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 02/27/2024

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

(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 impairment: 30 Number of tenants with cognitive impairment: 4 Total census: 34 The following regulatory insufficiencies were cited during the investigation of Complaint #119094-C.	A 000	See Attached POC 4/30/24	
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 interviews and record review, staff failed to follow the Program's policy regarding tenant falls for 1 out of 3 tenants reviewed (Tenant #2). Findings include: 1. On 2/27/24, Tenant #2's record revealed an admission date of 6/2/21. Tenant #2 had a diagnosis of dementia. On 2/8/24, Tenant #2 scored a 4 on her most recent Global Deterioration Score (GDS) testing. A review of Tenant #2's incident reports, revealed Tenant #2 had a fall on 2/16/24 at 4:30 am. The incident report revealed Tenant #2 was discovered standing in her apartment with blood on her face. Tenant #2 had an abrasion on her right eyebrow and blood had dripped from both nostrils upon	A 150		

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

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A 150	Continued From page 1	A 150		

discovery. Tenant #2 had a bump to the back of her head, a swollen face, and the back of her right hand was bruised. Tenant #2 relayed to staff she had tripped in her apartment but could not recall details.

2. On 2/27/24 at 9:04 am, Staff B stated she discovered Tenant #2 standing in her apartment with blood on her face and on the floor. Staff B stated Tenant #2 told her she had fallen. Staff B stated she believed Tenant #2 had a broken nose because Staff B heard a whistling sound when Tenant #2 breathed and her nose was swollen. Staff B stated Tenant #2 also had a laceration above her right eye which had dried blood on it. Staff B cleaned Tenant #2's face up with water and took her vitals which were within normal limits. Staff B stated she called the Registered Nurse (RN) Manager on-call as that was what she was trained to do. Staff B stated the RN Manager wanted to video chat but Staff B could not figure out to do the video option. So Staff B stated she text a picture of Tenant #2's face to the RN.
Staff B stated the RN Manager told her to apply steri strips to the laceration above the eye. Staff B stated she did not do that as she was not trained on how to apply steri strips and the laceration was no longer bleeding. Staff B stated Tenant #2 complained her head hurt. Staff B stated the RN Manager instructed Staff B to apply ice to Tenant #2's face and back of head. Staff B stated the RN Manager never came in to assess Tenant #2 during Staff B's shift. Staff B stated she had Tenant #2 lie on her couch with ice applied to her face and head. Staff B also completed an incident report and faxed Tenant #2's physician. Staff B stated Staff D arrived to work at 5:55 am. Staff B showed Staff D Tenant #2's injuries. Staff D stated she would call Tenant #2's family right

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A 150	Continued From page 2 away. Staff B stated she wasn't comfortable calling 911 without calling the RN Manager on-call first. 3. On 2/27/24 at 9:16 am, Staff D stated she arrived for work at around 6:00 am on 2/16/24. Staff D stated Staff B immediately approached her and wanted her to look at Tenant #2's injuries. Staff D stated she observed Tenant #2 laying on her couch. Staff D stated Tenant #2's face looked bad. Staff D believed Tenant #2 needed to be assessed at the hospital. Staff B stated to Staff D the RN Manager on-call stated Tenant #2 was to be treated in-house and not sent out. Staff D stated she called Tenant #2's family to inform them of the fall. Staff D stated the family asked what the RN Manager said to do. Staff D stated the RN Manager stated Tenant #2 was to be treated in-house until an RN assessed her. The family was okay with that. Staff D waited for the RN to arrive. Staff D stated the RN Manager never arrived but the Assistant RN arrived to work at 7:30 am. Staff D asked the Assistant RN if she had been told about Tenant #2's fall. The Assistant RN had not been informed. Staff D stated the Assistant RN cleaned up Tenant #2 to better examine her injuries. Staff D stated the Assistant RN wanted to send Tenant #2 to the emergency room to be assessed so she called the RN Manager on-call. The RN Manager told the Assistant RN Tenant #2 should be treated in-house and was not to be sent to the emergency room. Staff D stated the Assistant RN appeared to be upset about this and called the on-call physician for directives. The on-call physician directed the Assistant RN to send Tenant #2 to the hospital for assessment. Staff D stated Tenant #2 complained her face, nose, and neck hurt.	A 150		

