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
	S0382	A. BUILDING: _____ B. WING _____	C 08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORES AT PLEASANT HILL	1500 EDGEWATER DRIVE PLEASANT HILL, IA 50327

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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 disorders: 31 Number of tenants with cognitive disorders: 1 Total: 32 The following regulatory insufficiency was cited during the investigation of Complaint #98891	A 000	Plan of Correction Intake # 98891 10/14/2021 The regulatory insufficiency sited was 481.67.3(2) Tenant Rights: To receive care, treatment and services which are adequate and appropriate. Tenant #1 was transferred to Methodist Hospital ER and admitted. Tenant #1 did not return to the community. Assisted Living Nurse Manager and designee completed in-service for care staff	
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 reviews the Program failed to provide care, treatment and adequate services for 1 of 1 tenants reviewed who was hospitalized (Tenant #1). Findings include: 1. When interviewed on 8/3/21 at 9:22 am the complainant stated the Program was not following Tenant #1's service plan. The complainant noted Tenant #1 was to wear compression socks. The complainant gave the Assisted Living (AL) Manager/RN the prescription for the compression socks on 7/9/21 but the tenant did not get the socks until 7/23/21. The complainant then noted	A 160	on August 12 and 13, 2021 for the following: a. Abuse and Neglect and when to report and to who they should report, if they suspect any abuse or neglect of a resident. b. Documentation on a resident; including change of condition, medication and treatments administered to the resident, daily charting expectation including when a resident refuses care/services. c. Notification of the AL Nurse Manager or AL RN; when a resident has had a change in condition or refusal of medications, treatments care or services. An agency checklist was implemented on August 12, 2021 to be reviewed with new agency staff assigned to the community, on expectations when they are in the community for a shift. An agency RN was contracted for 40 hour/week, to assist the AL Nurse Manager until an RN is hired to assist the AL Nurse Manager in the community. a. The Shores Lead RN hired on September 7, 2021	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 160	Continued From page 1 the tenant did not wear the socks but someone had documented she had been wearing them. In addition, the tenant was being followed by a home health wound care Registered Nurse (RN). The wound care RN noted the tenant's left big toe was black. The wound care RN told the AL Manager/RN. It was decided Tenant #1 was to go to the ER and she was admitted to the hospital. The complainant stated Tenant #1's toe was amputated. The complainant thought if staff had been applying the stocking, they would have noted the issue with the toe at an earlier time. The complainant also noted Tenant #1 had an "air bed" to assist with circulation but the bed was never inflated. 2. Records provided by the Program and complainant, reviewed on 8/3/21 and 8/24/21, revealed the following: Tenant #1 was 89 years old, low risk cognition scale, alert and oriented x3. Diagnoses included rheumatoid arthritis involving multiple sites, essential hypertension, emphysema, acquired hypothyroidism, coronary artery disease, pure hypercholesterolemia, osteopenia of left hand, venous insufficiency, constipation, a-fib (atrial fibrillation), and PVD (peripheral vascular disease). Tenant #1 ambulated with a walker. Prior to admission to the Program, she lived in an independent living apartment. The tenant had reportedly fallen three times. After the third fall, she was admitted to the hospital where it was discovered she had a sacral insufficiency fracture. The hospital admission assessment and discharge orders dated 7/6/21 noted the tenant would be discharged to the Program on 7/9/21 and would need Physical Therapy (PT) and Occupational Therapy (OT) home health services for the "sacral insufficiency fracture, weakness."	A 160	Meetings were held on or before August 12, 2021 with outside agencies, providing services at the community. Collaboration, visiting with the AL Nurse Manager or designee when they exit the building, and providing copies of assessment, nurses notes, care plans, physician order, etc. Weekly Skin Log established and managed by The Shore's nurses. Audits will be completed, at least 10 per month for 1st quarter (10/21 to 12/21) and 5 per month for the 2nd quarter (1/22 to 3/22) on the following areas: a. Change of Condition Communication Log; communication and care notes. b. Daily charting; including edema wear charting AL Nurse Manager or designee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance at least quarterly for the next 6 months then reassess the need for continued monitoring based on compliance. Regulatory insufficiency will be corrected by November 1, 2021. Completed by: Debby Cooper, Executive Director	

