice if it was administered. Staff was to give it from pre-filled syringes in the narcotic box in the medication room refrigerator. A nurse pre-filled	A 085		

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 03/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 085	Continued From page 15 the syringes. Progress Notes indicated the following: on 1-6-20 it was noted per a private caregiver that Tenant #2 had a suspected seizure from 1:59 to 2:02 p.m. as indicated by flailing arms and restless movements. The private caregiver had called Hospice and staff called Hospice at 2:10 p.m. It was noted Tenant #2 bit her upper lip and had a small laceration. January 2020 MARs did not reflect a dose given of the Lorazepam take 2 ML, by mouth every 15 minutes as needed for a seizure on 1-6-20. Staff was to call Hospice if it was administered. Further record review revealed Tenant #2's signed service plan dated 4-19-19 did not reflect Tenant #2's seizures and interventions. 3. Record review on 3-2-20 of Tenant #3's file revealed Tenant #3 was staged at a six on the GDS, which indicated severe cognitive decline. Progress Notes indicated the following: -On 2-3-20 it was noted Tenant #3 got up around 2:15 a.m. and wanted staff to come with her and led staff to the exit door. She was crying and said she couldn't go into her apartment because of a man. It was noted Tenant #3 resided in a unit where there were no males present and male staff had not been in her apartment. -On 2-19-20 it was noted Tenant #3 was agitated and staff walked with Tenant #3 to try and reduce agitation. Tenant #3 leaned on staff against the wall and would not move. Staff attempted (without success) to have Tenant #3 sit on the chair. Tenant #3 voiced concerns of a man hurting her and that she needed to get away.	A 085		

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
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A 085	Continued From page 16 Tenant #3 held onto to staff very tight and would not let go. Continued record review of Tenant #3's service plan dated 2-3-20 revealed (for severe confusion) staff was to redirect with dancing, singing, or to take Tenant #3 for a walk. The service plan was not updated to reflect Tenant #3's behaviors as indicated in Progress Notes. 4. When interviewed on 3-2-20 at 1:30 p.m. the Director of Health and Wellness revealed a 30 day service plan was not found for Tenant #1. She further confirmed Tenant #2's service plan did not reflect seizure activity and Tenant #3's service plan reflected redirection.	A 085		

✓ 6/1/20 OK 6/28/20

Plan of Correction
Grand Living at Bridgewater
Complaint #88150-C

A003 -Program Policies and Procedures

Regulatory Insufficiency

1. The program failed to complete a medication incident report when medication error was noted.
2. The program failed to complete a resident incident report when direct care staff had knowledge of fall occurring.
3. The program failed to complete Shift Narcotic Count documents in accordance with the nurse delegation document regarding narcotic count.

Plan of Correction: The insufficiency will be corrected as follows

1. With any tenant medication error, a report will be completed per Medication Records and Administration policy (Attachment A).
2. With any tenant accidents or unusual occurrences, an incident report will be completed per Incident Reporting policy (Attachment B).
3. Direct care staff (current and oncoming shift) will complete narcotic count at each shift change.

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

Review and re-education of *Medication Records and Administration and Incident Reporting Policy and Procedure*; *and Shift Change Narcotic Count documents* (Attachment C)*;* related to medication errors and tenant accidents or unusual occurrences provided to direct care staff, including step-by-step instructions of completing the report within EMR (Attachment D) will be provided to all direct care staff sent via personal emails with read receipt along or a conference call completed by June 12, 2020.

The program will monitor performance to ensure compliance as follows

Program nurse or designee will monitor completion of medication incident reports for reported tenant medication errors and resident incident reports for all reported tenant accidents and unusual occurrences.

Program nurse or designee will complete weekly review of shift change narcotic count documents for 6 weeks and then at least monthly thereafter.

Date insufficiencies corrected by June 12, 2020

A061 -Staffing

Regulatory Insufficiency

1. The program failed to provide nurse delegated training that included all tasks including the administration of liquid and powder medications.
2. Direct care staff training regarding correct electronic MAR documentation.
3. Failure to specify which PRN medication to administer based on symptoms presented.

Plan of Correction: The insufficiency will be corrected as follows

1. Nurse delegation completed for all direct care staff for liquid and powder medication will be completed (Attachment E).
2. All current delegated direct care staff provided education regarding proper documentation for electronic MAR system.
3. Labels placed on the bags of syringes for Lorazepam with indication listed.

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

1. All new direct care staff will be delegated for liquid and powder medication.
2. All new direct care staff will be educated regarding proper documentation for electronic MAR system.
3. Nurse on call will specify which PRN medication to administer based on symptoms presented. Nurse will document a nurse note in tenant electronic record for one month to ensure the problem does not recur.

The program will monitor performance to ensure compliance as follows

1. Program executive director or designee will audit new direct care staff delegations to ensure liquid and powder medication delegation is completed monthly for 3 months.
2. Program nurse or designee will perform weekly audits for 6 weeks and then periodically of the EMAR dashboard to ensure proper documentation.
3. Program executive director or designee will audit EMAR PRN's dashboard for one month to ensure compliance.

Date insufficiencies corrected by June 12, 2020

A147-Medications

Regulatory Insufficiency
The program failed to administer medications as prescribed by a tenant's physician.

Plan of Correction: The insufficiency will be corrected as follows
All tenants receiving medication administration by the program will be administered per physician's order per Medication Needs of Resident's Policy (Attachment G).

The following measures will be taken to ensure the problem does not recur
Direct care staff will be instructed and educated to notify nurse on call when a tenant is displaying or complaining of abnormal symptoms. The nurse will then determine and specify by name which PRN medication to administer, if indicated.

Review and re-education provided to direct care staff on Medication Needs of Residents.

The program will monitor performance to ensure compliance as follows
Program nurse or designee will perform weekly audits for 6 weeks and then periodically of the EMAR dashboard to ensure proper documentation

Date insufficiencies corrected by June 12, 2020

A037-Evaluation of Tenant

Regulatory Insufficiency
The program failed to complete assessments/evaluations within 30 days and annually.

Plan of Correction: The insufficiency will be corrected as follows
Program nurse or designee will complete tenant 30 day and/or annual assessments, including cognitive evaluation, according to the Evaluation of a Resident policy (Attachment G).

The following measures will be taken to ensure the problem does not recur
30 day and annual assessments/evaluation due reports will be obtained and assigned to designee for completion within allowed timeframe.

The program will monitor performance to ensure compliance as follows
Program executive director or designee will monitor and audit completion of assessment due reports for 3 months and then periodically thereafter.

Date insufficiencies corrected by June 12, 2020

A085 Service Plans

Regulatory Insufficiency
Program failed to update service plans within 30 days of taking occupancy, as needed with significant change or annually.

Plan of Correction
All service plans will be developed for each tenant based on evaluations per Resident Service Plan policy (Attachment H).

The following measures will be taken to ensure the problem does not recur
Program nurse or designee will obtain assessment reports and audit and make changes to the service plans accordingly.

The program will monitor performance to ensure compliance as follows
Program executive director or designee will monitor and audit completion of assessment due reports and service plans for 3 months and then periodically thereafter.

Date insufficiencies corrected by June 12, 2020