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 08/24/2022

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: 10 Number of tenants with cognitive disorder: 17 TOTAL Census of Assisted Living Program for People with Dementia: 27 The investigation of Incident #99882-I and Complaint #99962-C was completed and the following regulatory insufficiencies were identified:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policy and procedure related to the completion of incident reports. This pertained to 1 of 2 current tenants reviewed (Tenants #1) and 2 of 2 discharged tenants reviewed (Tenants C1 and C2). 1. Record review on 8-22-22 and 8-23-22 revealed Resident Incident Reports indicated the following: On 8-5-22 staff heard the alarm sounding and responded to the exit door. Tenant #1 exited through the stairwell to the driveway. Tenant #1 said he was looking for his bicycle. He was assisted back to the Program. The incident report reflected the physician was notified on 8-15-22 at	A 150		

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A 150	Continued From page 1	A 150		

8:00 a.m. via fax (10 days after the incident). The report was completed by the Regional Director of Health and Wellness on 8-22-22 at 11:15 a.m.

On 8-14-22 at 10:15 a.m. staff called the nurse on call to report Tenant #1 came into the front of the building and told the staff at the front desk he went for a walk. Tenant #1 left the memory care unit via the courtyard. The physician was notified on 8-15-22. The report was created on 8-18-22 by the Director of Health and Wellness.

3. Record review on 8-17-22 and 8-18-22 of Tenant C1's file revealed Progress Notes indicated the following:

-On 6-12-21 Tenant C1 was exit seeking and tried to open the door. When it did not open, he slammed his body into it.

-On 6-12-21 Tenant C1 was very agitated and had "violent outbursts" multiple times towards staff and tenants.

-On 9-3-21 Tenant C1 attempted to elope and he became aggressive after staff closed the door. Tenant C1 hit staff in the arm and it was noted he could not be calmed down initially.

Continued record review of Tenant C1's file revealed incident reports were not completed related to the incidents noted above on 6-12-21 and 9-3-21.

Further record review revealed a Resident Incident Report with an incident date and time of 9-11-21 at 5:56 p.m. indicated the type of incident was physical aggression. The report documented staff observed him walk to the hallway as if he was going to his apartment. "Next thing I knew he

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A 150	Continued From page 2	A 150		

had another resident round the neck and flung him to the ground." Emergency medical services arrived at 6:30 p.m. and he was transported to the emergency room (ER). The incident report was completed dated 9-11-21 by Staff B; however, the incident report lacked documentation of physician notification. Additional record review revealed a lack of witness statements available to accompany the incident report.

4. Record review on 8-18-22 of Tenant C2's file revealed Progress Notes indicated the following:

-On 9-24-21 Tenant C2 cried, yelled and threw furniture and broke things.

-On 10-5-21 staff notified the nurse Tenant C2 said "killing myself is the only thing on my mind and all that I think about" and "I do not want to be in this world anymore." All potential items of self-harm were removed from his apartment, increased checks (hourly) were added, and new orders were received.

Continued record review of Tenant C2's file revealed incident reports were not completed related to the incidents noted above on 9-24-21 and 10-5-21.

5. Record review of the Program's policy and procedure related to the incident reports indicated the person in charge at the time of the incident should complete and sign the incident report. The incident report would include witness statements from any staff who witnessed the incident and all unusual occurrences or accidents that "affect residents" would be incidents.

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A 150	Continued From page 3 6. When interviewed on 8-23-22 at 4:00 p.m. the Regional Director of Health and Wellness confirmed all incident reports and witness statements for the tenants listed above were provided.	A 150		
A 106	231C.5 1 Occupancy Agreement 231C.5 Written occupancy agreement required. 1. An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide a written notice for a tenant discharge. This pertained to 1 of 1 discharged tenants reviewed that had a program initiated discharge (Tenant C1). Findings follow: 1. Record review on 8-17-22 and 8-18-22 of Tenant C1's file revealed diagnoses included major neurocognitive disorder secondary to	A 106		

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anoxic brain injury. Tenant C1 was staged at five on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant C1 was admitted on 1-27-20 and a discharge date of 9-13-21 was provided.

Continued record review revealed a Resident Incident Report with an incident date and time of 9-11-21 at 5:56 p.m. indicated the type of incident was physical aggression. The report indicated staff observed him walk to the hallway as if he was going to his apartment. "Next thing I knew he had another resident round the neck and flung him to the ground." Emergency medical services arrived at 6:30 p.m. and he was transported to the emergency room (ER).

Further record review revealed Progress Notes indicated the following:

-On 7-20-21 (late entry for 7-7-21) a 90 day review was completed. Tenant C1 had one episode of physical aggression since the last evaluation. Tenant C1's legal representative continued to look for a higher level of care. He was not accepted at one alternative placement due to his prior aggression and elopements (prior to medication changes). It noted Tenant C1 had paranoia and anxiety, which was "likely secondary to his PTSD."

-On 9-15-21 (late entry for 9-11-21) a telephone call was received from staff for the Assistant Director of Health and Wellness to come to the memory care unit. Staff reported another tenant had hit his head and was bleeding. When the Assistant Director of Health and Wellness arrived, the other tenant was on his back in the hallway. There was a "significant amount of blood on his hands and under his head." Staff told her Tenant

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C1 had thrown the other tenant on the floor. The other tenant was taken to the hospital via ambulance. Tenant C1 was taken to the hospital for a psychiatric evaluation.

