

OK
1/29/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALPD365	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER GRAND MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 GRAND MEADOW DRIVE ASBURY, IA 52002		
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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 11 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 14 TOTAL Census of Assisted Living Program for People with Dementia: 30 The following regulatory insufficiencies were cited during the investigation of Incident #86012-I, Complaint #87115-C and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program. ***** ***** 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This Requirement is not met as evidenced by: Based on observation, interview and record review the Program failed to have an operating alarm system connected to each exit door in a dementia-specific program. This potentially	A 000	See attached POC 1/30/2020	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 000	Continued From Page 1 affected all tenants of the Program (census of 30 tenants). Findings follow: 1. Observation on 11-12-19 at 2:45 p.m. and 11-21-19 at approximately 12: 00 p.m. revealed the Program had five houses attached by structure. Three of the five houses were certified as a Dedicated Dementia Specific Assisted Living Program and the other two houses were nursing facility level of care. There were no door alarms observed when exiting the Program and entering the nursing facility houses. Alarms were not observed on each exit door from the Program. 2. Record review revealed the Program had a certificate issued from the Department for a Dedicated Dementia Specific Assisted Living Program. 3. Continued record review revealed a layout of the building indicated five houses attached by structure. Three of the houses were certified as a Dedicated Dementia Specific Assisted Living Program. The other two houses were licensed as a nursing facility. 4. When interviewed on 11-21-19 at 12:10 p.m. the Director of Nursing revealed the doors entering the nursing facility were not alarmed with a code but did have a electronic wandering monitoring system. 5. When interviewed on 11-21-19 at 12:40 p.m. the Administrator indicated revealed the doors entering into the nursing facility were not alarmed. ***** ***** 481-69.23(231C) Criteria for admission and	A 000		

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A 000	Continued From Page 2 retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: j. Despite intervention, chronically urinates or defecates in places that are not considered acceptable according to societal norms, such as on the floor or in a potted plant. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to discharge a tenant who exceeded the level of care for retention. This pertained to 1 of 4 current tenants reviewed (Tenant #3). Findings follow: 1. Record review on 11-20-19 of Tenant #3's file revealed Tenant #3 was admitted on 5-15-19 and diagnosis included dementia. Tenant #3 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Interdisciplinary Notes indicated the following: -On 6-18-19 Tenant #3 had a bowel movement in the garbage can in the bathroom. -On 7-9-19 Tenant #3 held onto the door handle and urinated on the carpet in the hallway. Tenant #3 was fully nude. -On 7-22-19 Tenant #3 was more incontinent and staff was unable to find clean underwear. Tenant #3's family was notified. -On 7-24-19 the previous evening Tenant #3 urinated on the couch and hid the soiled clothes in the couch cushions.	A 000		

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A 000	Continued From Page 3 -On 7-29-19 urine was all over the bathroom floor. -On 7-31-19 during the over night hours Tenant #3 was found nude on the common area living room couch. Tenant #3 was approached in different ways and became verbally aggressive with staff. Tenant #3 was in the common areas for a few hours in the nude. Tenant #3 did get dressed and was found eating notebook paper. -On 8-16-19 Tenant #3 refused to let staff assist with cares and walked around in the nude. Clothes were stuffed in bags and the garbage can. Staff attempted to help Tenant #3 get clothes on and Tenant #3 became verbally aggressive. He came out of the door with a shirt tied around his waist. Tenant #3 was redirected to his apartment and became upset and slammed the door. -On 10-1-19 wet protective undergarments and pants were found inside drawers and garbage cans. -On 10-7-19 it was noted on 10-4-19 staff reported a strong smell of bowel movement (BM) and he would not allow staff to help cares. When asked about a shower he became upset. -On 10-9-19 Tenant #3 was found across the hall in another tenant's apartment, nude and used others bathroom supplies. -On 10-10-19 Tenant #3 went into other tenants' apartments, walked up to people in the common area and made them uncomfortable. Tenant #3 refused medications. He was also defecated in the dining area and scooped the BM on the plate and rubbed it on the table and chairs. -On 10-14-19 it was noted on 10-13-19 Tenant #3 was found in the nude in the den area of the	A 000		

