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 10/05/2023

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 impairment: 93 Number of tenants with cognitive impairment: 3 Total census: 96 The following regulatory insufficiencies were cited during the investigation of Complaint #115081-C and the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program:	A 000	See Attached POC 9/4/23	
A 340	481-67.9(4)a Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse delegation training within 60 days of the nurse's employment. This pertained to 2 of 3 staff	A 340		

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

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 10/05/2023

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 340	Continued From page 1 reviewed that administered medications (Staff E and Staff F). Findings follow: 1. Record review of a staff list indicated the Director of Health and Wellness' date of employment was 3/20/23. 2. Record review on 9/19/23 of Staff E's training documents reflected Staff E was hired on 11/20/22 and administered medications. Continued record review revealed Staff E' nurse delegations regarding medications were dated 5/23/23; which was greater than 60 days from the Director of Health and Wellness' date of employment. 3. Record review on 9/19/23 of Staff F's training documents was dated 2/3/23 and administered medications. Continued record review revealed Staff F's nurse delegation regarding medications were dated 6/1/23, which was greater than 60 days from the Director of Health and Wellness' date of employment. 4. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed all delegations for the listed above were provided.	A 340		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16.	A 380		

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 10/05/2023

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 380	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed dependent adult abuse training within six months of employment. This pertained to 1 of 4 staff reviewed employed greater than six months (Staff C). Findings follow: Record review on 9/19/23 of Staff C's training documents revealed a hire date of 5/15/22. Continued record review failed to produce documentation of dependent adult abuse training. When interviewed on 10/5/23 at 2:30 p.m. the Executive Director confirmed no dependent adult abuse training was located Staff C.	A 380		
A 120	481-69.21(3) Occupancy Agreement 69.21(3) The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update the occupancy agreement as needed with changes in services. This pertained to 6 of 6 tenants reviewed related to occupancy agreements (Tenants #3, #7, #9, #10, #11, #12 and #13) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. During a community meeting with tenants held on 9/20/23 at 2:15 p.m. tenants voiced concern with the addition of a third meal and the	A 120		

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 10/05/2023

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 120	Continued From page 3	A 120		

accompanying charge, as well as the change from what the Program considered independent living to assisted living. The tenants said the change occurred in the late spring or early summer of 2023. Tenants who were previously considered independent living were now considered assisted living. Tenants also voiced concern regarding an increase in fees and the third meal provided daily.

Two tenants were interviewed on 9/20/23 and reported they moved into the Program believing they were moving to an independent living program, but were now told they lived in an assisted living program. Additionally, the Program added a third meal per day, which they did not want or want to pay for.

2. When interviewed on 10/4/23 at 2:30 p.m. the Executive Director reported floors one through three were certified assisted living apartments. The apartments on the 4th floor were not certified as assisted living programs and were independent living apartments. She explained, previously tenants in floors one through three were considered independent living and assisted living tenants. In February, following a visit with the Department (of Inspections and Appeals) and it came to light assessments were not being done for tenants floors one through three that received no services. Independent living tenants on floors one through three were being treated the same as tenants on the fourth floor (independent living). An annual rent increase and proper notice of the increase was provided to the tenants in the spring. Before tenants who resided on floors one through three that were not getting services received two meals per day. There were three meetings related to the changes and information. An approximate 7.5 % rent increase was

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 10/05/2023

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 120	Continued From page 4 indicated. The Executive Director furthehr explained there was also an increase of $200.00 per person or $300.00 per couple, for those that were previously considered to be independent living on floors one through three and were now considered assisted living receiving no services. The increase was to help cover nursing time and assessments and affected approximatley 45 to 55 tenants. Tenants affected by the clarification did not receive a full increase for assisted living services, which was $1020.00, as new tenants coming in did. Tenants were offered to move to the fourth floor (independent living), but only one tenant moved. The Executive Director stated the it was looped into the rent increase and they were verbally told at three meetings. 3. Record review of a letter sent to tenants, dated 4/14/23, indicated an annual rent increased occurred, effective 6/1/23. The letter served as a written 30 day notice of the change to the occupancy agreement. It indicated the new rental rates and charges would be attached. Continued record review of a Resident Meeting dated 4/27/23 indicated tenants were informed if they were independent living on floors one through three, an assessment needed to be completed every 90 days. Floors one through three were assisted living per state regulations and assessments needed to be completed. The letter indicated a tenant could live in an assisted living apartment and not receive services. 4. Record review of Tenant #3's documents revealed at the time of the rent increase notice Tenant #3 resided in a certified assisted living apartment and did not receive any services.	A 120		

