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
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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: 13 Number of tenants with cognitive impairment: 1 Total census: 14 No regulatory insufficiencies were cited during the investigation of Incident #116763-I. The following regulatory insufficiencies were cited during the investigation of Complaint #116968-C.	A 000	See Attached POC 2/24/24	
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 interview and record review, Program staff failed to follow the established policy regarding completion of incident reports for 1 out of 11 tenants reviewed (Tenant #1). Finding follows: On 1/24/24, a review of Tenant #1's record revealed an admission date of 11/18/21. Tenant #1's file contained two incident reports for the past four months. Tenant #1's incident reports documented she fell out of bed on 11/9/23 and on 10/4/23 Tenant #1 received someone else's medication.	A 150		

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
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 150	Continued From page 1 When interviewed on 1/25/24 at 10:20 am, Tenant #1's confidential family friend stated Tenant #1 had two small cuts under her eye glasses several days after the medication error on 10/4/23. The confidential family friend stated she notified Tenant #1's daughter regarding the cuts. Record review on 1/23/24 revealed the Program's Incident Report Policy directed the Program kept accurate and efficient reports of incidents. The Program's policy further directed medication errors, accidents, and unusual occurrences within the facility or on the premises that affected tenants be reported as incidents. When interviewed 1/30/24 at 11:00 a.m., the Director of Assisted Living stated she was notified of Tenant #1's injury by Tenant #1's daughter after the injury was noticed by staff. The Director of Assisted Living stated staff had not notified her of the injury and so an incident report was not completed as the Program's policy directed.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to provide tenants with adequate	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 160	Continued From page 2	A 160		

and appropriate treatment. This affected 5 of 11 tenants reviewed (Tenant #1, Tenant #3, Tenant #4, Tenant #8, and Tenant #11). Findings include:

1. On 1/24/24, a review of Tenant #1's record revealed an admission date of 11/18/21. Tenant #1 had a Global Deterioration Scale (GDS) score of 3 (moderate memory loss). Tenant #1's incident report dated 11/9/23, indicated Tenant #1 fell out of her bed at 2:30 a.m. onto the floor and yelled for help. Tenant #1 had her apartment door locked. Tenant #1's neighbor heard Tenant #1 yell for help and notified staff.

When interviewed on 1/25/24 at 9:56 am, Tenant #1 stated she pressed her pendant on the night of 11/9/23. Tenant #1 explained she rolled out of bed and could not get up. Tenant #1 stated it took the staff quite awhile to respond to her pendant because her apartment door was locked and they could not locate the key. Tenant #1 stated she did not sustain injuries when she fell.

When interviewed on 1/25/24 at 3:12 p.m., Staff D stated she worked in the long-term care unit on the night Tenant #1 rolled out of bed and used her pendant. Staff D explained she normally didn't answer pendant calls because the long-term aide responded to other unit pendant calls if they were on too long. Staff D stated her aide in long-term care completed rounds when the light came on, so Staff D headed to the memory care unit to answer the light. Staff D recalled it was between 2:00- 2:30 a.m. Staff D stated the assisted living staff, Staff F was not on the unit because she was covering the memory care units for staff breaks. Staff D stated the assisted living could be left unattended while staff breaks were provided and the long-term care unit staff covered any pendant calls. Staff D recalled when she arrived to Tenant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 160	Continued From page 3	A 160		

#1's apartment, Tenant #11 stood outside of Tenant #1's apartment and stated Tenant #1 was on the floor but the apartment door was locked. Staff D went to retrieve the master apartment key but could not locate it. Staff D left the assisted living and located Staff F for the key. Staff D located Staff F and returned to the assisted living and unlocked Tenant #1's apartment door. Staff D assessed Tenant #1 for injuries but she had none. Staff D stated Tenant #1's daughter and physician were notified.