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A 000	Continued From Page 4 Program and there was a wet spot on the floor. -On 10-17-19 staff found three electronic wandering devices in the garbage can and several sets of silverware and soiled protective undergarments in the dresser drawer. The electronic wandering monitoring device was replaced on the right ankle. -On 10-23-19 it was noted on 10-22-19 it was noted Tenant #3 was exit seeking and when attempted to redirected he became angry. Tenant #3 refused to wear pants and was sitting on the couch in a protective undergarment. -On 10-26-19/10-24-19 (entered date and event date) it was noted Tenant #3 had more incontinent episodes and began to hide soiled protective undergarments in dresser drawers or in the shower. He had come out his apartment in the nude on many occasions and wandered into other tenants' apartments without clothing too. Tenant #3 recently was involuntary of stool in the dining room. He was in the dining room with only his shirt on. He was found scooping his stool with a spoon and he put it a bowl. He walked around with a spoon full of stool and would not throw it away. He tried to go into the kitchen area with the spoon full of stool and was blocked from that area. Tenant #3 threw away the spoon and staff disposed on the bowl of stool. There were spots of stool throughout the dining room floor. Tenant #3 took the mop and cleaned the floor. He gave staff the mop to staff who changed the mop head and re-washed and sanitized the floor. At times urine was found the floor or the bath a few times per day. -On 10-29-19 it was noted on 10-29-19 on third shift Tenant #3 was found attempting to urinate in the family room/den area. Tenant #3 became very	A 000			

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A 000	Continued From Page 5 verbally aggressive with staff attempted to redirect. -On 11-5-19 it was noted the progression of Tenant #3's level of care and incontinence was discussed with family. Family was educated that Tenant #3 exceeded the level of care due to increased incontinence and behaviors. Family was told that Tenant #3 would benefit from the chronic confusion or dementing illness (CCDI) unit when a bed was available for Tenant #3's safety and exiting seeking behaviors. Family had been informed Tenant #3 refused to shower with interventions from staff and had been urinating in inappropriate places. Family asked how soon he would need to move and was told once there was bed availability family would be contacted again and that maintenance staff could help with the move. 2. When interviewed on 11-21-19 at 12:10 p.m. the Director of Nursing revealed they were waiting for a bed to open up in the CCDI unit on the other campus and the expected timeframe was next week. 3. When interviewed on 11-21-19 at 12:40 p.m. the Administrator indicated Tenant #3's placement in the CCDI was planned for next week otherwise a 30 day notice would be given. 4. Continued record review revealed the Program's Admission and Occupancy Criteria indicated the Program would assess each tenant prior to taking occupancy and during the continued occupancy to maintain the tenant's safety and ensure the tenant continued to be appropriate for the Program and services provided. Persons could not be admitted or retained to the Program who: despite interventions, chronically urinated or defecated in the places that were not considered	A 000		

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A 000	Continued From Page 6 acceptable according to societal norms.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to complete incident reports as directed by the Program's policy. This pertained to 4 of the 4 current tenants reviewed (Tenants #2, #3, #4 and #5). Findings follow: 1. Record review on 11-20-19 of Tenant #2's file revealed his diagnosis included Parkinson's disease and dementia with behavioral disturbance. Interdisciplinary Notes indicated the following: -On 7-25-19 it was noted Tenant #2 grabbed staff around the waist yesterday afternoon and looked at staff in sexual manner. Tenant #2 asked staff to come see him "later tonight." -On 8-27-19 it was noted Tenant #2 was	A 003		