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A 150	Continued From page 3 4. On 2/27/24 at 10:40 am, the Assistant RN stated she walked in to the Program on 2/16/24 at 7:30 am. The Assistant RN stated Staff D immediately approached her and asked if she had heard about Tenant #2. The Assistant RN went to Tenant #2's room. Tenant #2 was sitting on her couch and was bloody. The Assistant RN showered Tenant #2 so she could better examine the injuries. The Assistant RN stated Tenant #2 eventually complained her neck hurt and she could not turn her head. The Assistant RN stated the Program's history was they really did not like to send tenants out to the hospital if they do not need too. The Assistant RN stated it was not required by nursing staff on-call to physically come in to the building to do an assessment if called by staff. The Assistant RN stated they have completed assessments by using video phone calls. The Assistant RN stated she had in fact called the RN Manager and she was instructed by her to not send Tenant #2 out to the emergency room and to treat her in-house. The Assistant RN stated she had not completed vitals as the staff had completed them and they were within normal limits. The Assistant RN stated Tenant #2 joked with staff and made light of the incident prior to leaving for the hospital. 5. On 2/27/24 at 1:23 pm, the RN Manager stated she received a call on the morning of 2/16/24 at around 4:30 am from Staff B. Staff B reported Tenant #2 had fallen and was bleeding. Staff B reported Tenant #2 had a cut above her eyebrow and her nose was bleeding. The RN Manager stated she talked to Staff B about how facial injuries could look worse than they were. The RN Manager asked Staff B if the tenant was in pain and if Staff B took her vitals? The RN Manager	A 150		

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A 150	Continued From page 4 stated she was told by Staff B that Tenant #2's eyebrow was hurt and that vitals were within normal limits. The RN Manager stated she instructed Staff B to apply ice to Tenant #2's face and to administer acetaminophen. The RN Manager stated she did not recall being told Tenant #2 had complaints of pain in the back of her head nor could she recall instructing Staff B to apply ice to the back of Tenant #2's head. The RN Manager stated she trained all staff to call the RN on-call for a fall but that staff had the right to call 911 had they felt it was necessary. The RN Manager stated she had not worked in the building until later in the day on 2/16/24 and could not recall if she had called the Assistant RN or not to inform her of Tenant #2's fall. The RN Manager stated once the Assistant RN assessed Tenant #2, they talked back and forth on the phone and the Assistant RN stated Tenant #2 began having neck pain at that time. The RN Manager stated she called the on-physician and asked for guidance and received directives to send Tenant #2 to the emergency room for assessment. The RN Manager stated she called the Assistant RN to inform her of the physician's directives. 6. On 2/27/24, a review of hospital records for Tenant #2 during her stay from 2/16/24 through 2/22/24, revealed Tenant #2 received the following injuries after her 2/16/24 fall: a closed nondisplaced odontoid fracture with type II morphology, a mildly displaced bilateral nasal bone and a minimally displaced fracture of the upper anterior bony nasal septum. The hospital record revealed Tenant #2 was seen in the emergency room at 9:30 am on 2/16/24, 5 hours after being discovered by Staff B in her room.	A 150		