-On 9-15-21 (late entry for 9-11-21) staff from the hospital reported Tenant C1 had 900 cubic centimeter of urine removed from his bladder and the incident was "likely caused from irritation related to his full bladder." The Former Assistant Director of Health and Wellness said he would need a full psychiatric evaluation and reconciliation of medications. The hospital staff said Tenant C1 would be discharged that night. It was explained to the hospital staff that per regulations Tenant C1 could not come back. A doctor from the hospital called and asked for details related to the incident. The doctor said Tenant C1 would not be admitted due to being calm and cooperative he would not be admitted to psych (also no beds available). Regarding interventions related to his urinary retention the doctor said he would need "intermittent cathing." The doctor was told that service could not be provided at the Program as there was not 24 hour nursing staff to assist. The doctor indicated Tenant C1 could stay overnight with a "sitter" but was not going to be admitted or for kept for observation and needed to be discharged as soon as possible.

-On 9-15-21 (late entry for 9-14-21) the Former Assistant Director of Health and Wellness contacted ER case management staff who told her Tenant C1 was "medically ready" for discharge that day and was waiting in the lobby. The nurse informed the ER case management staff that they needed assistance in finding placement for Tenant C1 as "he cannot return to our program due to his aggression and medical

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A 106	Continued From page 6	A 106		

needs and that he would either need to find other placement or family would need to secure 24/7 supervision from an outside agency, which none are available due to staffing shortages." The Former Assistant Director of Health and Wellness asked the ER case management staff if he could assist with notification of Tenant C1's family of different placement choices. The ER case management staff said Tenant C1 was their "problem" and they needed to figure something out for him and it was "unacceptable" to leave him in the ER. He was told Tenant C1 could not be re-admitted due to causing an injury to another tenant (unprovoked) and they could not meet his needs related to "intermittent cathing."

-On 9-15-21 an email that was received from the Director of Luminations on 9-13-21 indicated she had made calls regarding placement for Tenant C1 and was not able to secure placement. Both places contacted felt the Veterans Affairs (VA) "should be responsible to him at this point." The VA was contacted and had not received any referrals from the hospital. The ER case management worker was contacted and was asked if a referral was sent. The ER case management staff said Tenant C1 was treated him for the bladder infection and set up with antibiotics. The notes indicated the ER case management staff said "it was against the law to not give someone a 30-day notice. He told us that we would need to provide the appropriate arrangements for ... to have 24-7 care."

-On 9-16-21 (late entry for 9-14-21) the Director of Luminations and Tenant C1's legal representative had been emailing and had phone conversations daily about the progress.

-On 9-16-21 (late entry for 9-15-21) Tenant C1

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was not longer needing a catheter. Tenant C1's legal representative asked the Director of Luminations to fill out paper work for another facility.

-On 9-16-21 the Director of Luminations spoke with Tenant C1's legal representative after speaking with management staff. It was determined they could not accept Tenant C1 back to the Program and a 30 day notice would sent (from the first discussion on 9-13-21).

-On 9-16-21 Tenant C1's legal representative was informed Tenant C1 could not return to the Program and a 30 day notice would sent from when it was first discussed with Tenant C1's legal representative on 9-13-21.

2. When interviewed on 8-18-22 at 3:54 p.m. Staff A said worked on second shift with Staff B. They were both at the nurse's area and observed Tenant C1 and Tenant C2 in the hallway. She said out of the corner of her eye she saw Tenant C1's hand around Tenant C2's neck and then Tenant C2's head was on the ground. She described it as self-defense type motion. They responded right away and she said Tenant C1 understood what he had done was wrong and Staff B took him to his apartment. Tenant C2 was kept on the ground. He had a laceration on the back of his head and it was bleeding. The Former Assistant Director of Health and Wellness was called and came to the unit and paramedics were called. Tenant C2 was taken to the hospital via ambulance and Tenant C1 was taken to the hospital later that night. Tenant C1 did not return from the hospital. She was not aware of any history of physical aggression between Tenant C1 and Tenant C2 or between Tenant C1 and other tenants.

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A 106	Continued From page 8 When interviewed on 8-22-22 at 5:03 p.m. Staff B said worked second shift and it was around dinner time (5:30/6:00 p.m.) She was training another staff. Tenant C2 had gotten up to walk down to his apartment and Tenant C1 got up. Tenant C1 came behind Tenant C2 and had a "choke hold" on him and Tenant C2 was on the ground. She said it happened very quickly. Staff went running towards them. Tenant C2 was on the ground and he had had a laceration on the back of his head. She said it could be seen on Tenant C1's face regarding what he had done. The Former Assistant Director of Health and Wellness was in the building and responded. Tenant C2 was sent out. She said she was really surprised and it came out of no where. She was not aware of any other incidents between Tenant C1 and Tenant C2. She said in the memory care unit that day there were two staff, including the one staff that was in training. There was supposed to be two staff, in addition to the staff in training. When interviewed on 8-23-22 at 8:20 a.m. the Director of Luminations said she was not working when the incident occurred between Tenant C1 and Tenant C2. She was told Tenant C1 followed Tenant C2 unprovoked, came from behind and physically assaulted him and pulled him to the ground. There was no known trigger. Tenant C1 had pushed staff and raised his fist at staff previously. She said there might have been one other incident with Tenant C1 and physical behavior towards another tenant but it did not result in any significant injury. She said after Tenant C1 was sent out the Former Assistant Director of Health and Wellness had a lot of discussions with staff at the hospital and they wanted to send him back. The Director of	A 106		