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A 003	Continued From Page 7 inappropriate with a shower. When it was discussed with Tenant #2 he said he asked for help washing his perineal area. Continued record review revealed incident reports were not completed related to the above incidents. 2. Record review on 11-20-19 of Tenant #3's file revealed Tenant #3, admitted on 5-15-19 had a diagnosis that included dementia. Tenant #3 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Interdisciplinary Notes indicated the following: -On 10-26-19/10-24-19 (entered date and event date) it was noted Tenant #3 had more incontinent episodes and began to hide soiled protective undergarments in dresser drawers or in the shower. He had come out his apartment in the nude on many occasions and wandered into other tenants' apartments without clothing too. Tenant #3 recently was incontinent of stool in the dining room. He was in the dining room with only his shirt on. He was found scooping his stool with a spoon and he put it a bowl. He walked around with a spoon full of stool and would not throw it away. He tried to go into the kitchen area with the spoon full of stool and was blocked from that area. Tenant #3 threw away the spoon and staff disposed on the bowl of stool. There were spots of stool throughout the dining room floor. Tenant #3 took the mop and cleaned the floor. He gave staff the mop to staff who changed the mop head and re-washed and sanitized the floor. At times urine was found the floor or the bath a few times per day. Continued record review revealed an incident report was not completed related to the incident noted above.	A 003		

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A 003	Continued From Page 8 3. Record review 11-21-19 of Tenant #4's file revealed diagnoses included dementia without behavioral disturbance and history of depression. Interdisciplinary Notes indicated the following: -On 11-8-19 staff reported Tenant #4 was upset they removed some personal items for safety reasons and she made the comment, "I will just slit my wrists then!" When the Director of Nursing (DON) spoke with her she said she was not going to harm herself or others. Tenant #4 said her brain worked too well to cause herself harm. Continued record review revealed an incident report was not completed related to the incident noted above. 4. Record review on 11-21-19 of Tenant #5's file revealed Tenant #5 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Interdisciplinary Notes indicated the following: -On 7-23-19 staff reported Tenant #5 reported a suicidal ideation. Tenant #5 reported she did say it when she was upset and that she might have overreacted due to a misplaced item. Tenant #5 reported she did not want to kill herself or have any plans to do so. -On 9-24-19 (annual review) it was noted in July Tenant #5 had some suicidal ideations and was started on 30 minute checks. for a week. Tenant #5 had sexual behavior noted and monitored. The male tenant was moved to a different house and the behavior subsided.	A 003		

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A 003	Continued From Page 9 Continued record review revealed an Employee/Witness Statement Form dated 8-15-19 indicated between 6:30 a.m. to 6:45 a.m. she went to Tenant #6's apartment to do his 30 minute check and did not see him. Staff then went to Tenant #5's apartment and Tenant #6 was leaving. Staff asked Tenant #6 what he was doing and Tenant #6 replied "nothing." Staff went into Tenant #5's apartment and observed her without a bra or shirt on. Staff asked Tenant #5 what was going on and Tenant #5 did not know. Further record review revealed incident reports were not completed for the incidents noted above. 5. When interviewed on 11-21-19 at 12:10 p.m. the DON confirmed all incident reports for the time period requested were provided. 6. When interviewed on 11-21-19 at 12:40 p.m. the Administrator confirmed all incident reports for the time period requested were provided. 7. Continued record review of the Program's Policy and Procedure for Incident Reports indicated the Program would maintain accurate and efficient reporting of incidents including allegations of dependent adult abuse. An incident report would be in detail and would be provided on the incident report form. The staff in charge at that time of the incident would prepare and sign the report. All accidents and unusual occurrences within the Program or the premises that affect tenants would be reported as incidents.	A 003			
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant.	A 037			

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A 037	Continued From Page 10 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also 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 or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days of taking occupancy and as needed with significant change. This pertained to 3 of 5 tenants reviewed (Tenants #1, #2, and #3). Findings follow: 1. Record review on 11-20-19 of Tenant #1's file revealed diagnoses included history of falling, dementia and vascular dementia. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Interdisciplinary Notes indicated the following: -On 7-31-19 (9:07 a.m.) staff found Tenant #1 on the floor on his back by the recliner. There was a hematoma on the left temple and he complained of hip pain with a reddened area on the left hip. Tenant #1 was sent to the emergency room (ER)	A 037			

