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 05/15/2025

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 impairment: 3 Number of tenants with cognitive impairment: 31 Total census: 34 The following regulatory insufficiencies were cited related the investigation of Complaint #126085-C:	A 000	See attached POC 7/1/25	
A 160	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 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Review of Tenant C2's file on 5/5/25 revealed an Incident Report dated 3/1/24 indicating at 5:45 a.m. Tenant C2 had an unwitnessed fall and was found lying on the floor on her back. Tenant C2 did not know what had occurred. She had an	A 160		

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A 160	Continued From page 1	A 160		

abrasion on her right elbow. Vital signs were taken. Staff A called for another staff (Staff C) for assistance. It was noted Tenant C2 did not want to get up. The nurse on-call, the former Assistant Director of Health and Wellness (ADHW), was called. She said she would notify Tenant C2's family. Staff B called 911 and Tenant C2 was transported to the hospital. The report indicated emergency medical services (EMS) was called at 6:45 a.m. Tenant C2's family was called at 6:37 a.m. The former ADHW was called at 5:57 a.m. Tenant C2 was sent to the hospital for evaluation.

A review of the ambulance record dated 3/1/24 indicated EMS (emergency medical services) was called at 6:45 a.m. and arrived at the patient's side at 6:58 a.m. The chief complaint was a fall and the secondary complaint was pain all over. Signs and symptoms included weakness, altered mental status, fever, injury to face and urinary incontinence. Her skin was noted to be hot and pale. There was dried blood around Tenant C2's mouth. She had pain in her neck, head and back. Tenant C2 was found lying next her to bed. She was covered with a blanket and had a pillow under her head when they arrived. Staff reported she was found on the floor at about 5:45 a.m. Staff attempted to put her back in bed but she refused their help. She had been last seen around midnight. It appeared she had been in the bathroom and might have fallen, due to blood observed on the floor near the doorway. She was transported to the hospital and left in their care.

Review of hospital records indicated Tenant C2 was admitted on 3/1/24 and discharged on 3/5/24. It was noted as a discharge summary of a deceased patient. The reason for admission was humerus fracture and respiratory failure. The principal diagnosis was acute respiratory failure

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A 160	Continued From page 2	A 160		

with hypoxia. It was noted Tenant C2 presented due to a fall and had a right humerus fracture. Tenant C2 reported she fell that morning but could not provide further details. Labs indicated her calcium was 11.3 and she was positive for influenza. The primary cause of death was acute hypoxia and hypercapnic respiratory failure. On 3/2/24 it was noted Tenant C2 had worsening hypoxia and she was transferred to a higher level of care. The summary indicated Tenant C2's family elected to pursue comfort care. Tenant C2 was moved to palliative care unit for hospice care.

2. When interviewed on 5/6/25 at 9:36 a.m. Staff A said he knew he suggested to call for an ambulance when he called the nurse after finding the tenant on the floor on 3/1/24. He believed he was told by the nurse not to call for an ambulance but to try and get the tenant up while she called the family. Staff A told the nurse the tenant did not want to move. He believed the nurse was the former ADHW. It was a female staff who worked first shift who called the ambulance. He thought from the time he first called the nurse until 911 was called was approximately 15 to 30 minutes.

When interviewed on 5/15/25 at 9:30 a.m. Staff C said he came in to work about 6:00 a.m. Staff A had told him Tenant C2 had a fall, was on the floor by her bed and would not get up, and the on-call nurse had been notified. A third shift person had come down to help. Staff A had said there was blood on the tenant's arm and on the bathroom floor. Staff B came in and she called the former ADHW. Although Staff A had put his name on the incident report, he was not the staff who had come down to help with Tenant C2.

During an interview on 5/6/25 at 2:15 p.m. Staff B

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A 160	Continued From page 3	A 160		

said she had worked first shift and arrived between 6:50 a.m. and 7:00 a.m. There were two co-workers, Staff A and Staff C, at the desk when she arrived. It was reported Tenant C2 was on the floor. Staff B went to her apartment and found her laying on the floor. There was a trail of blood on the floor from the bathroom and dried blood in her mouth. Her pants were down as if she was trying to use the bathroom. She had a pillow under her head. Staff B completed a video call with the on-call nurse and the on-call nurse said to call 911. The ambulance arrived and Staff B explained she had just gotten there. She said third shift staff did not report the severity of the fall to the nurse in her opinion.

An attempt to interview the former ADHW was made; however, was not successful.

When interviewed on 5/6/25 at 11:47 a.m. the Director of Health and Wellness said she heard about the incident after it had happened. There was a former employee who was upset after the fact and came to her about it. The former employee's concern was that Tenant C2 was not sent to the hospital immediately after the fall was discovered. The Director of Health and Wellness said EMS arrived 50 minutes after the on-call nurse was notified.