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A 106	Continued From page 9 Luminations reached out to other placements and resources and had a discussion with staff at the hospital regarding placement for Tenant C1. He was accepted to another assisted living program. She said she believed the Former Executive Director emailed Tenant C1's legal representative a written letter regarding Tenant C1's transfer. She said they were happy to have Tenant C1 but it was not the best place to support him. Tenant C1 did not have a dementia diagnosis and had a traumatic brain injury diagnosis. Attempts to interview the Former Assistant Director of Health and Wellness were not successful. 3. Continued record review revealed A Resident Occupancy Agreement was dated 1-27-20 and was signed by Tenant C1's legal representative. The agreement indicated a significant change in a tenant's condition "may result in the need for the provision of services that exceed the type or level of services (i) allowed by law in an assisted living Community or (ii) permitted pursuant to the Occupancy Agreement. In those circumstances, the Community will provide written notice to the Resident of the need for discharge, the reason for the discharge, whether the discharge results from a monitoring evaluation or complaint investigation conducted by the Iowa Department of Inspections & Appeals, and the contact information of the long-term care ombudsman. " The Program would "terminate the Occupancy Agreement and initiated procedures which ensure a safe and orderly transfer of the Resident to an appropriate setting" if they met one or more of the discharge criteria. The agreement indicated the "Community shall have the right to terminate this Agreement based on the Discharge Criteria set forth above with not less than thirty (30) days	A 106		

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A 106	Continued From page 10 written notice to Resident and Representative; provided that such advance notice shall not be required:" "1. When the Resident's health status or behavior constitutes a substantial threat to the health or safety of the Resident, other Residents, or others, including when the Resident refuses to consent to relocation." "2. When an emergency or significant change in the Resident's condition results in the need for provision or services that exceed the type or level of services included in the occupancy agreement and the necessary services cannot be safely provided by the assisted living community." 4. Further record review revealed the Program provided an email dated 9-24-21 from the Former Executive Director to Tenant C1's legal representative. The email indicated the formal 30 day written notice was attached for Tenant C1. The letter was dated 9-13-21 (emailed on 9-24-21) and was addressed to Tenant C1's legal representative. The letter indicated to consider the letter "as a formal written follow-up to the conversation" with the Former Assistant Director of Health and Wellness on 9-13-21 related to the discharge of Tenant C1. The notice provided the transfer effective date of 10-13-21 and the reason for Tenant C1's transfer. Continued record review of Tenant C1's file revealed Tenant C1 was sent out to the hospital on 9-11-21, after an incident of physical aggression towards another tenant. Tenant C1 was not allowed to return to the Program and a date of discharge was provided as 9-13-21; however, he did not return to the Program after being sent out to the hospital on 9-11-21. A	A 106		

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A 106	Continued From page 11 written 30 day notice of transfer, per the occupancy agreement, was not provided to Tenant C1 or Tenant C1's legal representative until 9-24-21 and provided an effective date for Tenant C1's discharge as 10-13-21. A written 30 day notice was not provided to Tenant C1 or Tenant C1's legal representative per the signed the occupancy agreement.	A 106		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall 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, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 2 current tenants reviewed (Tenants #1 and #2) and 2 of 2 discharged tenants reviewed (Tenants C1 and C2). Findings follow: 1. Record review on 8-22-22 and 8-23-22 of Tenant #1's file revealed Tenant #1 moved in on 8-1-22. Continued record review of Resident	A 145		

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A 145	Continued From page 12 Incident Reports indicated the following: An incident report for Tenant #1 indicated on 8-5-22 staff heard the alarm sounding and responded to the exit door. Tenant #1 had exited through the stairwell to the driveway. Tenant #1 said he was looking for his bicycle. He was assisted back to the Program. An incident report for Tenant #1 indicated on 8-14-22 at 10:15 a.m. staff called the nurse on call and reported Tenant #1 had come into the front of the building and told the staff at the front desk he went for a walk. Tenant #1 left the memory care unit via the courtyard. Further record review revealed Progress Notes indicated the following: -On 8-21-22 (late entry for 8-17-22) a discussion was held with Tenant #1's legal representative regarding steps to take after Tenant #1's elopement. Staff would review interventions and would update the service plan. -On 8-22-22 (late entry for 8-5-22) it was reported Tenant #1 set off the stairwell door alarm, staff responded and followed Tenant #1 out onto the driveway. Tenant #1 reported he was looking for his bicycle. No injuries were noted. Staff was aware to monitor for wandering and exit seeking behaviors. -On 8-22-22 (late entry for 8-14-22 at 10:30 a.m.) staff called the nurse on call and reported at approximately 10:15 a.m. Tenant #1 had eloped. Tenant #1 had been on the patio for memory care and "somehow left that area." Tenant #1 came back in the front door of the Program. Tenant #1 was gone for a few minutes per the report given	A 145		

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by the nurse on-call. After the investigation it was determined Tenant #1 went out of the patio of the memory care unit and walked around the building and came in the front entrance. He told the front desk staff that he went for a walk. Tenant #1 had no injuries. Staff was instructed that Tenant #1 was not to go outside unattended. Tenant #1's spouse was notified on 8-14-22 at 11:00 a.m.

Continued record review revealed evaluations dated 8-1-22 (electronically signed on 8-21-22) and 8-17-22 (electronically signed on 8-21-22). Evaluations were not completed after two incidents when Tenant #1 left the memory care unit, including one incident where he left without staff knowledge.

2. Record review on 8-22-22 of Tenant #2's file revealed Resident Incident Reports indicated the following:

On 6-22-22 staff noticed Tenant #2 in another tenant's apartment. Staff tried to get her back into her own apartment but she would not move from the doorway. She would not come out and would not let anyone else in. She screamed and called two tenants by other's names. She was verbally and physically aggressive. She had a hanger and used it "almost a weapon." She hit staff and pushed staff away with the hanger.