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A 037	Continued From Page 11 to evaluate and treat. -On 7-31-19 (3:33 p.m.) Tenant #1 returned from the ER with a diagnosis of a fracture (hip). Tenant #1 transferred poorly with assist of two people. A call was placed to the doctor to request skilled nursing facility (SNF) orders. An order was received to transfer to SNF level of care with the same orders and treatments. -On 7-31-19 (8:18 p.m.) it was noted staff reported Tenant #1 refused supper, remained on 15 minute checks due to a fall. Staff used max assist of two to transfer Tenant #1 and he needed max assist for all activities of daily living (ADLs). Tenant #1 was not able to walk to the bathroom and staff transferred Tenant #1 in the wheelchair. -On 8-1-19 staff checked on Tenant #1 at 5:00 a.m. and he was in bed. At 5:20 a.m. staff checked on him and found on the floor on his back by the bed. Tenant #1 complained of hip pain. The walker was not near Tenant #1 and was across the apartment. Tenant #1 was sent to the ER. -On 8-2-19 it was noted Tenant #1's family called and Tenant #1 had passed away at the hospital. When interviewed on 11-20-19 at 3:26 p.m. Staff H said when Tenant #1 returned after the hip fracture everything on third shift was done in bed. She got a portable urinal for toileting. Tenant #1 kept trying to stand up or sit up. He moved around in bed a lot. He was a two person transfer at that time and was a fall risk. At 5:00 a.m. he was asleep in bed and when she checked on him next he was on the floor. Tenant #1 seemed more out of it than normal. A nurse came over, paramedics were called and Tenant #1 was sent to the hospital.	A 037		

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A 037	Continued From Page 12 When interviewed on 11-21-19 at 12:40 p.m. the Administrator revealed she was aware Tenant #1 fell and fractured his hip. She was notified of Tenant #1's return to the Program as Tenant #1 was on his way back to the Program via ambulance. She called and spoke to the ER doctor and was assured Tenant #1 was a one person assist, weight bearing as tolerated for six weeks. When she observed Tenant #1, he was a two person assist with a gait belt. A nurse was contacted and was going to complete the assessment the following day. Tenant #1 fell again and complained of hip pain and was sent back to the ER. Tenant #1 declined in the hospital and passed away. Evaluations were last completed on 6-12-19 and 6-13-19. Cognitive, health and functional evaluations were not completed as needed with significant change when Tenant #1 fell, went to the ER, returned with a hip fracture, required max assist of two for transfers, max assist for all ADLs and was on 15 minute checks. 2. Record review on 11-20-19 of Tenant #2's file revealed an admission date of 6-26-19. A health evaluation was not completed within 30 days of taking occupancy. A significant change assessment for increased incontinence was completed on 10-17-19; however, a health evaluation was not completed when the significant change occurred. 3. Record review on 11-20-19 of Tenant #3's file revealed an admission date of 5-15-19. A health evaluation was not completed within 30 days of taking occupancy.	A 037		

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A 037	Continued From Page 13 4. When interviewed on 11-21-19 at 12:10 p.m. the Director of Nursing confirmed all evaluation documents requested for the tenants listed above were provided. 5. When interviewed on 11-21-19 at 12:40 p.m. the Administrator confirmed all evaluation documents requested for tenants listed above were provided.	A 037		
A 058	481-67.9(4)a Staffing 481-67.9(231B,231C,231D) 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 ensure staff were competent in all tasks assigned or delegated. This pertained to 3 of 3 staff reviewed hired as universal workers prior to the employment of the registered nurse (Staff D, E and G). 1. Record review of the ALP/ADS/EGH Monitoring Entrance Form revealed the Director of Nursing	A 058		