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 10/05/2023

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 120	Continued From page 5 Tenant #3's Occupancy Agreement signed 12/13/22 included Exhibit A-1, which indicated was Independent Living (floors 1-4). Tenant #3's new Monthly Rate Changes document indicated the new rental amount for the rental charge and the effective date of 6/1/23. The rate change sheet did not indicate the change from independent living to assisted living (no services) or the additional assisted living fee charge that was added to the annual rent increase. 5. Record review of Tenant #7's documents revealed at the time of rent increase notice Tenant #7 resided in a certified assisted living apartment and did not receive any services. The Occupancy Agreement wassigned on 6/11/21. Tenant #7 transferred to another apartment on 11/30/21 an a new signature was obtained on Exhibit A-IL, which indicated independent living. Tenant #7's new Monthly Rate Changes document indicated the new rental amount for the rental charge and the effective date of 6/1/23. The rate change sheet did not indicate the change from independent living to assisted living (no services) or the additional fee that added to the annual rent increase. 6. Record reivew of Tenant #9 and #10's documents (occupied the same apartment) revealed at the time of the rent increase notice Tenant #9 and #10 resided in a certified assisted living apartment and did not receive any services. The Occupancy Agreement was signed on 1/19/23 and included the Exhibit A-1, which indicated Independent Living (floors 1-4). Tenant #9 and #10's new Monthly Rate Changes document indicated the new rental amount for the rental charge and the effective date of 6/1/23. The rate change sheet did not indicate the change from independent living to assisted living	A 120		

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 10/05/2023

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 120	Continued From page 6 (no services) or the additional assisted living fee charge that was added to the annual rent increase. 7. Record reivew of Tenant C1's and Tenant #11's documents (occupied the same apartment prior to Tenant C1's discharge) revealed at the time of rent increases Tenant C1 and Tenant #11 resided in a certified assisted living apartment and did not receive any services. The Occupancy Agreement was signed 6/11/18 and included the Exhibit A-which indicated no health care services. Tenant C1's and Tenant #11's new Monthly Rate Changes document indicated the new rental amount for the rental charge and the effective date of 6/1/23. The rate change sheet did not indicate the change from independent living to assisted living (no services) or the additional assisted living fee charge that was added to the annual rent increase. 8. Record reivew of Tenant #12 and #13's documents (occupied the same apartment) revealed at the time of the rent increase notice Tenant #12 and #13 resided in a certified assisted living apartment and did not receive any services. The Occupancy Agreement was signed 1/31/23 and included the Exhibit A-1, which indicated Independent Living (floors 1-4). Tenant #12 and #13's new Monthly Rate Changes document indicated the new rental amount for the rental charge and the effective date of 6/1/23. The rate change sheet did not indicate the change from independent living to assisted living (no services) or the additional assisted living fee charge that was added to the annual rent increase. In summary, the tenants listed above moved into the Program and signed occupancy agreements and exhibits that indicated they were independent	A 120		

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 10/05/2023

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 120	Continued From page 7 living and received no healthcare services. On 4/14/23 a letter went out to to tenants regarding an annual rent increase and they received their new monthly charges related to the increase, which was effective 6/1/23. An annual rent increase occurred and additional amount was added to the increase for those that were previously independent living (floors one to three) and were now considered assisted living no services. The letter dated 4/14/23 or the new monthly rent sheet did not indicated the change from independent living to assisted living with no services. Additionally, the letter or monthly rent sheet did not indicate there would be an increase in fees related to that change. That change that occurred pertained to the tenants listed above; however, it was estimated 45 to 55 tenants went from independent living (floors one to three) to assisted living with no services. The occupancy agreements were not updated as needed to reflect to change in services and cost related to those changes.	A 120		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	A 145		