When interviewed on 1/29/24 at 9:00 a.m., Staff F stated she worked as the assisted living staff on the night Tenant #1 rolled out of her bed and used her pendant for help. Staff F stated she could not recall what time she left the assisted living to break staff but stated when she arrived to the first memory care unit, Tenant #1's pendant light was lit up on the master switch board. Staff F stated she could not recall if she notified the long-term care side that she left to break staff, but stated the long-term care staff were instructed to always respond to a light if it was on for awhile and was not being answered. Staff F stated she then went to a second memory care unit while that staff took a break. Staff F thought she was there for around 20 to 25 minutes. Staff F stated Staff D arrived to the memory care unit and stated she responded to Tenant #1's pendant call but her apartment door was locked and she had not located the keys to enter. Staff F stated the keys were in the staff desk drawer in the assisted living unit where they were always kept. Staff D and Staff F went to Tenant #1's apartment and opened the door. Tenant #1 sat on the floor on a blanket. Tenant #1 had no injuries.

When interviewed on 1/29/24 at 9:33 a.m., the Director of Assisted Living stated tenants could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 160	Continued From page 4	A 160		

use their pendant for any reason which included non-emergencies and emergencies. The Director of Assisted Living stated she believed staff responding to a pendant within 10 minutes seemed to be reasonable. The Director of Assisted Living stated the Program's policy had not indicated what the time frame was for staff to respond in for a pendant call.

On 1/29/24, a review of pendant response times revealed on 11/9/23 staff took 28 minutes and 35 seconds to respond to Tenant #1's pendant call. Tenant #1's neighbor, Tenant #11 also used her pendant to alert staff of Tenant #1's fall and it was not answered for 20 minutes and 1 second.

Further review of the pendant response times for a selection of eight random days, revealed on 11/10/23 at 7:17 a.m., Tenant #3 waited for 26 minutes and 55 seconds after using his pendant for a non-emergency request and on that same day at 9:07 a.m., he waited 26 minutes and 55 seconds for a second non-emergency request.

On 1/23/24, a review of Tenant #3's record revealed an admission date of 4/28/23. When interviewed on 1/25/24 at 9:45 a.m., Tenant #3 stated staffing was terrible at the assisted living. Tenant #3 stated they were told there was going to be two staff members but there was typically only ever one. Tenant #3 stated staff often answered his pendant in a timely manner but told him they couldn't help him at the time or they would come back later when they finished a different task because they were the only staff available.

On 1/29/24, a review of Tenant #8's record revealed an admission date of 4/13/23. The pendant response times revealed on 11/8/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 160	Continued From page 5 3:32 a.m., Tenant #8 waited for 21 minutes and 28 seconds for a non-emergency request. Tenant #8 was unavailable for interview. When interviewed on 1/29/24 at 3:00 p.m., the Director of Assisted Living, Administrator, and Director of Nursing - Skilled Side confirmed the above pendant times above 20 minutes. 2. On 1/25/24, a review of Tenant #4's record revealed an admission date of 5/22/23. Tenant #4's service plan dated 6/22/23 showed Tenant #4 required assistance with bathing 1-2 times per week. Tenant #4's record contained no documentation of whether staff assisted her with bathing each week. Observation on 1/25/24 at 9:30 a.m., revealed Tenant #4 sat in her apartment wearing a housecoat and waited for staff to assist her with her bathing during a brief interview with the surveyor. Tenant #4 stated she was supposed to get assistance with bathing the day before but Staff A, a male staff worked in the assisted living and she preferred a female to assist her. Tenant #4 stated Staff A told her there was no one else to do it and she would have to wait until the next day. Tenant #4 stated the female staff scheduled on 1/25/24 indicated she would complete it. Tenant #4 stated she was worried about not getting bathing assistance because staff recently skipped two of her scheduled bathing times and never made them up. She believed it was because male staff were scheduled and they couldn't find anyone else to assist her. Tenant #4 stated recently one of her family members was upset by the skipped bathing assistance. When interviewed on 1/24/24 at 1:14 p.m., Staff A	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 160	Continued From page 6 stated he was supposed to assist two tenants (one was Tenant #4) with bathing assistance today but he couldn't complete the tasks because they are female tenants that preferred female staff to assist with bathing. Staff A stated there were no staff to switch out with him for the tenant assistance in bathing. Staff A stated he passed the info on to the next day's staff so they could complete the bathing assistance. When interviewed on 1/24/24 at 2:03 p.m., Staff B stated there were supposed to be two staff available in the assisted living but staff were told because of budget cuts they often worked alone. Staff B stated some days it was terrible and some days it was easy. When interviewed on 1/29/24 at 3:00 p.m., the Director of Assisted Living, Administrator, and Director of Nursing - Skilled Side confirmed the above findings.	A 160		
A 280	481-67.5(2)f(3) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (3) The program shall maintain a list of each tenant's medications and document the medications administered. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to consistently document	A 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 280	Continued From page 7	A 280		