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A 150	Continued From page 5 Tenant #2 was discharged from the hospital to a skilled care unit for rehabilitation until she could return to her apartment. 7. On 2/27/24, a review of the Program's policy titled: "Fall - Assisting Residents Post Fall," revealed the following procedures: Procedure: 1.) Stay calm. The calmer you are, the more at ease the resident will be. Explain to the resident with each task you complete what you are doing and why. 2.) The staff member will assist with taking residents' vital signs, ask the resident if they are experiencing an injury, pain, discomfort, dizziness or hit their head. If resident voices any of these symptom call 911 then to notify nurse and family at this time. Visually observe if any apparent injuries are present, and if they are able to move all extremities within their normal limits. It may not be wise for a resident to move in some cases. 8. In summary, Tenant #2 was found after a fall on 2/16/24 by Staff B. Staff B stated Tenant #2 complained of her head hurting and Staff B observed obvious facial injuries on Tenant #2. Staff B had not called 911 as the Program's policy instructed. Staff D arrived to work at 6:00 am and observed Tenant #2's injuries. Staff D described Tenant #2's facial injuries as pretty bad. Staff D had not called 911 as the Program's policy instructed. The RN Manager was contacted by Staff B at 4:30 am regarding Tenant #2's facial injuries received from a fall. The RN Manager had not instructed Staff B to call 911. After 7:30 am, the Assistant RN called the RN Manager after she observed Tenant #2's facial injuries. The RN had not instructed the Assistant RN to call 911.	A 150		

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A 150	Continued From page 6 9. On 2/27/24 at 2:00 pm, the Program's Nurse Consultant, Regional Director of Community Operations, and the Assistant RN confirmed Staff B, Staff D, and the RN Manager all failed to call 911 as the Program's policy directed.	A 150		
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 interviews and record reviews, the Program failed to assess and document the health status of 1 out of 3 tenants reviewed who had a falls between January and February 2024 to make recommendations and referrals as appropriate (Tenant #2) Findings include: 1. On 2/27/24, Tenant #2's record revealed an admission date of 6/2/21. Tenant #2 had a diagnosis of dementia. On 2/8/24, Tenant #2 scored a 4 on her most recent Global Deterioration Score (GDS) testing. A review of Tenant #2's incident reports, revealed Tenant #2 had a fall on 2/16/24 at 4:30 am. The incident	A 430		

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A 430	Continued From page 7	A 430		

report revealed Tenant #2 was discovered standing in her apartment with blood on her face. Tenant #2 had an abrasion on her right eyebrow and blood had dripped from both nostrils upon discovery. Tenant #2 had a bump to the back of her head, a swollen face, and the back of her right hand was bruised. Tenant #2 relayed to staff she had tripped in her apartment but could not recall details.

2. On 2/27/24 at 9:04 am, Staff B stated she discovered Tenant #2 standing in her apartment with blood on her face and on the floor. Staff B stated Tenant #2 told her she had fallen. Staff B stated she believed Tenant #2 had a broken nose because Staff B heard a whistling sound when Tenant #2 breathed and her nose was swollen. Staff B stated Tenant #2 also had a laceration above her right eye which had dried blood on it. Staff B cleaned Tenant #2's face up with water and took her vitals which were within normal limits. Staff B stated she called the Registered Nurse (RN) Manager on-call as that was what she was trained to do. Staff B stated the RN Manager wanted to video chat but Staff B could not figure out to do the video option. So Staff B stated she text a picture of Tenant #2's face to the RN.
Staff B stated the RN Manager told her to apply steri strips to the laceration above the eye. Staff B stated she did not do that as she was not trained on how to apply steri strips and the laceration was no longer bleeding. Staff B stated Tenant #2 complained her head hurt. Staff B stated the RN Manager instructed Staff B to apply ice to Tenant #2's face and back of head. Staff B stated the RN Manager never came in to assess Tenant #2 during Staff B's shift. Staff B stated she had Tenant #2 lie on her couch with ice applied to her face and head. Staff B also completed an incident

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A 430	Continued From page 8	A 430		

report and faxed Tenant #2's physician. Staff B stated Staff D arrived to work at 5:55 am. Staff B showed Staff D Tenant #2's injuries. Staff D stated she would call Tenant #2's family right away.

3. On 2/27/24, further review of Tenant #2's record revealed an interdisciplinary note completed by Staff B which indicated the following: Staff B observed Tenant #2 had a laceration over her right eyebrow, a scraped and swollen nose that dripped blood from both nostrils and her right hand was bruised. Staff B documented Tenant #2 stated she hit her head. Staff B documented she applied ice to the back of Tenant #2's head and face. Staff B notified the RN Manager of the injuries and the status of Tenant #2's vital signs.