On 6-26-22 staff was in another tenant's apartment when Tenant #2 came in. Staff tried to get Tenant #2 out of the apartment and she "jabbing" staff with her walker. She went into another tenant's apartment and continued to "jab" at staff.

On 8-3-22 Tenant #2 tried to elope out of the

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three doors and then went to another tenant's apartment. Staff attempted to get Tenant #2 out of the apartment and she "became aggressive and slapped me in the face and then put her hands on my throat and choked me."

Further record review revealed Progress Notes indicated the following:

-On 6-28-22 Tenant #2 was agitated and she ran her walker into staff's leg. The nurse spoke with family at her agitation and confusion and family said she had been aggressive when she was at a skilled nursing facility previously but family was able to calm her down.

-On 6-28-22 (late entry for 6-22-22) Tenant #2 was very upset and did not want to go back to her apartment. Tenant #2 was very aggressive with staff and they were not able to redirect her.

-On 7-5-22 (late entry for 7-4-22) staff reported that Tenant #2 was very agitated and redirection was unsuccessful.

-On 8-2-22 Tenant #2 was upset and crying in the common areas. Staff not able to redirect her at first and she opened all unlocked doors and tried to leave. Tenant #2 was hitting walls in the hallway with her walker and crying. Tenant #2 called her family prior to coming out to common area and told them there was a woman who needed her help but she could not help her. "It escalated from there."

Continued record review revealed evaluations were completed on 5-17-22 and 6-29-22. Evaluations were not completed with Tenant #2's continued physically aggressive behavior.

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A 145	Continued From page 15 3. Record review on 8-17-22 and 8-18-22 of Tenant C1's file revealed Progress Notes indicated the following: -On 6-12-21 Tenant C1 was exit seeking and tried to open the door. When it did not open, he slammed his body into it. -On 6-12-21 Tenant C1 was very agitated and had "violent outbursts" multiple times towards staff and tenants. -On 6-14-21 Tenant C1 was spitting "non stop" in the common area. -On 6-26-21 Tenant C1 was exit seeking earlier in the day and was upset. Another tenant came over to talk to Tenant C1 and he hit him in the chest. Staff separated the two tenants. -On 7-20-21 (late entry for 7-7-21) a 90 day review was completed. Tenant C1 had one episode of physical aggression since the last evaluation. Tenant C1's legal representative continued to look for a higher level of care. He was not accepted at one alternative placement due to his prior aggression and elopements (prior to medication changes). It noted Tenant C1 had paranoia and anxiety, which was "likely secondary to his PTSD." -On 7-25-21 Tenant C1 was "very exit seeking" and set off door alarms. When a family member was let out of the memory care unit, he walked out and refused to come back in. "Going for walks does not seem to help much with his exit seeking behaviors." -On 8-4-21 Tenant C1 had a weight loss of 9.62% in the past three months. The primary care	A 145		

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A 145	Continued From page 16 provider was notified. -On 8-31-21 (late entry for 8-30-21) Tenant C1's eloped from the memory care unit. -On 9-3-21 Tenant C1 attempted to elope and he became aggressive after staff closed the door. Tenant C1 hit staff in the arm and it was noted he could not be calmed down initially. -On 9-15-21 (late entry for 9-11-21)a telephone call was received from staff for the Assistant Director of Health and Wellness to come to the memory care unit. Staff reported another tenant hit his head and was bleeding. When the Assistant Director of Health and Wellness arrived, the other tenant was on his back in the hallway. There was a "significant amount of blood on his hands and under his head." Staff told her Tenant C1 had thrown the other tenant on the floor. The other tenant was taken to the hospital via ambulance. Tenant C1 was taken to the hospital for a psychiatric evaluation. -On 9-15-21 (late entry for 9-11-21) a nurse from the hospital reported Tenant C1 had 900 cubic centimeters of urine removed from his bladder and the incident was "likely caused from irritation related to his full bladder." -On 9-16-21 Tenant C1's legal representative was informed Tenant C1 could not return to the Program and a 30 day notice would sent from when it was first discussed with Tenant C1's legal representative on 9-13-21. Further record review revealed evaluations were completed on 4-21-21 and 7-7-21. Evaluations were not completed as needed with significant change, including physical aggression towards	A 145		

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A 145	Continued From page 17 staff and a tenant (with injury) and weight loss. 4. Record review on 8-18-22 of Tenant C2's file revealed a Resident Incident Report dated 9-11-21 at 5:56 p.m. documented Tenant C2 was observed laying on his back and was bleeding from the head. The incident report indicated he had a "big wound" on his head. Pressure was applied to the wound, the on-call nurse was notified and 911 was called. Further record review revealed Progress Notes indicated the following: -On 9-15-21 the Former Assistant Director of Health and Wellness received a telephone from staff to come to the memory care unit due to Tenant C2 hitting his head. Tenant C2 was observed laying on his back with "significant amount of blood on his hands and under his head." An assessment revealed a "softball size lump and an inch long laceration in the middle of the back of his head." Staff told the Former Assistant Director of Health and Wellness that another tenant had thrown Tenant C2 onto the floor. An ambulance was called Tenant C2 was taken to the hospital. Tenant C2's legal representative reported all tests came back negative and he would be returning to Program. He returned at about 11:00 p.m. -On 9-15-21 it was noted on 9-14-21 Tenant C2 was assessed for a head injury and he did not have any "further complications with the site or any adverse side effects related to the injury." -On 9-24-21 Tenant C2 cried, yelled and threw furniture and broke things.	A 145		