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 10/05/2023

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 145	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 1 of 8 current tenants reviewed (Tenant #1) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review on 9/21/23 revealed Tenant #1's Master Assessment dated 7/25/23 was the most current evaluation. The evaluation indicated Tenant #1 required a physical one person assist with transfers. When interviewed on 9/20/23 at 1:31 p.m. Staff D said it took 30 to 45 minutes for morning cares for Tenant #1 and at times it was longer if her bed linens needed to changed due to urinary incontinence. She said Tenant #1 required two people for transfers all day today and it was dependent on the day. It took two staff to get her out of bed and one to assist her off and on the toilet. When interviewed on 9/20/23 at 4:20 p.m. Staff G said it took 45 minutes to one hour for cares for Tenant #1 (on second shift). She said it was dependent (on day) but Tenant #1 usually took two staff to transfer her. Continued record review revealed a fax was sent to the primary care provider (PCP) dated 8/7/23 and indicated Tenant #1 had become increasingly weak and required two people to assist with transfers and was minimally bearing weight. Tenant #1 was not taking her medications	A 145		

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 10/05/2023

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 145	Continued From page 9	A 145		

appropriately due to her limitations physically and had shortness of breath with minimal exertion.

Further record review revealed Progress Notes indicated the following:

a. On 8/8/23 a meeting was held with Tenant #1's family, regarding Tenant #1's level of care, two person assistance with transfers and possibly needing a higher level of care. Tenant #1's family reported Tenant #1 had an appointment on 8/16/23 with her PCP and to discuss therapies to help with her endurance. Another meeting was scheduled for 8/28/23 to discuss level of care.

b. On 8/12/23 it was noted it was very difficult to get Tenant #1 up and multiple attempts were made.

c. On 9/7/23 it was noted a meeting was held with Tenant #1's family to discuss therapy and level of care. Another meeting was scheduled for 9/15/23.

Continued record review revealed evaluations were not completed as needed for Tenant #1 with the use of two staff for transfers at times, minimal weight bearing status, therapy services and shortness of breath with minimal exertion.

2. Record review on 9/25/23 of Tenant C1's file revealed Tenant C1 was admitted on 6/14/18. Incident reports indicated the following:

a. On 7/29/23 at 4:00 a.m. another tenant located Tenant C1 outside the building and and redirected him and notified overnight staff. It was noted staff reported Tenant C1 sleep walking outside of the building. Tenant C1's spouse was woken up when he returned to the apartment and

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 10/05/2023

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 145	Continued From page 10 was very concerned. b. On 7/31/23 at 3:00 a.m. Tenant C1 was found wandering outside the building. It was noted staff reported Tenant C1 was sleep walking and when they approached him, Tenant C1 said he was following the "dead people." Continued record review revealed the most current evaluations for Tenant C1 were dated 2/28/23. Evaluations were not completed as needed after the incidents occurred on 7/29/23 and 7/31/23 where Tenant C1 left the building at night. 3. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed all evaluations for the tenants reviewed were provided.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 3 of 8 current tenants reviewed (Tenants #2, #3 and #6) and 1	A 290		

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 10/05/2023

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 290	Continued From page 11 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review on 9/21/23 of Tenant #2's file revealed Progress Notes dated 7/26/23 indicated Tenant #2 returned to from the hospital. A nurse's note was not completed when Tenant #2 went to the hospital or the reason for Tenant #2's hospitalization. Continued record review revealed the ALP Monitoring Entrance Form reflected Tenant #2 was a tenant who had been hospitalized in the last three months. Further record review revealed Tenant #2's nurse's notes were not documented by exception for Tenant #2 related to his hospitalization. 2. Record review on 9/21/23 of Tenant #3's file revealed Tenant #3 was admitted to the Program 12/13/22. She had previously lived at the building in an independent living apartment (non-certified apartment). Continued record review of Progress Notes revealed one entry in Progress Notes since her admission on 12/13/22, dated 3/13/23. A nurse's note was not completed when Tenant #3 was admitted. Further record review revealed the ALP Monitoring Entrance Form reflected Tenant #3 had a tenant who had been hospitalized in the last three months. Continued record review revealed nurse's notes were not completed by exception, including when Tenant #3 was admitted and with her	A 290		