medications and physician's orders for 2 of 4 tenants reviewed who received medication administration assistance (Tenant #1 and Tenant #3). Findings include:

On 1/24/24, a review of Tenant #1's record revealed an admission date of 11/18/21. Tenant #1's diagnoses included heart failure, type II diabetes, hypertension, hyperlipidemia, and was on hospice. Tenant #1's physician's order dated 9/8/23, directed daily weights were to be taken. The order directed if Tenant #1's weight was above 188 pounds (lbs) the medication Metolazone 5 mg as needed (PRN) should be administered. Staff notified the registered nurse (RN) if Tenant #1's weight exceeded 188 lbs so the physician could be notified. Tenant #1's nurse's notes for October 2023 through January 2024 revealed the RN documented in nurse's notes when she notified Tenant #1's physician of weights exceeding 188 lbs.

On 1/24/24, a review of Tenant #1's medication administration record (MAR) for 10/2023, 11/2023, 12/2023, and 1/2024 revealed the following times Tenant #1's weight was over 188 pounds but there was no documentation the RN was notified.
a. 11/10/23: Weight was 189 lbs, no documentation the RN was notified in nurse's notes.
b. 12/19/23: Weight was 188.40 lbs, no documentation the RN was notified in nurse's notes.
c. 12/20/23: Weight was 190.80 lbs, no documentation the RN was notified in nurse's notes.
d. 12/21/23: Weight was 192.20 lbs, no documentation the RN was notified in nurse's notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 280	Continued From page 8 e. 12/24/23: Weight was 189.20 lbs, no documentation the RN was notified in nurse's notes. f. 12/30/23: Weight was 188.60 lbs, no documentation the RN was notified in nurse's notes. g. 12/31/23: Weight was 194.60 lbs, no documentation the RN was notified in nurse's notes. h. 1/1/24: Weight was 195.60 lbs, no documentation the RN was notified in nurse's notes. i. 1/19/24: Weight was 190.20 lbs, no documentation the RN was notified in nurse's notes. j. 1/20/24: Weight was 191.10 lbs, no documentation the RN was notified in nurse's notes. k. 1/21/24: Weight was 190.40 lbs, no documentation the RN was notified in nurse's notes. l. 1/22/24: Weight was 190.80 lbs, no documentation the RN was notified in nurse's notes. Further review of Tenant #1's MARs for 10/2023, 11/2023, 12/2023 and 1/2024 revealed the following times the medication, Metolazone 5 mg was not documented as given when Tenant #1's weight was over 188 lbs. a. 10/20/23: Weight was 192 lbs, no documentation Metolazone 5 mg was administered to Tenant #1. b. 10/29/23: Weight was 189.20 lbs, no documentation Metolazone 5 mg was administered to Tenant #1. c. 11/10/23: Weight was 189 lbs, no documentation Metolazone 5 mg was administered to Tenant #1.	A 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 280	Continued From page 9 2. On 1/23/24, a review of Tenant #3's record revealed an admission date of 4/28/23. Tenant #3's order dated 4/13/23, directed staff took Tenant #3's daily weight and recorded it on the MAR. A review of Tenant #3's MARs for 8/2023, 9/2023, 10/2023, and 11/2023 revealed Tenant #3's weights were not documented on 8/10/23, 9/23/23 and 11/16/23. On 1/29/23 at 3:00 p.m., the Director of Assisted Living, Administrator and Director of Nursing-Skilled Side confirmed the above findings.	A 280		