4. On 2/27/24 at 9:16 am, Staff D stated she arrived for work at around 6:00 am on 2/16/24. Staff D stated Staff B immediately approached her and wanted her to look at Tenant #2's injuries. Staff D stated she observed Tenant #2 laying on her couch. Staff D stated Tenant #2's face looked bad. Staff D believed Tenant #2 needed to be assessed at the hospital. Staff B stated to Staff D the RN Manager on-call stated Tenant #2 was to be treated in-house and not sent out. Staff D stated she called Tenant #2's family to inform them of the fall. Staff D stated the family asked what the RN Manager said to do. Staff D stated the RN Manager stated Tenant #2 was to be treated in-house until an RN assessed her. The family was okay with that. Staff D waited for the RN to arrive. Staff D stated the RN Manager never arrived but the Assistant RN arrived to work at 7:30 am. Staff D asked the Assistant RN if she had been told about Tenant #2's fall. The Assistant RN had not been informed. Staff D

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A 430	Continued From page 9	A 430		

stated the Assistant RN cleaned up Tenant #2 to better examine her injuries. Staff D stated the Assistant RN wanted to send Tenant #2 to the emergency room to be assessed so she called the RN Manager on-call. The RN Manager told the Assistant RN Tenant #2 should be treated in-house and was not to be sent to the emergency room. Staff D stated the Assistant RN appeared to be upset about this and called the on-call physician for directives. The on-call physician directed the Assistant RN to send Tenant #2 to the hospital for assessment. Staff D stated Tenant #2 complained her face, nose, and neck hurt.

4. On 2/27/24 at 10:40 am, the Assistant RN stated she walked in to the Program on 2/16/24 at 7:30 am, 3 hours after Tenant #2 was discovered. The Assistant RN stated Staff D immediately approached her and asked if she had heard about Tenant #2. The Assistant RN went to Tenant #2's room. Tenant #2 was sitting on her couch and was bloody. The Assistant RN showered Tenant #2 so she could better examine the injuries. The Assistant RN stated Tenant #2 eventually complained her neck hurt and she could not turn her head. The Assistant RN stated the Program's history was they really did not like to send tenants out to the hospital if they do not need too. The Assistant RN stated it was not required by nursing staff on-call to physically come in to the building to do an assessment if called by staff. The Assistant RN stated they have completed assessments by using video phone calls.
The Assistant RN stated she had in fact called the RN Manager and she was instructed by her to not send Tenant #2 out to the emergency room (ER) and to treat her in-house. The Assistant RN stated she had not completed vitals as the staff

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A 430	Continued From page 10 had completed them and they were within normal limits. The Assistant RN stated Tenant #2 joked with staff and made light of the incident prior to leaving for the hospital. 5. On 2/27/24 at 1:23 pm, the RN Manager stated she received a call on the morning of 2/16/24 at around 4:30 am from Staff B. Staff B reported Tenant #2 had fallen and was bleeding. Staff B reported Tenant #2 had a cut above her eyebrow and her nose was bleeding. The RN Manager stated she talked to Staff B about how facial injuries could look worse than they were. The RN Manager asked Staff B if the tenant was in pain and if Staff B took her vitals? The RN Manager stated she was told by Staff B that Tenant #2's eyebrow was hurt and that vitals were within normal limits. The RN Manager stated she instructed Staff B to apply ice to Tenant #2's face and to administer acetaminophen. The RN Manager stated she did not recall being told Tenant #2 had complaints of pain in the back of her head nor could she recall instructing Staff B to apply ice to the back of Tenant #2's head. The RN Manager stated she trained all staff to call the RN on-call for a fall but that staff had the right to call 911 had they felt it was necessary. The RN Manager stated she had not worked in the building until later in the day on 2/16/24 and could not recall if she had called the Assistant RN or not to inform her of Tenant #2's fall. The RN Manager stated once the Assistant RN assessed Tenant #2, they talked back and forth on the phone and the Assistant RN stated Tenant #2 began having neck pain at that time. The RN Manager stated she called the on-physician and asked for guidance and received directives to send Tenant #2 to the ER for assessment. The RN Manager stated she called the Assistant RN to inform her of the physician's directives.	A 430		

