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
	S0381	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE KENSINGTON	2210 AVENUE H FORT MADISON, IA 52627

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 45 Number of tenants with cognitive disorder: 1 Total census of Assisted Living Program: 46 The following regulatory insufficiencies were cited during the investigation into Complaint #111442-C.	A 000		
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete an incident report form for 1 of 3 former tenants reviewed (Tenant C1). Findings follow: Record review on 9/28/23 of an Observations sheet revealed Staff A documented on 1/15/23 at 1:05 AM that Tenant C1 was sent to the emergency room for symptoms of asthma. The Licensed Practical Nurse (LPN) documented on 1/15/23 at 1:03 PM that staff reported Tenant	A 130		

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A 130	Continued From page 1 C1 had paged with complaints of asthma. He had no relief from his rescue inhaler shortly after midnight. Staff called 911 and the tenant was transferred to the local emergency room for an evaluation. The tenant had since been transferred to a hospital in Iowa City for exacerbation of Chronic Obstructive Pulmonary Disorder and had passed a blood clot. The tenant was currently having decreased neurological response to stimuli. The program had a policy on Accident/Incident reporting. All accidents or incidents were to be documented on an Incident Report form. An Incident Report form would be completed for any incident jeopardizing or affecting a tenant's health, life or safety. There was no Incident Report form documenting Tenant C1's medical emergency. The Director of Nursing confirmed this finding on 9/28/23 at 12:52 PM.	A 130	AS of 11-30-23 all incident reports will be done and completed via our ECP incident reporting within 24 hours of the incident. The DON and the Director will ensure this is done within 24 hours via signing those incident reports.	
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 the established policy on Routine Care in Emergency Situations regarding family notifications for 1 of 3 former tenants reviewed (Tenant C1). Findings follow: Record review on 9/28/23 of an Observations sheet revealed Staff A documented on 1/15/23 at	A 150		

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A 150	Continued From page 2 1:05 AM that Tenant C1 was sent to the emergency room for symptoms of asthma. The Licensed Practical Nurse (LPN) documented on 1/15/23 at 1:03 PM that staff reported Tenant C1 had paged with complaints of asthma. He had no relief from his rescue inhaler shortly after midnight. Staff called 911 and the tenant was transferred to the local emergency room for an evaluation. The tenant had since been transferred to a hospital in Iowa City for exacerbation of Chronic Obstructive Pulmonary Disorder and had passed a blood clot. The tenant was currently having decreased neurological response to stimuli. On 9/28/23 at 2:00 PM, Staff B reported she received a page from Tenant C1 on 1/15/23. He said he was having a hard time breathing. Staff B contacted Staff A who collected the emergency kit. They called the LPN and the emergency medical technicians. Staff B reported it was the nurse's job to call the family about medical situations. On 9/28/23 at 11:30 AM, Tenant C1's step-daughter stated she was notified by a doctor at the University of Iowa Hospital and Clinic (UIHC) the day after the incident. She did not learn of the hospitalization from staff at the program or by personnel at the local hospital. On 9/28/23 at 9:25 AM Tenant C1's son reported he was notified by staff at the UIHC about his father's transfer from the program to the local hospital and then to Iowa City. The first contact he had from the program was on a Tuesday when the Executive Director called to apologize about the lack of communication. The son reported his father exhibited symptoms of illness around 12:00	A 150	As of 11-30-23 any incident including ER visit's will be relayed to the resident's emergency contact by the DON and/or Director immediately following the incident. The Director will ensure compliance.	

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A 150	Continued From page 3 AM on a Sunday night. On 9/28/23 at 12:25 PM the LPN reported she received a call from staff informing her Tenant C1 was alert and oriented but requested to be sent to the emergency room as his inhaler was not working to control his asthma. The LPN called the program in the morning and asked if there was any update on Tenant C1's condition. Tenant C1's step-daughter had been in the building already and was aware of Tenant C1's condition. The LPN confirmed no one from the program called Tenant C1's family when he was sent to the hospital. The program had a Routine Care in Emergency Situations policy. When it was necessary to transport a tenant during an emergency situation, the following procedures would be followed: - once emergency services have been activated, a member of staff would notify the licensed nurse on call; - the tenant's family would be notified of the situation as soon as possible.	A 150		

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