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 10/05/2023

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 290	Continued From page 12 hospitalization that occurred in the last three months. 3. Record review on 9/25/23 of Tenant #6's file revealed Progress Notes indicated the following: a. On 6/23/23 Tenant #6 was taken to urgent care and it was recommended he be taken to the hospital b. On 6/27/23 (late entry for 6/26/23) Tenant #6 would be going to a skilled nursing facility care for 10 to 14 days. c. On 9/25/23 (late entry for 7/5/23)a change on condition evaluation was completed related to a hospitalization and stay for rehabilitation. d. On 9/25/23 (late entry for 9/6/23) Tenant #6 had cardioversion completed and felt much better. Continued record review revealed the nurse's notes completed for Tenant #6 were late entries, including one entry that was over two months late. Nurse's notes were not completed by exception. 4. Record review on 9/25/23 of Tenant C1's file revealed Tenant C1 was admitted on 6/14/18 and moved to memory care on 8/28/23. Incident reports indicated the following: a. On 7/29/23 at 4:00 a.m. another tenant located Tenant C1 outside the building and and redirected him and notified overnight staff. It was noted staff reported Tenant C1 sleep walking	A 290		

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 10/05/2023

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 290	Continued From page 13 outside of the building. Tenant C1's spouse was woken up when he returned to the apartment and was very concerned. b. On 7/31/23 at 3:00 a.m. Tenant C1 was found wandering outside the building. It was noted staff reported Tenant C1 was sleep walking and when they approached him, Tenant C1 said he was following the "dead people." Continued record review reflected Progress Notes indicated the following: a. On 8/3/23 (late entry for 7/31/23 at 11:00 a.m.) staff reported Tenant C1 was sleep walking outside the building. Tenant C1's spouse was very concerned and made an appointment. b. On 8/28/23 Tenant C1 would be discharged from the hospital psychiatry unit. Further record review revealed a nurse's note was not completed related to the incident on 7/29/23 when another tenant found Tenant C1 outside the building at 4:00 a.m. or when Tenant C1 went to the hospital. Additionally, a nurse's note was not completed related to Tenant C1' discharge from the Program (moved to memory care on 8/28/23). 5. When interviewed on 10/5/23 at 2:30 p.m. the Director of Health and Wellness confirmed all nurse's notes for the tenants listed above were provided.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted	A 350		

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 10/05/2023

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 350	Continued From page 14 in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to based service plans on evaluations, failed to update service plans as needed at least annually and failed to have service plans reflect the service needs of the tenants. This pertained to 7 of 8 current tenants reviewed (Tenants #1, #2, #4, #5, #6, #7 and #8) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review on 9/21/23 of Tenant #1's file revealed the Master Assessment dated 7/25/23 was the most current evaluation. The evaluation indicated Tenant #1 required a physical one person assist with transfers. When interviewed on 9/20/23 at 1:31 p.m. Staff D said it took 30 to 45 minutes for morning cares for Tenant #1 and at times it was longer if her bed linens needed to changed due to urinary incontinence. She said Tenant #1 took two people for transfers all day today and it was dependent on the day. It took two staff to get her out of bed and one to assist her off and on the toilet. When interviewed on 9/20/23 at 4:20 p.m. Staff G said it took 45 minutes to one hour for cares for Tenant #1 (on second shift). She said it was	A 350		

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 10/05/2023

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 350	Continued From page 15	A 350		

dependent (on day) but Tenant #1 usually took two staff to transfer her.

Continued record review revealed a fax sent to the primary care provider (PCP,) dated 8/7/23, indicated Tenant #1 had become increasingly weak and required a two person assist with transfers and was minimally bearing weight. Tenant #1 was not taking her medications appropriately due to her limitations physically and she had shortness of breath with minimal exertion.

Further record review revealed Progress Notes indicated the following:

a. On 8/8/23 a meeting was held with Tenant #1's family, regarding Tenant #1's level of care, two person assistance with transfers and possibly needing a higher level of care. Tenant #1's family reported Tenant #1 had an appointment on 8/16/23 with her PCP and to discuss therapies to help with her endurance. Another meeting was scheduled for 8/28/23 to discuss level of care.

b. On 8/12/23 it was noted it was very difficult to get Tenant #1 up and multiple attempts were made.

c. On 9/7/23 it was noted a meeting was held with Tenant #1's family to discuss therapy and level of care. Another meeting was scheduled for 9/15/23.