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A 145	Continued From page 18 -On 10-5-21 staff notified the nurse that he was making suicidal comments. Staff reported C2 said "killing myself is the only thing on my mind and all that I think about" and "I do not want to be in this world anymore." All potential items of self-harm were removed from his apartment, increased checks (hourly) were added, and new orders were received. -On 10-5-21 new orders included: risperidone 0.5 milligram (mg), one tablet, twice daily, sertraline 25 mg every day, risperidone 0.5 one tablet every day as needed. -On 10-9-21 Tenant C2 refused his main entree. Tenant C2 said it was difficult for him to eat food with utensils. He had been eating two bowls of soup and dessert at dinner and also just asked for bread. -On 10-11-21 it was noted finger foods would be provided. Further record review revealed evaluations were completed on 8-6-21 and 12-2-21. Evaluations were not completed after the incident of physical aggression and placement of staples, behavior including self-harm statements and difficulty with eating. 5. When interviewed on 8-23-22 at 4:00 p.m. the Regional Director of Health and Wellness confirmed all evaluations were provided for the tenants listed above.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be	A 290		

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A 290	Continued From page 19 maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes. This pertained to 2 of 2 current tenants reviewed (Tenants #1 and #2) and 2 of 2 discharged tenants reviewed (Tenants C1 and C2). Findings follow: 1. Record review on 8-22-22 and 8-23-22 of Tenant #1's file revealed Incident Reports indicated the following: On 8-5-22 staff heard the alarm sounding and responded to the exit door. Tenant #1 had exited through the stairwell to the driveway. Tenant #1 said he was looking for his bicycle. He was assisted back to the Program. On 8-14-22 at 10:15 a.m. staff called the nurse on call and reported Tenant #1 came into the front of the building and told the staff at the front desk he went for a walk. Tenant #1 left the memory care unit via the courtyard. Further record review revealed Progress Notes indicated the following: -On 8-21-22 (late entry for 8-17-22) a discussion was held with Tenant #1's legal representative	A 290		

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regarding steps to take after Tenant #1's elopement. Staff would review interventions and would update the service plan.

-On 8-22-22 (late entry for 8-5-22) it was reported Tenant #1 set off the stairwell door alarm, staff responded and followed Tenant #1 out onto the driveway. Tenant #1 reported he was looking for his bicycle. No injuries were noted. Staff was aware to monitor for wandering and exit seeking behaviors.

-On 8-22-22 (late entry for 8-14-22 at 10:30 a.m.) staff called the nurse on call and reported at approximately 10:15 a.m. Tenant #1 had eloped. Tenant #1 had been on the patio for memory care and "somehow left that area." Tenant #1 came back in the front door of the Program. Tenant #1 was gone for a few minutes per the report given by the nurse on-call. After the investigation it was determined Tenant #1 went out of the patio of the memory care unit and walked around the building and came in the front entrance. He told the front desk staff that he went for a walk. Tenant #1 had no injuries. Staff was instructed that Tenant #1 was not to go outside unattended. Tenant #1's spouse was notified on 8-14-22 at 11:00 a.m.

Continued record review of Tenant #1's file revealed nurse's notes reflected late entries including for elopements. One of the entries was charted over 15 days past the occurrence.

2. Record review on 8-22-22 of Tenant #2's file revealed Incident Reports indicated the following:

On 6-22-22 staff noticed Tenant #2 in another tenant's apartment. Staff tried to get her back into her own apartment but she would not move from the doorway. She would not come out and

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would not let anyone else in. She screamed and called two tenants by other's names. She was verbally and physically aggressive. She had a hanger and used it "almost a weapon." She hit staff and pushed staff away with the hanger.

On 6-26-22 staff was in another tenant's apartment when Tenant #2 came in. Staff tried to get Tenant #2 out of the apartment and she "jabbing" staff with her walker. She went into another tenant's apartment and continued to "jab" at staff.

On 8-3-22 Tenant #2 tried to elope out of the three doors and then went to another tenant's apartment. Staff attempted to get Tenant #2 out of the apartment and she "became aggressive and slapped me in the face and then put her hands on my throat and choked me."

Further record review revealed Tenant #2's Progress Notes indicated the first documented nurse's note for Tenant #2 (admitted on 6-1-22) was dated 6-28-22 (late entry for 6-27-22) and 6-28-22 (late entry for 6-22-22). A nurse's note was not completed related to the incident that occurred on 8-3-21 noted above.

3. Record review on 8-17-22 and 8-18-22 of Tenant C1's file revealed Progress Notes indicated the following:

-On 7-20-21 (late entry for 7-7-21) it was noted a 90 day review was completed. Tenant C1 had one episode of physical aggression since the last evaluation. Tenant C1's legal representative continued to look for a higher level of care. He was not accepted at one alternative placement due to his prior aggression and elopements (prior

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to medication changes). It noted Tenant C1 had paranoia and anxiety, which was "likely secondary to his PTSD."

-On 8-31-21 (late entry for 8-30-21) it was noted Tenant C1's eloped from the memory care unit.

On 9-15-21 (late entry for 9-11-21) it was noted a telephone call was received from staff for the Assistant Director of Health and Wellness to come to the memory care unit. Staff reported another tenant had hit his head and was bleeding. When the Assistant Director of Health and Wellness arrived, the other tenant was on his back in the hallway. There was a "significant amount of blood on his hands and under his head." Staff told her Tenant C1 had thrown the other tenant on the floor. The other tenant was taken to the hospital via ambulance. Tenant C1 was taken to the hospital for a psychiatric evaluation.