A 361	481-67.9(4)f 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: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, one staff member failed to administer medications as trained for 1 of 2 tenants observed during a medication pass (Tenant #3). Finding includes: Observation on 1/24/24 at 11:51 a.m. during a medication pass revealed Staff A placed Tenant #3's medications in a medication cup. The medications included Alprazalam (psychotropic) 0.5 mg, Furosemide (fluid retention) 40 mg, and 2 tabs of Tylenol 500 mg. Staff A placed the medication cup on a tray with the tenant's noon	A 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 361	Continued From page 10 meal. Staff A delivered the tray to Tenant #3's apartment and placed the tray on the TV stand next to the tenant's recliner and left the apartment. Staff A failed to observe Tenant #3 ingest the medications. When interviewed on 1/24/24 at 3:40 p.m., the Director of Assisted Living confirmed staff were to observe tenants ingest medications unless otherwise indicated on the service plan. On 1/23/24, a review of Tenant #3's most recent service plan dated 4/25/23, documented Tenant #3 required assistance with medication administration but did not indicate medications could be left at bedside. On 1/29/24, a review of Staff A's personnel record revealed Registered Nurse (RN) delegations regarding the administration of oral medications dated 10/13/23 directed the staff ensured medications were swallowed. When interviewed on 1/29/24 at 3:00 p.m., the Director of Assisted Living, Administrator, and Director of Nursing - Skilled Side confirmed the above finding.	A 361		
A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are	A 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 330	Continued From page 11 doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to document the completion of all routine personal or health-related cares on task sheets for 4 out of 4 tenants reviewed who received routine services (Tenant #1, Tenant #2, Tenant #3, and Tenant #4). Findings include: 1. On 1/24/24, a review of Tenant #1's record revealed an admission date of 11/18/21. Tenant #1's service plan dated 12/26/23 documented Tenant #1 required staff assistance with bathing, dressing and room cleans. Tenant #1's record lacked documentation of whether staff completed tasks of bathing and dressing assistance for the months of January 2024, December 2023, and November 2023. A review of weekly room clean documentation for December 2023 through January 2024 revealed no room cleaning service documented for the week of January 14th through January 20th, 2024 for Tenant #1. When interviewed on 1/25/24 at 10:20 a.m., Tenant #1's confidential family friend confirmed bedding should be washed when a room clean occurred. The family friend stated Tenant #1 had two colors of bedding/sheets, cream and green. The family friend stated she noted Tenant #1's bedding was cream colored on 1/12/24. The family friend visited Tenant #1 on 1/15/24, which was the tenant's room clean day. Tenant #1 still had cream colored bedding. On 1/22/24, the family friend visited Tenant #1 and asked Staff B if Tenant #1's apartment had been cleaned. Staff B stated she did the best she could but had not washed the bedding because Tenant #1 was lying	A 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 330	Continued From page 12	A 330		

on the bed. The sheets were still cream. The family friend asked Staff to leave a note for the next shift staff to wash and change the bedding when Tenant #1 was up. Staff B left a note and the bedding was washed and changed on 1/23/24.

2. On 1/24/24, a review of Tenant #2's record revealed an admission date of 8/31/21. Tenant #2's service plan dated 12/26/23 documented Tenant #2 required staff assistance with bathing, dressing and room cleans. Tenant #2's record lacked documentation of whether staff completed tasks of bathing and dressing assistance for the months of January 2024, December 2023, and November 2023. A review of weekly room clean documentation for December 2023 through January 2024 revealed no room cleaning service documented for the week of January 7th through January 13th, 2023 for Tenant #2.

