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 05/15/2025

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: 94 Number of tenants with cognitive impairment: 3 Total census: 97 The following regulatory insufficiency was cited related to the investigation of Complaint #125209-C and Incident #125439-I:	A 000	See attached POC 7/10/25	
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 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 update service plans as needed to reflect the needs of the tenants. This pertained to 3 of 4 current tenants reviewed (Tenants #2, #3, and #4). Findings follow: 1. Review of Tenant #2's file on 5/1/25 revealed Progress Notes dated 4/17/25 (late entry for	A 350		

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A 350	Continued From page 1	A 350		

4/16/25) indicating the tenant returned from the hospital for a fall, weakness and urinary tract infection (UTI) and a stay at a rehabilitation facility. She had an indwelling catheter due to urinary retention. Staff would be providing assistance with cares and the catheter would be managed by home care.

Tenant #2's service plan dated 4/16/25 reflected staff assisted with emptying the catheter bag and changing the bag type. The catheter changes were managed by home health, hospice or other nursing agency. The service plan did not reflect Tenant #2's history of a UTI.

2. Review of Tenant #3's file on 5/1/25 and 5/5/25 revealed Progress Notes indicating the following:
- On 4/9/25 tenant was admitted to hospice services.
- On 4/16/25 new orders were received from hospice, including to apply Betadine to scabbed area on the left leg and cover with Mepilex. Change every three days and as needed.
- On 4/21/25 staff reported Mepilex was not adhering to the tenant. Hospice would be out to evaluate on 4/22/25.
- On 4/22/25 the area on the left shin, stage 3 with demarcated borders. The area was 2 centimeters (cm) x 4 cm. There was no odor or redness noted on or around the wound. There were two skin tears on the right shin that were approximately 1.5 cm each. The areas were cleansed with soap and water. It was wiped with Betadine, skin prep around the wound and Mepilex was applied. Hospice was to manage the wound care.
- On 5/1/25 a text message was sent to hospice to ask for a one-time therapy evaluation of transfers with an assist of one person and for

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staff education.
- On 5/2/25 Mepilex to both shins was removed and replaced as ordered. The wound had a moderate amount of "greenish to tan drainage." There was no odor or redness noted. It was requested the treatment be changed to Monday, Wednesday and Friday.
- On 5/1/25 Tenant #3 was reassessed for level of care. She required a maximum assist of one person for transfers using a walker and gait belt. She also required a maximum assist of one person for toileting. She required maximum assistance of one person with a walker and gait belt to transfer to bed.
- On 5/5/25 an order was received to change dressing changes to Monday, Wednesday and Friday from three times per week.

Tenant #3 had a service plan dated 4/10/25. The service plan did not reflect Tenant #3's wounds or wound treatment as noted above. The service plan dated 5/2/25 reflected the wound and wound care; however, was not added to the service plan until then despite orders for wound care on 4/16/25.

3. Review of Tenant #4's file on 5/1/25 revealed Progress Notes indicating the following:
- On 3/27/25 was discharged from physical therapy (PT) on 4/7/25. It was noted he continued to have falls with care givers present (private duty caregivers). It was reiterated to caregivers that they were not to be further than an arm's length at all times.
- On 4/3/25 a telephone call was made to the home caregiving office (private duty caregivers) regarding the caregivers needed to be in an arm's reach of Tenant #4 at all times. The person at the home caregiving office would educate caregivers about it related to fall prevention.

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A 350	Continued From page 3 - On 4/8/25 the nurse walked by and observed Tenant #4 standing between the arms of his wheelchair, holding onto the arms and looking at the menu. The caregiver (private duty caregiver) was seated at a table on her phone, "well away" from Tenant #4. A call was placed to the home caregiving office regarding caregivers being within an arm's length of him at all times. - On 4/17/25 (late entry for 4/12/15) Tenant #4 and his caregiver (private duty caregiver) were standing at the desk, he lost his balance and hit his back on the wood stand. He had a small mark on this right lower back. The caregiver was told to be within an arm's length of him at all times. Tenant #4's service plan dated 3/17/25 reflected he was a high fall risk and had a safety check daily overnight. The service plan reflected private duty caregivers helped with bathing. The service plan did not reflect the hours or days private duty caregivers were present or the directive to have caregivers within an arm's length of him at all times. The service plan also did not reflect PT services when it was provided. 4. When interviewed on 5/6/25 at 11:47 a.m. the Director of Health and Wellness confirmed Tenant #2's service plan was not specifically labeled to reflect a history of UTIs. She said Tenant #3's wound was a skin tear and between hospice and the nurse treatments were completed as ordered. She confirmed Tenant #4 had a private duty caregiver.	A 350		

ok
6/30/25

	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
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 in accordance with subrules 69.22(10 and 69.22(2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall be updated at least annually and whenever changes are needed. 1. Tenant #2's service plan has been updated to reflect his history of UTIs. Tenant #3's had a new service plan created on 5/2/25 that reflected the wound care Tenant #4's service plan has been updated to reflect the hours and days of his private duty caregivers and also that the caregivers were to be within an arm's length of him at all times 2. All program nurses have been reeducated in the process of developing a service plan and updating it as needed. Any new program nurses will be educated in this process prior to completing any service plans 3. The DOHW/designee will perform weekly audits, for the next 90 days, on all newly developed service plans as well as service plans for all tenants with new orders, a known illness, behavior, or incident report. Any concerns will be corrected. Audits will be documented in the State survey audit manual.	7/10/2025