-On 9-15-21 (late entry for 9-11-21) it was noted staff from the hospital reported Tenant C1 had 900 cubic centimeters of urine removed from his bladder and the incident was "likely caused from irritation related to his full bladder." The Former Assistant Director of Health and Wellness said he would need a full psychiatric evaluation and reconciliation of medications. The hospital staff said Tenant C1 would be discharged that night. It was explained to the hospital staff that per regulations Tenant C1 could not come back. A doctor from the hospital called and asked for details related to the incident. The doctor said Tenant C1 would not be admitted due to being calm and cooperative he would not be admitted to psych (also no beds available). Regarding interventions related to his urinary retention the doctor said he would need "intermittent cathing."

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A 290	Continued From page 23 The doctor was told that service could not be provided at the Program as there was not 24 hour nursing staff to assist. The doctor indicated Tenant C1 could stay overnight with a "sitter" but was not going to be admitted for kept or for observation and needed to be discharged as soon as possible. -On 9-15-21 (late entry for 9-14-21) it was noted the Former Assistant Director of Health and Wellness contacted ER case management staff who told her Tenant C1 was "medically ready" for discharge that day and was waiting in the lobby. The nurse informed the ER case management staff that they needed assistance in finding placement for Tenant C1 as "he cannot return to our program due to his aggression and medical needs and that he would either need to find other placement or family would need to secure 24/7 supervision from an outside agency, which none are available due to staffing shortages." The Former Assistant Director of Health and Wellness asked the ER case management staff if he could assist with notification of Tenant C1's family of different placement choices. The ER case management staff said Tenant C1 was their "problem" and they needed to figure something out for him and it was "unacceptable" to leave him in the ER. He was told Tenant C1 could not be re-admitted due to causing an injury to another tenant (unprovoked) and they could not meet his needs related to "intermittent cathing." -On 9-16-21 (late entry for 9-14-21) it was noted the Director of Luminations and Tenant C1's legal representative had been emailing and had phone conversations daily about the progress. -On 9-16-21 (late entry for 9-15-21) it was noted Tenant C1 was not longer needing a catheter.	A 290		

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Tenant C1's legal representative asked the Director of Luminations to fill out paper work for another facility.

Continued record review of Tenant C1's file revealed nurse's notes reflected late entries including for a incident related to physical aggression and injury of another tenant.

4. Record review on 8-18-22 of Tenant C2's file revealed a Resident Incident Report dated 9-11-21 at 5:56 p.m. revealed Tenant C2 observed laying on his back and was bleeding from the head. The incident report indicated he had a "big wound" on his head. Pressure was applied to the wound, the on-call nurse was notified and 911 was called.

Continued record review revealed Progress Notes indicated the following:

-On 9-15-21 it was noted the Former Assistant Director of Health and Wellness received a telephone from staff to come to the memory care unit due to Tenant C2 hitting his head. Tenant C2 was observed laying on his back with "significant amount of blood on his hands and under his head." An assessment revealed a "softball size lump and an inch long laceration in the middle of the back of his head." Staff told the Former Assistant Director of Health and Wellness that another tenant had thrown Tenant C2 onto the floor. An ambulance was called Tenant C2 was taken to the hospital. Tenant C2's legal representative indicated all tests came back negative and he would be returning to Program. He returned at about 11:00 p.m.

-On 9-15-21 it was noted that on 9-14-21 Tenant

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	S0375	A. BUILDING: _____ B. WING _____	C 08/24/2022

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GRAND LIVING AT BRIDGEWATER ALP/D	3 RUSSELL SLADE BLVD CORALVILLE, IA 52241

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A 290	Continued From page 25 C2 was assessed for a head injury and he did not have any "further complications with the site or any adverse side effects related to the injury." Further record review revealed the incident with Tenant C2 occurred on 9-11-21. The entry in nurse's notes related to the incident was dated 9-15-21 and was not indicated as a late entry but was not dated 9-11-21. The notes indicated Tenant C2 was assessed on 9-14-21 and did not appear to have any further injury. The entry was not charted as late entry. 5. When interviewed on 8-23-22 at 4:00 p.m. the Regional Director of Health and Wellness confirmed all nurse's notes for the tenants listed above were provided. She said the expectation for documentation of nurse's notes was as soon as prudent.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 2 current tenants reviewed (Tenants #1 and	A 350		

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A 350	Continued From page 26 #2) to 2 of 2 discharged tenants reviewed (Tenants C1 and C2). Findings follow: 1. Record review on 8-22-22 and 8-23-22 of Tenant #1's file revealed Tenant #1 moved in on 8-1-22. Continued record review of Resident Incident Reports indicated the following: On 8-5-22 staff heard the alarm sounding and responded to the exit door. Tenant #1 exited through the stairwell to the driveway. Tenant #1 said he was looking for his bicycle. He was assisted back to the Program. On 8-14-22 at 10:15 a.m. staff called the nurse on call and reported Tenant #1 came into the front of the building and told the staff at the front desk he went for a walk. Tenant #1 left the memory care unit via the courtyard. Further record review revealed Progress Notes indicated the following: -On 8-21-22 (late entry for 8-17-22) a discussion was held with Tenant #1's legal representative regarding steps to take after Tenant #1's elopement. Staff would review interventions and would update the service plan. -On 8-22-22 (late entry for 8-5-22) it was reported Tenant #1 set off the stairwell door alarm, staff responded and followed Tenant #1 out onto the driveway. Tenant #1 reported he was looking for his bicycle. No injuries were noted. Staff was aware to monitor for wandering and exit seeking behaviors. -On 8-22-22 (late entry for 8-14-22 at 10:30 a.m.) staff called the nurse on call and reported at	A 350		