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A 160	Continued From page 2 Tenant #1 was admitted to the Program on 7/9/21. A Nurse Review/Assessment, completed by the AL Manager/RN on 7/9/21, noted the tenant needed assistance with edema wear application and removal in AM/PM. The document stated she had a "sore on inside of L leg." The Review/Assessment noted Tenant #1 had limited ROM (range of motion) in her right shoulder. It stated Tenant #1 was independent with transfers. She used a walker for transfers and was independent in walking to the dining room. The elopement risk document stated she was fully ambulatory. Tenant #1's Service Plan, completed by the AL Manager/RN on 7/13/21, noted the tenant needed assistance for edema wear application in AM and removal in PM. The Service Plan was modified on 7/19/21 to include "Uses walker for ambulation inside her apartment. Staff should encourage [tenant] to use her wheelchair outside of her apartment. Staff to provide escorts to meals and activities. [Tenant] is unable to self-propel her wheelchair due to her shoulder ROM." An Interdisciplinary Note, written by the AL Manager/RN on 7/9/21 stated, "Res has area to her lower leg that has a tx dally." "Staff will assist with ADSL as identified in the service plan after assessment completed. Res will work with UnityPoint at Home for PT/OT." A UnityPoint at Home order for services dated 7/14/21 noted the Physical Therapist's Admission Summary indicated, "Pt has wound to left lower leg and agrees to RN referral for wound care." A wound procedure home health visit by a SN (skilled nurse) on 7/15/21. The home health SN	A 160		

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A 160	Continued From page 3 noted Tenant #1 had edema (RT pedal) and an anterior-left pretibial venous ulcer first observed on 7/12/2021. The wound dimensions were 2.10 cm in length and 2.40 cm in width. No pain was associated with the wound. The SN noted supplies were ordered for the wound care. A telfa pad was applied and held in place with soft netting rather than tape. The SN indicated treatment would start when the supplies arrived. The plan was to order the supplies and to see Tenant #1 twice a week. A wound procedure home health visit was made on 7/19/21. The home health SN indicated edema on the tenant's right and left legs. An intervention indicated the tenant was to administer compression wraps as ordered; however, the tenant stated she was unable to find the compression wraps. She would apply them once they were found. The ulcer was assessed and wound care was performed (cleaned with liquid soap, applied moisturizer, applied therahoney to wound, covered with mepilex). This dressing was to be changed twice a week. The wound dimensions were 1.50 cm in length and 2.30 cm in width. A next visit was planned for 7/22/21. A wound procedure home health visit was attempted on 7/22/21. Tenant #1 did not answer her door and her door was locked. The SN noted she would attempt a 7/23/21 visit. A wound procedure home health visit was made on 7/26/21. The home health SN noted the wound was noticeably more yellow, the lower leg was bright red in color and the wound was more indurated. The tenant had no fever. A puncture type wound was noted to the bottom of the ball of the foot. The SN reported Tenant #1 was taken off therahoney because of stinging, then placed	A 160		

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A 160	Continued From page 4 an antibiotic ointment on the wound and attempted to wrap the wound. The SN noted, "PCP notified, new antibiotic ordered for pt." The wound assessment noted left plantar foot- 1st metatarsal head trauma was first observed on 7/26/21. The wound dimensions were 1.50 cm in length and 0.50 cm in width. Tenant #1 indicated there was intermittent pain associated with the wound. She was unable to recall the cause of the wound. The home health SN provided wound care. The plan for the next visit included antibiotic education, wound status and new orders for the wound on the ball of foot. The next planned visit was for 7/29/21. An interdisciplinary note written on 7/30/21 by Staff B (care assistant) stated, "late entry on 7/26/2021 the wound nurse was in to see resident and had made a phone call to the doctor about sores on resident's left leg and sores on the bottom of foot. The resident refused stocking at the time I was in room." A wound procedure home health visit was made on 7/29/21. The home health SN noted Tenant #1's left large toe was numb, blue in color. The tenant stated the onset was the previous day. The SN noted the tenant stated she was only wearing the compression stocking on her right leg and continued to take the mepilex bandage off due to stinging. The report noted the left lower extremity continued to be red and swollen. The SN noted, "Pt states onset of discoloration and numbness to left large toe began yesterday. Pt states no nurse was present to look at her toe yesterday. Pt states she had a call out to nurse to look at toe today when SN arrived for assessment. AL nurse and SN in agreement patient to be seen in ER. Pt sent by ambulance to Methodist Hospital."	A 160		

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A 160	Continued From page 5 A 7/29/21 Interdisciplinary Note written by the AL Manager/RN noted Tenant #1 complained a toe was swollen and turning purple/blue. The AL Manager/RN noted the resident had a wound on the bottom of her foot just under her toe. When she touched the tenant's toe, it was cold. After the touch assessment she noted the base became darker/deep purple, almost black. The toe area became increasingly darker and there was no pedal pulse noted. The tenant had no complaints of pain. In addition the "area being treated by home health is now size of quarter and on admission (to the Program) from hospital was smaller than dime size. Wound nurse stated res complained of mepilex and took it off a few days ago." A 7/30/21 home health note written by a home health SN revealed Tenant #1 was hospitalized on 7/29/21 due to wound infection or deterioration. Tenant #1's Medication Administration Record (MAR) noted compression stockings (JOBST 15-20mmHG KN small) were to be worn daily. The originated/written date for compression stockings was 7/21/21. A Pass Note in the Tenant's MAR noted on 7/22/21 at 9:28PM the stockings arrived from the pharmacy. The MAR indicated the stockings were taken off on 7/22/21 and worn daily (on and off) from 7/23/21 thru 7/28/21. There was no indication the left stocking was not being worn. 3. On 8/3/21 at 1:15PM Staff A (care assistant) revealed she had noticed a stocking in Tenant #1's room when she was administering her medications on 7/22/21. She asked Tenant #1 why she was not wearing her stocking and the tenant told her because her left leg was too	A 160		