Continued record review revealed the service plan was not updated as needed for Tenant #1 with the use of two staff for transfers at times, minimal weight bearing status, therapy services and shortness of breath with minimal exertion. The service plan also did not reflect therapy

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 10/05/2023

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 350	Continued From page 16 services. 2. Record review on 9/21/23 of Tenant #2's file revealed A Medication Pass Detail document indicated staff provided medication reminders to Tenant #2 twice daily. The note indicated the reminders started on 7/26/23. Progress Notes indicated the following: a. On 8/22/23 (late entry for 8/21/23) Tenant #2 returned from the hospital. Tenant #2 continued on 5 liters of oxygen per nasal cannula b. On 8/26/23 Tenant #2 denied using the toilet, but there were protective undergarments in the toilet and it was almost overflowing c. On 8/26/23 Tenant #2 wanted to go on a walk without his oxygen d. On 8/27/23 Tenant #2's buttocks was raw and a barrier cream was applied e. On 8/29/23 it was noted to remind Tenant #2's of the importance of wearing his oxygen and if it was off to check his oxygen saturation f. On 9/2/23 Tenant #2 was confused about which medications to take, refused cares, was soiled and would not allow staff to change his brief g. On 9/4/23 Tenant #2 told staff to get out and called staff a name Continued record review revealed the Services Received document reflected Tenant #2 at times refused toileting cares.	A 350		

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 10/05/2023

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 350	Continued From page 17 An Order Recap Report (from nursing facility placement) reflected orders dated 8/21/23 compression to scrotum (jock strap) for edema, check every shift. When interviewed on 9/20/23 at 1:31 p.m. Staff D said Tenant #2 at times Tenant #2 would refuse cares. He would tell staff to get out and at times made comments to staff about their race. Further record review revealed the service plan did not reflect Tenant #2 had oxygen, his care refusals, removing his oxygen at times, the reddened area on his buttocks, the assistance with medication reminders, behavior at times towards staff or the compression garment to the scrotum. 3. Record review on 9/21/23 of Tenant #4's file revealed the service plan dated 6/19/23 reflected staff assisted Tenant #4 to take his medications five times daily. The Med Pass Detail document indicated effective 6/20/23 staff reminded Tenant #4 to take his medications and watch him take them. It was discontinued on 9/15/23 (staff fully administered medications). The service plan dated 6/19/23 did not reflect the type of assistance Tenant #4 received related to medications. Continued record review revealed the service plan reflected Tenant #4 was a high fall risk and there were safety checks completed related to falls. The service plan identified Tenant #4 was a fall risk; however, did not provide additional interventions related to his falls except wellness checks.	A 350		

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 10/05/2023

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 350	Continued From page 18 4. Record review on 9/25/23 of Tenant #5's file revealed the July, August and September medication administration records (MARs) reflected Tenant #5 at times refused medications and treatments. The service plan dated 8/14/23 did not reflect Tenant #5's refusals. Continued Tenant #5 was a high fall risk and there were safety checks completed related to falls. The service plan identified Tenant #4 was a fall risk; however, did not provide additional interventions related to his falls except wellness checks. 5. Record review on 9/25/23 of Tenant #6's file revealed the service plan dated 7/5/23 reflected Tenant #6 was a high fall risk. The service plan did not provide additional interventions related to fall except wellness checks. 6. Record review on 9/25/23 of Tenant #7's file reflected the Master Assessment dated 9/5/23 indicated it was completed for the admission to hospice services. The service plan was updated on 9/5/23; however, did not reflect hospice services. Continued record review revealed the service plan also reflected Tenant #7 was at a high risk for falls; however, did not provide any interventions related to his falls, exception the safety/wellness checks. 7. Record review on 9/25/23 of Tenant #8's file revealed the Master Assessment was dated 9/15/23 and indicated Tenant #8 was removed	A 350		

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 10/05/2023

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 350	Continued From page 19	A 350		

from hospice services. It also indicated wound care was provided by the nurse and Tenant #8 had occasional weeping wounds to his bilateral lower extremities.

Continued record review revealed the service plan was updated on 9/15/23; however, still reflected hospice services. The service plan dated 9/15/23 indicated there would be coordination related to Tenant #8's wounds and treatment. The service plan did not reflect information related to Tenant #8's wounds, including location, condition or treatment of the wounds.

8. Record review on 9/25/23 of Tenant C1's file revealed Tenant C1 was admitted on 6/14/18. Incident reports indicated the following:

a. On 7/29/23 at 4:00 a.m. another tenant located Tenant C1 outside the building and and redirected him and notified overnight staff. It was noted staff reported Tenant C1 sleep walking outside of the building. Tenant C1's spouse was woken up when he returned to the apartment and was very concerned.

b. On 7/31/23 at 3:00 a.m. Tenant C1 was found wandering outside the building. It was noted staff reported Tenant C1 was sleep walking and when they approached him, Tenant C1 said he was following the "dead people."