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approximately 10:15 a.m. Tenant #1 had eloped. Tenant #1 had been on the patio for memory care and "somehow left that area." Tenant #1 came back in the front door of the Program. Tenant #1 was gone for a few minutes per the report given by the nurse on-call. After the investigation it was determined Tenant #1 went out of the patio of the memory care unit and walked around the building and came in the front entrance. He told the front desk staff that he went for a walk. Tenant #1 had no injuries. Staff was instructed that Tenant #1 was not to go outside unattended. Tenant #1's spouse was notified on 8-14-22 at 11:00 a.m.

Continued record review revealed service plans were dated 8-1-22 and 8-22-22. The service plan dated 8-22-22 reflected "Elopement Interventions" and indicated staff could redirect Tenant #1 away from exits with walks, puzzles and coffee. It noted if Tenant #1 exhibited elopement signs to notify the supervisor immediately. It also reflected Tenant #1 was not to go outside unattended. The service plan was not updated as needed after two incidents (8-5-22 and 8-14-22) when Tenant #1 left the memory care unit, including one incident where he left without staff knowledge and did not provide timely interventions.

2. Record review on 8-22-22 of Tenant #2's file revealed Resident Incident Reports indicated the following:

On 6-22-22 staff noticed Tenant #2 in another tenant's apartment. Staff tried to get her back into her own apartment but she would not move from the doorway. She would not come out and would not let anyone else in. She screamed and called two tenants by other's names. She was

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verbally and physically aggressive. She had a hanger and used it "almost a weapon." She hit staff and pushed staff away with the hanger.

On 6-26-22 staff was in another tenant's apartment when Tenant #2 came in. Staff tried to get Tenant #2 out of the apartment and she "jabbing" staff with her walker. She went into another tenant's apartment and continued to "jab" at staff.

On 8-3-22 Tenant #2 tried to elope out of the three doors and then went to another tenant's apartment. Staff attempted to get Tenant #2 out of the apartment and she "became aggressive and slapped me in the face and then put her hands on my throat and choked me."

Further record review revealed Progress Notes indicated the following:

-On 6-28-22 Tenant #2 was agitated and she ran her walker into staff's leg. The nurse spoke with family at her agitation and confusion and family said she had been aggressive when she was at a skilled nursing facility previously but family was able to calm her down.

-On 6-28-22 (late entry for 6-22-22) Tenant #2 was very upset and did not want to go back to her apartment. Tenant #2 was very aggressive with staff and they were not able to redirect her.

-On 7-5-22 (late entry for 7-4-22) staff reported that Tenant #2 was very agitated and redirection was unsuccessful.

-On 8-2-22 Tenant #1 was upset and crying in the common areas. Staff were not able to redirect her at first and she opened all unlocked doors

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and tried to leave. Tenant #2 was hitting walls in the hallway with her walker and crying. Tenant #2 called her family prior to coming out to common area and told them there was a woman who needed her help but she could not help her. "It escalated from there."

Continued record review revealed the service plan was developed on 5-17-22 and then updated on 6-30-22. The service plan staff was to redirect if she went into other tenant apartments. If she became agitated to back away if there was no harm to her others. The service plan was not updated to reflect physical behaviors towards staff and other tenants.

3. Record review on 8-17-22 and 8-18-22 of Tenant C1's file revealed Progress Notes indicated the following:

-On 6-12-21 Tenant C1 was exit seeking and tried to open the door. When it did not open, he slammed his body into it.

-On 6-12-21 Tenant C1 was very agitated and had "violent outbursts" multiple times towards staff and tenants.

-On 6-14-21 Tenant C1 was spitting "non stop" in the common area.

-On 6-26-21 Tenant C1 was exit seeking earlier in the day and was upset. Another tenant came over to talk to Tenant C1 and he hit him in the chest. Staff separated the two tenants.

-On 7-20-21 (late entry for 7-7-21) a 90 day review was completed. Tenant C1 had one episode of physical aggression since the last

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evaluation. Tenant C1's legal representative continued to look for a higher level of care. He was not accepted at one alternative placement due to his prior aggression and elopements (prior to medication changes). It noted Tenant C1 had paranoia and anxiety, which was "likely secondary to his PTSD."

-On 7-25-21 Tenant C1 was "very exit seeking" and set off door alarms. When a family member was let out of the memory care unit, he walked out and refused to come back in. "Going for walks does not seem to help much with his exit seeking behaviors."

-On 8-4-21 Tenant C1 had a weight loss of 9.62% in the past three months. The primary care provider was notified.

-On 8-31-21 (late entry for 8-30-21) Tenant C1's eloped from the memory care unit.

-On 9-3-21 Tenant C1 attempted to elope and he became aggressive after staff closed the door. Tenant C1 hit staff in the arm and it was noted he could not be calmed down initially.

-On 9-15-21 (late entry for 9-11-21) a telephone call was received from staff for the Assistant Director of Health and Wellness to come to the memory care unit. Staff reported another tenant had hit his head and was bleeding. When the Assistant Director of Health and Wellness arrived, the other tenant was on his back in the hallway. There was a "significant amount of blood on his hands and under his head." Staff told her Tenant C1 had thrown the other tenant on the floor. The other tenant was taken to the hospital via ambulance. Tenant C1 was taken to the hospital for a psychiatric evaluation.