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A 058	Continued From Page 14 (DON) as the delegating nurse and hire date of 7-29-19. 2. Record review on 11-19-19 of Staff D's training documents revealed a hire date of 7-9-19. Nurse delegations were documented on 11-20-19. The delegations were signed by Staff D and were not signed by the current DON. Nurse delegations were not completed within 60 days of the DON's employment. 3. Record review on 11-19-19 of Staff E's training documents revealed a hire date of 7-9-19. A Program RN Review for Universal Workers form was dated 9-3-19 by Staff E and on 9-4-19 by the DON. The form indicated the tasks listed had been reviewed and Staff E had demonstrated competency in the tasks. 4. Record review on 11-19-19 of Staff G's training documents revealed a hire date of 3-19-19. A Program RN Review for Universal Workers form was dated 8-29-19 by Staff G and the DON. The form indicated the tasks listed had been reviewed and Staff G had demonstrated competency in the tasks. A Review for Universal Workers form dated 9-4-19 reflected it was a review for being a UW at the Program and the staff was encouraged to ask questions for things that were unclear. During the review staff could go over any delegations they were unfamiliar with or had questions regarding. By signing the form, staff verified they had no questions over any delegations previously delegated and accepted the delegations. For completion of the review five delegations including medications would either be observed or reviewed. Delegations would be observed if possible. The five listed include medication administration, vital signs, insulin administration, fire and weather safety and elopement. It was signed by Staff G and the DON		A 058		

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A 058	Continued From Page 15 on 9-4-19. 5. When interviewed on 11-20-19 at approximately 10:15 a.m. and on 11-21-19 at 12:10 p.m. the DON revealed the forms were reviewed and staff trained on the floor with other universal workers. Staff could ask questions if they were not comfortable on the tasks. Staff were verbally signed off on tasks and trained three days in each house (with other staff). There was no documentation of the observations of tasks and she became aware of the observation tool for staff last week. There were no other delegation documents requested available for the staff listed above.	A 058		
A 083	481-69.26(1) Service Plans 481-69.26(231C) 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 and failed to ensure service plans reflected the service needs of tenants. This pertained to 5 of 5 tenants reviewed (Tenants #1, #2, #3, #4 and #5). Findings follow:	A 083		

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A 083	Continued From Page 16 1. Record review of Tenant #1's file on 11-20-19 revealed his diagnoses included history of falling, dementia and vascular dementia. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Interdisciplinary Notes indicated the following: -On 7-31-19 (9:07 a.m.) staff found Tenant #1 on the floor on his back by the recliner. There was a hematoma on the left temple and he complained of hip pain with a reddened area on the left hip. Tenant #1 was sent to the emergency room (ER) to evaluate and treat. -On 7-31-19 (3:33 p.m.) Tenant #1 returned from the ER with a diagnosis of a fracture (hip). Tenant #1 transferred poorly with assist of two people. A call was placed to the doctor to request skilled nursing facility (SNF) orders. An order was received to transfer to SNF level of care with the same orders and treatments. -On 7-31-19 (8:18 p.m.) staff reported Tenant #1 refused supper, remained on 15 minute checks due to a fall. Staff used max assist of two to transfer Tenant #1 and he needed max assist for all activities of daily living (ADLs). Tenant #1 was not able to walk to the bathroom and staff transferred Tenant #1 in the wheelchair. -On 8-1-19 staff checked on Tenant #1 at 5:00 a.m. and he was in bed. At 5:20 a.m. staff checked on him and found on the floor on his back by the bed. Tenant #1 complained of hip pain. The walker was not near Tenant #1 and was across the apartment. Tenant #1 was sent to the ER. -On 8-2-19 Tenant #1's family called and Tenant #1 had passed away at the hospital.	A 083			