On 5/6/25 at 10:38 a.m. the Executive Director (ED) said she heard Tenant C2 had a fall with fracture. She was told she was admitted to the hospital for influenza and passed away at the hospital four days later due to aspiration. The former ADHW reported Staff A said Tenant C2 did not complain of pain. First shift staff, Staff B, came in and said Tenant C2 had pain all over and either Staff B or the former ADHW called 911. The ED said it was one hour from when Tenant

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A 160	Continued From page 4 C2 was found on the floor. 3. In summary, Tenant C2 was found on the floor at 5:45 a.m. The incident report indicated the former ADHW was notified at 5:57 a.m. EMS services were not called until 6:45 a.m. The EMS report indicated the tenant was confused and had poor responsiveness. Tenant C2 had a complaint of pain and soreness everywhere. There was weakness noted throughout her body as well as tremors/shaking, altered mental status, fever, injury to face and urinary incontinence. EMS was not contacted until an hour after she was found on the floor and Tenant C2 was not sent out promptly to the hospital for evaluation.	A 160		
A 395	481-69.26(4)a 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 a service plan that reflected the identified needs of a tenant. This pertained to 1 of 3 tenants reviewed (Tenant #3). Findings follow: 1. Review of Tenant #3's file on 5/5/25 revealed a GL Assessment V2 dated 3/26/25 and 4/28/25 revealed he used a walker or manual wheelchair for mobility. Tenant #3 did not use an electric wheelchair due to safety concerns.	A 395		

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A 395	Continued From page 5 Continued record review revealed Tenant #3's service plan dated 4/24/25 indicated he received assistance with cueing and standby assistance for all transfers. Tenant #3 had a bed cane for bed mobility. The service plan did not reflect Tenant #3's use of assistive devices, including the manual wheelchair 2. When interviewed on 5/6/25 at 11:47 a.m. the Director of Health and Wellness confirmed Tenant #3 used a walker or manual wheelchair which he self-propelled. She confirmed all service plans were provided for the tenants reviewed.	A 395		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews as needed. This pertained to 1 of 3 current tenants reviewed (Tenant #1) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow:	A 430		

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A 430	Continued From page 6 1. Review of Tenant #1's file on 5/5/25 revealed a progress note dated 3/27/25 documenting the previous day (3/26/25) Tenant #1 was diagnosed with COVID-19 and was staying in her apartment. Meals were being taken to her apartment. It was noted she would continued to be monitored and at that time had no complaints of chest pain or trouble breathing. An Incident Report dated 4/28/25 indicated Tenant #1 had an unwitnessed fall. She was trying to pick up something and fell. There were no apparent injuries. Nurse reviews were not completed to follow up at the end of Tenant #1's isolation after testing positive for COVID-19 to determine if Tenant #1 had any further signs or symptoms of illness. Additionally, Tenant #1 had a fall on 4/28/25 and a nurse review was not completed post fall. 2. Review of Tenant C1's on 5/5/25 file revealed Progress Notes indicating the following: - On 12/26/23 was in a lot of severe pain all day. She screamed and cried in pain when staff tried to complete cares for her. Her speech was also slurred. She was very weak and very uncomfortable. It was reported by a caregiver. - On 12/26/23 increased need for physical assistance of two people due to weakness. It was reported by a caregiver. - On 12/28/23 tenant had bruising on her cheek, she ate much less, she cried in pain, had more confusion, she was unable to stand up on her own and difficulty using the restroom. Staff indicated "She may be on the decline, but it would be nice to have her checked out or spent some time with to see how she is." It was noted staff were worried about her. It was reported by a caregiver.	A 430		

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A 430	Continued From page 7 - On 12/29/23 was very weak and was non-responsive. It was reported by a caregiver. - On 1/6/24 "Noted" was documented by one of the nurses. - On 1/26/24 did not eat anything and was in pain all over - On 1/29/24 the hospice nurse was there to see Tenant C1. A new order was received for liquid acetaminophen 500/15 milliliters (ml) with meals. Nurse reviews were not completed for Tenant C1 after staff reported changes in health status as noted above. 3. When interviewed on 5/6/25 at 11:47 a.m. the Director of Health and Wellness said the follow up to the fall on 4/28/25 for Tenant #1 was on the incident report on 5/4/25. She confirmed there was not follow up note related to her COVID positive status. She also confirmed there were no other follow up nurse's notes or nurse review for Tenant C1.	A 430		

ok
7/1/25

f	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
A160	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. 1. Tenant C2 is deceased. The nurse involved in this incident is no longer employed by the facility 2. The program's nurses have been educated on the need to contact EMS immediately upon discovery of serious injury/change of conditions. 3. The DOHW/designee will perform weekly audits, for the next 90 days, on all transfers by EMS to ensure that EMS was called immediately on discovery of the serious injury/change of condition. Audits will be documented in the State survey audit manual.	7/10/2025
A395	481-69.26(4)a 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 1. Tenant #3's service plan has been updated to show all assistive devices used including the manual wheelchair. The service plans for all tenants in the program will be audited to ensure their identified needs and preferences for assistance are included. 2. The program's nurses have been educated on the need to include all identified needs and preferences for assistance on each tenant's service plans. 3. The DOHW/designee will audit all new service plans completed for the next 90 days to ensure all identified needs and preferences for assistance are included. All concerns will be corrected. Audits will be documented in the State survey audit manual.	7/10/2025
A430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; 1. Tenant #1 had a nurse review completed on 6/10/25 Tenant C1 is deceased	7/10/2025

	2. The program's nurses have been educated on the need to complete a nurse review on all tenants with an illness/change of condition, at the end of the any treatment for illness and post falls. 3. The DOHW/designee will audit progress notes for all tenants that have had an illness/change of condition and fall for the next 90 days to ensure nurse reviews have been completed. All concerns will be corrected. Audits will be documented in the State survey audit manual.	