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A 350	Continued From page 31 -On 9-15-21 (late entry for 9-11-21)a nurse from the hospital reported Tenant C1 had 900 cubic centimeters of urine removed from his bladder and the incident was "likely caused from irritation related to his full bladder." -On 9-16-21 Tenant C1's legal representative was informed Tenant C1 could not return to the Program and a 30 day notice would sent from when it was first discussed with Tenant C1's legal representative on 9-13-21. Further record review revealed the service plan was signed 6-1-21. There were no evaluations completed when the service plan was updated. The service plan reflected Tenant C1 had a history of paranoia. It also reflected Tenant C1 had a prior history of elopements and exit seeking. The service plan did not reflect Tenant C1's history of PTSD as noted in the 90 day evaluation. It also was not updated as needed and did not reflect physical aggression and interventions. 4. Record review on 8-18-22 of Tenant C2's file revealed diagnosis included progressive dementia. Tenant C2 was staged at a six on the GDS, which indicated severe cognitive decline. Continued record review revealed a Resident Incident Report dated 9-11-21 at 5:56 p.m. revealed Tenant C2 was observed laying on his back and was bleeding from the head. The incident report indicated he had a "big wound" on his head. Pressure was applied to the wound, the on-call nurse was notified and 911 was called. Further record review revealed Progress Notes	A 350		

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A 350	Continued From page 32 indicated the following: -On 9-15-21 the Former Assistant Director of Health and Wellness received a telephone from staff to come to the memory care unit due to Tenant C2 hitting his head. Tenant C2 was observed laying on his back with "significant amount of blood on his hands and under his head." An assessment revealed a "softball size lump and an inch long laceration in the middle of the back of his head." Staff told the Former Assistant Director of Health and Wellness that another tenant had thrown Tenant C2 onto the floor. An ambulance was called Tenant C2 was taken to the hospital. Tenant C2's legal representative reported all tests came back negative and he would be returning to Program. He returned at about 11:00 p.m. -On 9-15-21 on 9-14-21 Tenant C2 was assessed for a head injury and he did not have any "further complications with the site or any adverse side effects related to the injury." -On 9-24-21 Tenant C2 cried, yelled and threw furniture and broke things. -On 10-5-21 staff notified the nurse he was making suicidal comments. Staff reported C2 said "killing myself is the only thing on my mind and all that I think about" and "I do not want to be in this world anymore." All potential items of self-harm were removed from his apartment, increased checks (hourly) were added, and new orders were received. -On 10-5-21 new orders included: risperidone 0.5 milligram (mg), one tablet, twice daily, sertraline 25 mg every day, risperidone 0.5 one tablet every day as needed.	A 350		

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A 350	Continued From page 33 -On 10-9-21 Tenant C2 had been refusing his main entree. Tenant C2 said it was difficult for him to eat food with utensils. He had been eating two bowls of soup and dessert at dinner and also just asked for bread. -On 10-11-21 it was noted finger foods would be provided. Further record review revealed the service plan was not updated until 12-2-21 and was not updated to reflect Tenant C2's injury post incident of physical aggression with injury and the placement of staples, behavior including self-harm statements and difficulty with eating. 5. When interviewed on 8-23-22 at 4:00 p.m. the Regional Director of Health and Wellness confirmed all service plans for the tenants listed above were provided.	A 350		

GRAND LIVING

Regulatory Insufficiency Number	Corrective Action Taken for the Identified RI	System Measures Taken to Prevent a recurrence of the insufficiency	Monitoring of Compliance	Date of Compliance
A150- Program Policies and Procedures	Tenant #1 now has incident reports completed for any incident, according to Grand Living Incident Reporting Policy.	All tenants will have incident reports completed, according to Grand Living Incident Reporting policy. Staff to be retrained on completion of incident reports and proper documentation of incidents that occur.	On a regular basis, the ADOHW or designee will monitor for any incidents to ensure all have incident report completed.	01/20/2023
A106-Occupancy Agreements	Tenant #1 did receive written occupancy of discharge. This was located after review.	Program will provide a written notice for tenant discharge, upon the tenant being discharged from Assisted living or Memory support program. Transition coordinator will provide all residents written notice for tenant discharge, and keep copy on file, for Program, of discharge.	Executive Director will monitor all discharges from community to ensure proper documentation is given and obtained in the event of a tenant is discharging from program.	12/20/2022
A145- Evaluation of Tenants	Tenant #1 and Tenant #2 now have significant change assessments completed.	All tenant wisdom to acts will be reviewed for any resident needing significant change evaluations to be completed to include health, cognitive and functional evaluations. No less than weekly audits to be completed by ADOHW or designee for tenants possibly requiring significant change evaluations.	The DOHW will monitor on a regular basis all staff communication to ensure all tenants requiring significant change evaluations are completed.	12/20/2022
A350- Service Plans	Tenant #1 and Tenant #2 now have updated service plans based on updated evaluations.	All tenants will have service plans that reflects their individual needs based on the health, cognitive and functional evaluations, to include any weight loss.	The DOHW or designee will monitor quality dashboards for clinical compliance with the need for updates to service plans per schedule.	01/20/2023
A290- Nurses Notes	Tenant#1 and Tenant #2 have nurses notes that reflect exceptions in the plan of care.	All tenants will have nurse's notes completed in a timely manner to reflect exceptions in each resident's plan of care.	The DOHW or designee will monitor the clinical dashboard to ensure compliance with tenant nurses notes.	12/20/2022