3. On 1/23/24, a review of Tenant #3's record revealed an admission date of 4/28/23. Tenant #3's service plan dated 4/25/23 documented Tenant #3 required staff assistance with dressing and bathing. Hospice services provided weekly bathing assistance. Tenant #3's record lacked documentation of whether staff completed the task of dressing assistance for the months of January 2024, December 2023, and November 2023.

4. On 1/24/24, a review of Tenant #4's record revealed an admission date of 5/22/23. Tenant #4's service plan dated 6/22/23 documented Tenant #4 required staff assistance with bathing and room cleans. Tenant #4's record lacked documentation of whether staff completed the task of bathing assistance for the months of January 2024, December 2023, and November

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 330	Continued From page 13 2023. A review of weekly room clean documentation for December 2023 through January 2024 revealed no room cleaning service documented for the week of January 7th through January 13th, 2023 for Tenant #4. When interviewed on 1/29/24 at 3:00 p.m., the Director of Assisted Living, Administrator, and Director of Nursing - Skilled Side confirmed the above findings.	A 330		
A 710	481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the Program failed to keep all areas of the building clean and sanitary which affected all tenants residing in the Program. Findings include: On 1/24/24 at 9:30 a.m. during an observational tour given by the Administrator, the back hallway which housed the family sitting area and the laundry facilities revealed carpeted hallways which were dirty and required vacuuming. The garbage in the family sitting area overflowed. On 1/25/24 at 9:55 a.m., the hallways continued to need vacuuming and visible pieces of paper scattered the carpeting. The family sitting room garbage overflowed. On 1/29/24, the hallway carpeting was observed clean and the garbage was empty in the family sitting room.	A 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0423	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS ASSISTED LIVING	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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 710	Continued From page 14 When interviewed on 1/29/24 at 3:00 p.m., the Director of the Assisted Living, Administrator, and the Director of Nursing - Skilled Side confirmed the above finding.	A 710		

LUTHERMANOR
COMMUNITIES

Grand Meadows

ALPD S0423 Plan of Correction

Please accept this as Luther Manor Communities – Grand Meadows Assisted Living credible allegation of compliance. This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.

State Surveyor, Stephanie Radabaugh: Survey, 1/24-1/30.

Incident #116968-C

481-67.2(3) Program Policies and Procedures – The program shall follow the policies and procedures established by the program.
This requirement was not met as evidenced by Program staff failed to follow the established policy regarding completion of incident reports.

On tenant #1 and similarly situated residents, the standard of practice for recording accurate and efficient reports of incidents will be maintained to assure quality of care. All Universal Worker staff were in-serviced at a meeting on February 1, 2024 for AL staff on the adherence to the service plan, charting, and reporting all incidents to the Assisted Living Director. Resident injuries and incidents are to be documented in the clinical record and witness statements obtained. Associates were educated to report incidents including medication errors, accidents, and unusual occurrences within the facility or on the premises that affects tenants.

Director of AL or designee, to monitor the compliance of incident report completion weekly for the next 3 months and report to the QAPI committee to determine on-going monitoring needs.

Completion Date: January 19, 2024

<u>481-67.3(2)</u> Tenant Rights – All tenants have the right to receive care, treatment and services which are adequate and appropriate.

1. On tenant #1 and similarly situated residents, current staff from ALPD, ALP. Staff were in-serviced at a meeting on January 19, 2024 on responding to call lights. The standard of practice is for maintaining a facility free of Accident Hazards/Supervision/Devices by responding to call lights within a reasonable amount of time. All households including ALPD and ALP are to contact staff in the household where a call light remains unanswered for an unusual length of time. The Assisted Living Director and/or designee will audit Call Light reports on a weekly basis for response times. After three months, if no issues are noted, random audits will be conducted to ensure quality of care and standards of practice for quality of care. The Assisted Living Director and/or designee will report results of the audit to the interdisciplinary team and at the monthly staff meeting.

