✓ 2/3/20 OK 12/17/2020

PRINTED: 11/15/2019
FORM APPROVED

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
	S0383	A. BUILDING: _____ B. WING _____	C 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT BRIDGEWATER ALP	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 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: 70 Number of tenants with cognitive disorder: 4 TOTAL census of Assisted Living Program: 74 The following regulatory insufficiencies were cited during the investigation of Complaint # 85119-C and Incident # 85378-I.	A 000	POC 12/15/19	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy regarding the identification, investigation and reporting of dependent adult abuse after a report of	A 003	Please see attached Plan of Correction 12/15/19	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/30/19

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A 003	Continued From page 1 allegations by one tenant (Tenant #1) Findings include: On 9/23/19 at 11 AM, Tenant #1 stated in October 2018 after she moved in to her apartment, Staff A came in to install a shower head. Tenant #1 stated Staff A requested her to come in to the narrow shower area to show her where she wanted the shower head placed. Tenant #1 stated while in the shower area, Staff A rubbed his forearm up over her breasts and then back down. She stated she did not report this incident right away due to fear of retaliation. Tenant #1 stated that finally months later around the beginning of summer in 2019, she finally told her daughter about the event. Her daughter asked that she tell a Program staff. Tenant #1 spoke to a Corporate Grand Living Staff member that was assisting with the opening and early operation of the Program in the presence of her daughter. On 9/24/19 at 5:05 PM, the Corporate Grand Living Staff member stated Tenant #1 did in fact tell her about the incident regarding Staff A in her shower area. She could not recall an exact date but believed it was May or June of 2019, but definitely prior to the end of June. Tenant #1 reported Staff A brushed his forearm against her breasts up and down. She did not report the allegations sooner because she was afraid of retaliation. The Corporate Grand Living Staff member reported the allegations from Tenant #1 to the Director. On 9/24/19 at 5:25 PM, Tenant #1's daughter confirmed her mother told her about the allegations regarding Staff A in June of 2019. Tenant #1's daughter asked Tenant #1 to also speak with a program staff she was comfortable with and so she picked the Corporate Grand	A 003		

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A 003	Continued From page 2 Living Staff member to come to her apartment and talk with her. Tenant #1's daughter stated that the Program staff indicated they would address the concerns. Tenant #1's daughter stated they did not hear anything after that. On 9/23/19 the Director revealed a typed note she had created in June of 2019 indicating Tenant #1 had reported Staff A had brushed his arm against her breasts up and down. The note also indicated that Tenant #1 did not want him to know she made these allegations and that she did not want anything done about the matter. The note also indicated that the Director of Maintenance was instructed to not allow Staff A to do work in Tenant #1's apartment anymore. Staff A retired on 7/31/19. The Director confirmed no one ever mentioned the allegations to Staff A. A review of Program policies on 9/16/19 revealed the Program's policy titled: "Dependent Adult Abuse: Identification, Investigation, and Reporting" revealed the following duty regarding investigation: vii.) Interview the person(s) reporting the incident and the alleged perpetrator and document witness statements. On 9/19/19 at 9:28 AM, the Director confirmed Staff A was never told about the allegations or interviewed.	A 003		

OK 1/29/2020

✓ 2/3/20

Plan of Correction
Grand Living at Bridgewater

A003 -Program Policies and Procedures

Regulatory Insufficiency: The Program failed to follow policy regarding the identification, investigation and reporting of dependent adult abuse after a report of allegations by one tenant.

Plan of Correction:

The insufficiencies will be corrected as follows:

- With any tenant report of allegation of dependent adult abuse (DAA), all steps will be completed per policy (Attachment A).

The following measures will be taken to ensure the problem does not recur:

- Review and education of *Identification, Investigation and Reporting* related to Dependent Adult Abuse will be provided to all program staff.

The program will monitor performance to ensure compliance as follows:

- Program staff will be educated on *Identification, Investigation and Reporting* related to Dependent Adult Abuse upon hire and at least annually.
- Program Director or designee will monitor completion of steps for all allegations of DAA.

Date insufficiencies corrected by: December 15, 2019.