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A 083	Continued From Page 17 When interviewed on 11-20-19 at 3:26 p.m. Staff H said when Tenant #1 returned after the hip fracture everything on third shift was done in bed. She got a portable urinal for toileting. Tenant #1 kept trying to stand up or sit up. He moved around in bed a lot. He was a two person transfer at that time and was a fall risk. At 5:00 a.m. he was asleep in bed and when she checked on him next he was on the floor. Tenant #1 seemed more out of it than normal. A nurse came over, paramedics were called and Tenant #1 was sent to the hospital. When interviewed on 11-21-19 at 12:40 p.m. the Administrator revealed she was aware Tenant #1 fell and fractured his hip. She was notified of Tenant #1's return to the Program as Tenant #1 was on his way back to the Program via ambulance. She called and spoke to the ER doctor and was assured Tenant #1 was a one person assist, weight bearing as tolerated for six weeks. When she observed Tenant #1, he was a two person assist with a gait belt. A nurse was contacted was going to complete the assessment the following day. Tenant #1 fell again and complained of hip pain and was sent back to the ER. Tenant #1 declined in the hospital and passed away. Continued record review revealed Physician Order's reflected an order for knee high anti-embolism hose on in the a.m. and off at bedtime with an order date of 5-28-19. The most current service plan (6-13-19) failed to reflect the assistance with anti-embolism hose daily. The service plan was not updated as needed with significant change when Tenant #1 fell, went to the ER, returned with a hip fracture, required max assist of two for transfers, max	A 083		

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A 083	Continued From Page 18 assist for all ADLs and was on 15 minute checks. 2. Record review of Tenant #2's file on 11-20-19 revealed a diagnosis of Parkinson's disease and dementia with behavioral disturbance. When interviewed on 11-20-19 at 11:19 a.m. Staff I revealed Tenant #2 had had been sexually inappropriate to staff. Interdisciplinary Notes indicated the following: -On 7-25-19 Tenant #2 grabbed staff around the waist yesterday afternoon and looked at staff in sexual manner. Tenant #2 asked staff to come see him "later tonight." -On 8-27-19 Tenant #2 was inappropriate with a shower. When it was discussed with Tenant #2 he said he asked for help washing his perineal area. Tenant #2's service plan was not updated to reflect Tenant #2's behaviors and interventions related to the behavior. 3. Record review of Tenant #3's file on 11-20-19 revealed Tenant #3, admitted 5-15-19, had a diagnosis of dementia. Tenant #3 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Interdisciplinary Notes indicated the following: -On 6-18-19 Tenant #3 had a bowel movement in the garbage can in the bathroom. -On 7-9-19 Tenant #3 held onto the door handle and urinated on the carpet in the hallway. Tenant #3 was fully nude.	A 083			

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A 083	Continued From Page 19 -On 7-22-19 Tenant #3 was more incontinent and staff was unable to find clean underwear. Tenant #3's family was notified. -On 7-24-19 it was noted the previous evening Tenant #3 urinated on the couch and hid the soiled clothes in the couch cushions. -On 7-29-19 urine was all over the bathroom floor. -On 7-31-19 during the over night hours Tenant #3 was found nude on the common area living room couch. Tenant #3 was approached in different ways and became verbally aggressive with staff. Tenant #3 was in the common areas for a few hours in the nude. Tenant #3 did get dressed and was found eating notebook paper. -On 8-16-19 Tenant # refused to let staff assist with cares and walked around in the nude. Clothes were stuffed in bags and the garbage can. Staff attempted to help Tenant #3 get clothes on and Tenant #3 became verbally aggressive. He came out of the door with a shirt tied around his waist. Tenant #3 was redirected to his apartment and became upset and slammed the door. -On 10-1-19 wet protective undergarments and pants were found inside drawers and garbage cans. -On 10-7-19 it was noted on 10-4-19 staff reported a strong smell of bowel movement (BM) and he would not allow staff to help cares. When asked about a shower he became upset. -On 10-9-19 Tenant #3 was found across the hall in another tenant's apartment, nude and used others bathroom supplies.	A 083		