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A 160	Continued From page 6	A 160		

swollen. She said she observed Tenant #1 not wearing her stocking after the 22nd however never questioned the tenant again about not wearing the stocking. She did not communicate the tenant's refusal to wear the stocking to anyone. Staff A noted she was only responsible for passing medications and did not actually apply/take off the stockings. However, she was responsible for documenting in the MAR when the stockings were taken on and off. She did not document Tenant #1's refusal to wear the left stocking. Staff A stated she never observed a wound on Tenant #1's left leg.

On 8/3/21 at 2:00PM interview with Staff C revealed she was from a temporary staffing agency. She stated she had administered medication in the AM to Tenant #1 three times. She had never noticed a wound on Tenant #1's leg/foot, as she usually wore pants. The tenant never complained to her about any pains. She added Tenant #1 was always pleasant and she enjoyed talking to her.

An 8/5/21 at 10:27AM interview with Staff B (care assistant) revealed she saw the home health nurse in Tenant #1's apartment on 7/26/21. She was going to ask the home health RN about the tenant's stockings. However, the home health nurse, who was looking at the wound at the bottom of the tenant's foot, told Staff B to also look at the wound. The nurse said she was going to notify the doctor about the wound. Staff B said she did not tell the AL Manager/RN about communication with the home health nurse or the observation of the wound. She added she was not feeling well, left early, had the following day off and was sick the day after that. When she returned to work, she was told to write a late entry about the communication and observation which

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A 160	Continued From page 7 had occurred with Tenant #1 on 7/26/21. On 8/5/21 at 11:50AM Staff D, a temporary agency staff, stated she had put a stocking on Tenant #1's left leg. She knew it wasn't the right leg because the tenant said her right leg was sore. She added she forgot to tell the AL Manager/RN about the sore leg. In addition, Staff D said she was giving Tenant #1 a bath and noticed a sore on her left leg. She was going to write an incident report on the sore but the "regular worker" told her they already knew about the sore and there was no need to write an incident report. Tenant #1 was interviewed on 8/23/21 at 9:00AM, after being discharged from the hospital to a rehabilitation facility. The tenant confirmed she was admitted to the AL Program after she had fallen for a third time. She stated she used a walker for ambulation in her room and was to use a wheelchair outside her room. She thought the wheelchair was too big and bulky. The tenant stated she had an airbed for her circulation. She noted she was able to fill the bed herself with air (Sleep Number bed) but had not filled it while she was living at the Program. The tenant remarked she knew she was to wear compression stocking on both legs, however did not wear one on her left leg because of an abrasion on her left leg, it was too painful, and the stocking was too loose. Tenant #1 said she had told a staff person about the pain but could not recall when or whom she told. She noticed her left toe turning blue a day or two before she went to the hospital. She remarked it was not too painful. She stated she told the wound care SN about her toe but did not tell the Program's RN nor did the Program RN ever check her leg or toe.	A 160		

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A 160	Continued From page 8 The AL Manager/RN was interviewed on 8/3/21 and 8/5/21. On 8/3/21 at 2:20PM, she revealed she was told about Tenant #1's script for compression stocking on 7/9/21. She said Tenant #1's granddaughter had the script and the RN asked Tenant #1 to get the script from the granddaughter so it could be filled. The RN stated there was a delay in filling the script due to getting the script from the granddaughter and the need to order a tape measure to measure the size of stocking needed for the tenant. She confirmed the stockings were not received until 7/22/21. On 8/5/21 at 9:50 AM the AL Manager/RN revealed there was a home health referral for OT and PT services for Tenant #1, however she did not know who made the referral or when. She assumed Tenant #1 was being seen for wound care by a home health nurse. She herself had not observed the wound between 7/9/21 and 7/29/21. The RN noted the wound was the size of her thumbnail when she assessed it on 7/9/21. She stated Staff B might have told her about the wound on 7/26/21, however she could not recall for sure and there was no documentation of any conversation between them on that day. The AL Manager/RN did note that there was a new order for an antibiotic on the 26th, but she did not assess Tenant #1 at that time. The AL Manager/RN confirmed there was no direct communication between her and the home health nurse. Interviews with the Program Administrator on 8/3/21 and 8/5/21 noted Tenant #1 was an active member of the Program, used a walker and ambulated independently throughout the facility. The Administrator indicated staff training had begun on documentation, change of condition and daily charting. She confirmed staff did not	A 160		

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A 160	Continued From page 9 document Tenant #1's refusal to wear her left compression stocking. She also noted the home health nurse did not inform the Program RN of Tenant #1's wound treatment. The Administrator confirmed there was a lack of communication with the home health agency and plans were in place to improve communication between the Program and outside providers and to address staff training issues.	A 160		