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
	S0442	A. BUILDING: _____ B. WING _____	C 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT TOWER PLACE AL	540 S 51ST STREET WEST DES MOINES, IA 50265

(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: 91 Number of tenants with cognitive impairment: 5 Total census: 96 No regulatory insufficiencies were cited during the investigation of Complaints #119080-C. The following regulatory insufficiencies were cited during the investigation of Complaint 122461-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program.	A 000		
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 the Program failed to consistently follow policies and procedures for medication errors. This pertained to 1 of 1 tenants reviewed with an identified medication error(Tenant #2). Finding follows: Record review on 8/28/24 revealed Tenant #2's Medication Administration Record (MAR) for July 2024. On 7/31/24, program staff administered Tenant #2's gabapentin 300 mg and Clonazepam .25 mg at 10:13 p.m. Further review revealed the MAR specified the Gabapentin be administered at	A 150	In accordance with regulation 481-67.2(3) 67.2(3) The program shall follow the policies and procedures established by the program. Meeting set up to to review medication administration and proper documentation per policy and procedure with staff on 02/26/25. DOHW and ADOHW to review eMAR weekly to ensure that medications are being administered at proper times. Regulatory insufficiency to be completed by 03/01/25.	

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

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A 150	Continued From page 1	A 150		

9:00 p.m. and Clonazepam at 8:00 p.m. Record review on 8/28/24 revealed Tenant #2's service plan dated 1/4/24. The service plan directed staff to administer medications as ordered by the physician. The community was to assist tenant to take medications as ordered.

Record review on 8/28/24 revealed the Program's Medication Error policy (undated) defined a "wrong time error" as failure to administer medication within a predefined interval from its schedule administration time. This interval is clearly stated in Grand Living Policies. Further review of Grand Living's Medication error interval policy (undated) revealed medication administration error intervals were defined based on Industry Standards. If a medication is not administered one hour before or one hour after the scheduled time, it will be considered missed and a medication error will occur. The Program will follow the medication error policy.

When interviewed on 8/28/24 at 3:15 p.m. the Director of Health Care confirmed she failed to complete a medication error report per policy.

Record review on 8/29/24 revealed the Program's Medication Manager Course Skills Competency Checklist for Oral Medication. Review revealed directions on how to perform oral medication administration included medications can be administered one hour before and after scheduled time. Further review revealed Staff B, who administered Tenant #2's medication, signed her checklist acknowleging understanding on 7/6/23. The Assistant Director of Health Care/delegating nurse also signed the form dated 7/6/23.

During the exit on 12/3/24 at 11:15 a.m. the

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A 150	Continued From page 2 administrative team acknowledged the above findings.	A 150		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop individualized services plans with identified needs and preferences for assistance. This pertained to 1 of 2 tenants reviewed who did not receive health related care (Tenants #10). Finding follows: Record review on 8/26/24 revealed Tenant #10's service agreement/service plan dated 5/3/24. The Program failed to indicate Tenant #10's identified needs and preference for assistance. The document included demographic information that included emergency contact information only. When interviewed on 8/26/24 at 9:50 a.m. the Director of Health and Wellness said Tenant #10 was independent and waived all other services.	A 395	In accordance with regulation 481.69.26(4)a 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: DOHW has met with Infomatics nurse and assessment has been updated to include each resident's individualized needs that are offered to them by the program. These will now pull to the service plan to be reviewed with resident when signing service plan.	