Continued record review revealed the most current service plan at the time of the incidents was dated 9/18/20. An annual service plan was not developed in 2021 or 2022 for Tenant C1. Additionally, the service plan was not updated as needed after the incidents occurred on 7/29/23

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 10/05/2023

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 350	Continued From page 20 and 7/31/23 where Tenant C1 left the building at night. The service plan did not reflect the incidents or interventions related to his safety. 9. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed all service plans for the tenants listed above were provided.	A 350		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain signed service plans when a change of condition occurred. This pertained to 2 of 8 tenants reviewed (Tenants #7 and #8). Findings follow: 1. Record review on 9/25/23 of Tenant #7's file revealed a Master Assessment dated 9/5/23 indicated the evaluation was completed for a change of condition with the admission to hospice services. Continued record review revealed the Service Plan Agreement completed for a change of	A 370		

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 10/05/2023

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 370	Continued From page 21 condition was dated 9/5/23 and was signed by the Director of Health and Wellness. The service plan was not signed by Tenant #7 or his legal representative as applicable. 2. Record review on 9/25/23 of Tenant #8's file revealed a Master Assessment dated 9/15/23 indicated the evaluation was completed for a change of condition with the discharge from hospice services. Continued record review revealed the Service Plan Agreement completed for a change of condition was dated 9/15/23 was signed by the Director of Health and Wellness. The service plan was not signed by Tenant #8 or his legal representative as applicable. 3. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed all signed service plans for the tenants reviewed were provided.	A 370		
A 390	481-69.26(3)e Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. e. The service plan shall be reviewed, updated if necessary, and signed and dated by all parties at least annually. This REQUIREMENT is not met as evidenced by:	A 390		

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 10/05/2023

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 390	Continued From page 22 Based on interview and record review the Program failed to obtain a signed service plan annually. This pertained to 1 of 5 tenants reviewed that were admitted for over a year (Tenant #5). Findings follow: Record review on 9/25/23 of Tenant #5's file revealed the Master Assessment dated 8/14/23 indicated the evaluation was completed for the annual assessment. Continued record review revealed the Service Plan Agreement was dated 8/14/23 and it was not signed by a health or human service professional or by Tenant #5 or his legal representative as applicable. Further record review revealed Tenant #5's service plan was updated annually; however, it was not signed by all parties. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed all signed service plans for the tenant reviewed were provided.	A 390		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 465		

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 10/05/2023

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 465	Continued From page 23 Program failed to complete an annual in-service training on food protection. This pertained to 2 of 2 staff reviewed due for annual food safety training (Staff C and Staff D). Findings follow: 1. Record review on 9/19/23 of Staff C's training documents revealed a hire date of 5/15/22 and Staff C's title was a server. Staff C had food safety training completed 6/6/22 and did not have an annual in-service training on food protection. 2. Record review on 9/19/23 of Staff D's training documents revealed a hire date of 9/8/22. Staff D had food safety training completed on 9/15/22; however, did not have an annual in-service training on food protection. When interviewed on 9/20/23 at 1:31 p.m. Staff D confirmed on occasion she made breakfast for tenants in their apartments. 3. When interviewed on 10/5/23 at 2:30 p.m. the Executive Director confirmed Staff C served food and no annual food safety training was located. She said no annual food safety training was found for Staff D; however, Staff D did not serve or prepare food.	A 465		
A 470	481-69.28(5)a(1)(2)(3) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. a. In addition to the requirements above, a	A 470		

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 10/05/2023

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 470	Continued From page 24 minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by: (1) Obtaining certification as a dietary manager; or (2) Obtaining certification as a food protection professional; or (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have the person responsible for food preparation complete a state-approved food protection program. This pertained to 1 of 1 staff reviewed that was responsible for food preparation (Staff B). Findings follow: 1. Record review on 9/19/23 and 9/20/23 indicated Staff B, the Executive Chef, was hired on 5/24/18. Continued record review revealed Staff B had a ServSafe Certificate of completion valid from 4/25/18 to 4/25/23. A new ServSafe certificate or other state-approved food protection program was not completed at the time of the review and	A 470		