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A 430	Continued From page 11 6. On 2/27/24, Tenant #2's interdisciplinary notes revealed the RN Manager documented the RN assessment and follow-up to the fall even though she had not come to the facility to provide an in-person assessment to Tenant #2. The RN Manager's note dated 2/16/24 at 8:27 am noted the following: Resident noted to have small laceration above right eye brow, nose very swollen with large blood clots present in nares. Abrasions noted on and under nose. Resident face noted to have bruising present to base of nose and around inner eyes. Resident starting to complain of neck pain. Ice applied, PRN medication given, and phone call to physician to update on all of the above. New order received to send to ER for CT and follow-up. Phone call placed to family to update. Tenant complained of being dizzy as a reason for her fall. Paperwork was prepared and tenant was sent to ER of choice. 7. On 2/27/24, a review of hospital records for Tenant #2 during her stay from 2/16/24 through 2/22/24, revealed Tenant #2 received the following injuries after her 2/16/24 fall: a closed nondisplaced odontoid fracture with type II morphology, a mildly displaced bilateral nasal bone and a minimally displaced fracture of the upper anterior bony nasal septum. The hospital record revealed Tenant #2 was seen in the emergency room at 9:30 am on 2/16/24, 5 hours after being discovered by Staff B in her room. Tenant #2 was discharged from the hospital to a skilled care unit for rehabilitation until she could return to her apartment at the Program. 8. In summary, Tenant #2 was found after a fall on 2/16/24 by Staff B at approximately 4:30 am.	A 430		

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 02/27/2024

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

(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 430	Continued From page 12 Staff B stated Tenant #2 complained of her head hurting and Staff B observed obvious facial injuries on Tenant #2. Staff B called the RN Manager and expressed her concerns and described the injuries. The RN only assessed Tenant #2 by Staff B's telephone description and one photograph of the tenant's face which was sent by text messaging. At 7:30 am, the Assistant RN arrived to the Program at 7:30 am, unaware of Tenant #2's fall or injuries. After assessing Tenant #2, the Assistant RN called the RN Manager by phone and was instructed by the RN Manager to not send Tenant #2 to the ER but to treat in-house. The RN Manager failed to come to the Program and personally assess Tenant #2 to to make appropriate recommendations and/or referrals for her care. 9. On 2/27/24 at 2:00 pm, the Program's Nurse Consultant, Regional Director of Community Operations, and the Assistant RN confirmed the RN Manager had not come in to the Program on 2/16/24 to assess Tenant #2 but assessed her via telephone.	A 430		

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.

481-67.2(3) Program Policies and Procedures

67.2(3) The program shall follow the policies and procedures established by the program

Tenant #2 was sent to the emergency room on 02/16/2024 and is not returning to the community.

Policy was reviewed and updated on 4/1/24. All staff will be educated on "Post Fall- Assisting Residents" policy by 4/30/24.

Assisted Living Manager or designee will review tenant incident reports to determine if post fall-assisting resident policy is followed. This will be monitored weekly for 4 weeks and then monthly for 3 months.

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 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;

Tenant # 2 was sent to the emergency room on 02/16/2024 and is not returning to the community.

Registered Nurse (RN) Manager is no longer employed at Copper Shores Village.

Assistant RN was re-educated on documentation of tenant's health status, completion of both nurse review and significant change in condition, and the need to make recommendations or referrals as appropriate on 4/17/24.

Assistant RN or designee will complete chart audits of tenant's health status documentation, nurse reviews, changes in tenant's health status and need to make recommendation or referrals as appropriate. This will be monitored weekly for 4 weeks and then quarterly for 2 quarters.