   Completion Date: January 19, 2024

2. On tenant #4 and similarly situated residents, staff will be scheduled to accommodate tenant's shower needs. Universal Worker staff were in-serviced at a meeting on February 1, 2024 for AL staff on the adherence to the service plan and emphasized the TAR provides customized services for each tenant. The Assisted Living Director and/or designee will complete chart audits on the TAR daily and observe the completion of showers. After three months, if no issues are noted, random audits will be conducted to ensure quality of care and standards of practice for quality of care. The Assisted Living Director and/or designee will report results of the audit to the interdisciplinary team and at the monthly staff meeting.

   Completion Date: February 1, 2024

<u>481-67.5(2)f(3)</u> Medications – Each program shall follow its own written medication policy, and shall maintain a list of each tenant's medications and document the medications administered.

a. On tenant #1 and similarly situated residents, the standard of practice for assessment of weights and administration of medication if tenant exceeds an established weight by physician. All Universal Workers were in-serviced at a meeting on February 1, 2024 on the adherence to the service plan and emphasized the clear direction the service plan provides the tenant. The Assisted Living Director and/or designee will complete chart audits on the TAR daily and observe the proper dosage of medications. After three months, if no issues are noted, random audits will be conducted to ensure quality of care and standards of practice for quality of care. The Assisted Living Director and/or

designee will report results of the audit to the interdisciplinary team and at the monthly staff meeting.

Completion Date: February 1, 2024

b. On tenant #3 and similarly situated residents, the standard of practice for assessment of weights and accurate documentation will be maintained to assure quality of care. Universal Worker staff were in-serviced at a meeting on February 1, 2024 on the adherence to the service plan and emphasized the clear direction the service plan provides the tenant. The Assisted Living Director and/or designee will complete chart audits on the TAR daily and observe the completion of all tasks including resident weights. After three months, if no issues are noted, random audits will be conducted to ensure quality of care and standards of practice for quality of care. The Assisted Living Director and/or designee will report results of the audit to the interdisciplinary team and at the monthly staff meeting.

Completion Date: February 1, 2024

481-67.9(4)f Staffing – Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants.

On tenant #3 and similarly situated residents, the standard or practice for medication management and service planning will be maintained. Licensed nursing staff were in-serviced at a meeting on February 1, 2024 on the Policy and Procedure for Medication Administration. The Assisted Living Director and/or designee will complete chart audits on the MAR daily for completion, and observe the administration of medications to ensure staff confirm medications are swallowed. After three months, if no issues are noted, random audits will be conducted to ensure quality of care and standards of practice for medication management. The Assisted Living Director and/or designee will report results of the audit to the interdisciplinary team and at the monthly staff meeting.

Completion Date: February 1, 2024

481-69.25(1)q Tenant Documents – Documentation for each tenant shall be maintained by the program.

On tenants #1, #2, #3, +#4 and similarly situated residents, the standard of practice for assessing tenants to develop a service plan that meet the tenants' needs. Service Plans were updated to include bathing, dressing, room cleans, bed sheets changed, garbage removed, and showers are provided. Universal Worker staff were in-serviced at a meeting on February 1, 2024 on the adherence to the service plan and emphasized the TAR provides customized

services for each tenant. The Assisted Living Director and/or designee will complete chart audits on the TAR daily and observe the proper dosage of medications. After three months, if no issues are noted, random audits will be conducted to ensure quality of care and standards of practice for quality of care. The Assisted Living Director and/or designee will report results of the audit to the interdisciplinary team and at the monthly staff meeting.

Completion Date: February 1, 2024

<u>481-69.35(1)b</u> Structural Requirements – The buildings and grounds shall be well-maintained, clean, safe and sanitary.

Common areas shall be maintained for cleanliness and removal of trash. Universal Worker staff were in-serviced on maintaining the households clean and tidy in all areas. The Assisted Living Director and/or designee will complete rounding audits daily and observe the households are well kept. Results of continuing observations will be reported at monthly staff meetings with all Universal Workers.

Completion Date: February 24, 2024