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 10/05/2023

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 470	Continued From page 25 had not been current since April of 2023. Further record review revealed Staff B signed up for the ServSafe course on 9/19/23 and new ServSafe Certificate of completion was provided with dates from 9/27/23 to 9/27/28. 2. When interviewed on 10/5/23 at 2:30 p.m. the Executive Director confirmed Staff B was primarily responsible for food preparation as she was the Executive Chef. She said the length of time Staff B was without a valid certificate ServSafe was approximately from July to September.	A 470		
A 675	481-69.33(6) Transportation 481-69.33(231C) Transportation. When transportation services are provided directly or under contract with the program: 69.33(6) The driver shall have a valid and appropriate Iowa driver ' s license or commercial driver's license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure a driver had an appropriate driver's license for the vehicle used for transport. This pertained to 1 of 2 staff reviewed that drove vehicles (Staff A). Findings	A 675		

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 10/05/2023

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 675	Continued From page 26 follow: 1. Record review on 9/19/23 revealed Staff A's date of hire was 12/5/19. Continued record review revealed Staff A had a State of Iowa Class C Driver License. At the time of the review on 9/19/23 Staff A did not have a chauffeur's license with applicable passenger endorsement. Further record review revealed Staff A obtained a chauffeur's license with a passenger endorsement for a non-commercial vehicle with less than 16 passengers (temporary license) dated 9/28/23, after the Program was made aware Staff A did not have an appropriate license to drive the vehicles. 2. When interviewed on 9/19/23 and 10/5/23 at 2:30 p.m. the Executive Director confirmed there were three vehicles used for transportation for tenants, a car, mini-van and bus. She said Staff A drove the vehicles approximately three to four times per week. He had been driving Program vehicles prior to her employment as Executive Director (January 2023).	A 675		

	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
A 150	Clinical staff will be retrained on Incident Reports as well as Wisdom to Act forms and when to fill out each. DOHW responsible. Compliance for completion of incident reports and wisdom to act forms will be monitored by the DOHW, ADOHW, and LPN during Grand Rounds to ensure issues/concerns addressed have been documented by either an incident report or wisdom to act. Medication passers will be retrained on time frames for medication pass (between 1 hour before and 1 hour after the scheduled time) and the policy to follow if a medication needs to be passed outside of that time frame. DOHW responsible.	8/25/23
A 140	All assisted living tenants, including those without care services will receive an evaluation prior to occupancy, within 30 days of occupancy, with a significant change in condition, and at least annually. DOHW, ADOHW, and LPNs responsible. Tracking system has been updated to include tenants without care services who are residing in assisted living units. DOHW, ADOHW, LPNs, Director of Health & Wellness Informatics, and National Director of Health & Wellness responsible. Compliance will be monitored by the DOHW, ED, and/or the National Director of Health & Wellness through monthly audits of completed evaluations.	9/4/23
A 145	All assisted living tenants, including those without care services will receive an evaluation prior to occupancy, within 30 days of occupancy, with a significant change in condition, and at least annually. DOHW, ADOHW, and LPNs responsible. Change of condition evaluations (including those for increased cares, inappropriate behaviors & interventions, discontinuation of services, and addition of private care giving staff) will only be completed by an RN. DOHW responsible. Compliance with annual evaluations will be monitored by the DOHW, ED, and/or the National Director of Health & Wellness through monthly audits of completed evaluations.	9/4/23
A 290	ADOHW and LPN will be retrained on the completion of Nurse's Notes. ED & DOHW responsible. Compliance will be monitored by the ED and/or DOHW by random audit checks of at least 3-5 resident files per month.	9/4/23
A 355	Prior to occupancy, a preliminary service plan will be developed for each tenant residing in an assisted living unit, including those without care services. DOHW	8/11/23

	responsible. Compliance will be monitored by our Sales and Marketing Coordinator to ensure Service Plan is in place prior to advancing to the step of lease signing. Compliance will also be monitored by random quarterly audits conducted by the Executive Director.	
A 360	All assisted living tenants, including those without care services will receive an evaluation prior to occupancy, within 30 days of occupancy, with a significant change in condition, and at least annually. DOHW, ADOHW, and LPNs responsible. Change of condition evaluations (including those for increased cares, inappropriate behaviors & interventions, discontinuation of services, and addition of private care giving staff) will only be completed by an RN. DOHW responsible. Compliance with annual evaluations will be monitored by the DOHW, ED, and/or the National Director of Health & Wellness through monthly audits of completed evaluations.	9/4/23

Provider's Signature

8/10/23
Date