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A 083	Continued From Page 20 -On 10-10-19 it was noted Tenant #3 went into other tenants' apartments, walked up to people in the common area and made them uncomfortable. Tenant #3 refused medications. He was also defecated in the dining area and scooped the BM on the plate and rubbed it on the table and chairs. -On 10-14-19 it was noted on 10-13-19 Tenant #3 was found in the nude in the den area of the Program and there was a wet spot on the floor. -On 10-17-19 it was noted staff found three electronic wandering devices in the garbage can and several sets of silverware and soiled protective undergarments in the dresser drawer. The electronic wandering monitoring device was replaced on the right ankle. -On 10-23-19 it was noted on 10-22-19 Tenant #3 was exit seeking and when attempted to redirected he became angry. Tenant #3 refused to wear pants and was sitting on the couch in a protective undergarment. -On 10-26-19/10-24-19 (entered date and event date) it was noted Tenant #3 had more incontinent episodes and began to hide soiled protective undergarments in dresser drawers or in the shower. He had come out his apartment in the nude on many occasions and wandered into other tenants' apartments without clothing too. Tenant #3 recently was involuntary of stool in the dining room. He was in the dining room with only his shirt on. He was found scooping his stool with a spoon and he put it a bowl. He walked around with a spoon full of stool and would not throw it away. He tried to go into the kitchen area with the spoon full of stool and was blocked from that area. Tenant #3 threw away the spoon and staff disposed on the bowl of stool. There were spots of stool throughout the dining room floor. Tenant	A 083		

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A 083	Continued From Page 21 #3 took the mop and cleaned the floor. He gave staff the mop to staff who changed the mop head and re-washed and sanitized the floor. At times urine was found the floor or the bath a few times per day. A service plan was updated on 10-26-19 for a significant change for increased cognitive deficit, needing more cueing from staff to perform cares, refusals of cares and increased incontinence. Service plans were developed on 6-13-19 and 9-4-19; however, the service plans did not reflect Tenant #3' incontinence and behaviors. The behaviors were not reflected on the service plan until the 10-26-19 update despite documentation of incontinence and behavior months prior to the update. 4. Record review of Tenant #4's file on 11-21-19 revealed diagnoses included dementia without behavioral disturbance and history of depression. November 2019 medication administration records (MARs) reflected an order for Clopidogrel 75 milligrams, one tablet daily. Interdisciplinary Notes indicated the following: -On 10-26-19 Tenant #4 had a significant cerebrovascular accident (CVA), was hospitalized, went to skilled nursing facility care. Discharge orders were received back to the Program on 10-29-19. -On 10-29-19 signed discharge orders were received and orders for outpatient physical therapy (PT) and occupational therapy (OT). Tenant #4 was admitted to the Program with the same medications and treatments. Tenant #4 was an assist of one with a front wheeled walker.	A 083			

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A 083	Continued From Page 22 -On 11-8-19 staff reported Tenant #4 was upset they removed some personal items for safety reasons and she made the comment "I will just slit my wrists then!" When the Director of Nursing (DON) spoke with her she said she was not going to harm herself or others. Tenant #4 said her brain worked too well to cause herself harm. -On 11-12-19 Tenant #4 was not eating as she was embarrassed to eat and make a mess. Tenant #4 was also frequently incontinent of urine and bowels. -On 11-14-19 Tenant #4 was incontinent of stools and urine. -On 11-18-19 Tenant #4 had loose stools and had been involuntary of bowel movement. Continued record review revealed the service plan dated 10-29-19 did not reflect the assistance needed with ambulation, PT/OT services, the comment made regarding self-harm and interventions, incontinence of bowel and bladder, issues with eating or assistance with medication administration including the administration of an anti-coagulant medication. 5. Record review on 11-21-19 of Tenant #5's file revealed Tenant #5 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Interdisciplinary Notes indicated the following: -On 7-23-19 staff reported Tenant #5 reported a suicidal ideation. Tenant #5 reported she did say it when she was upset and that she might have overreacted due to a misplaced item. Tenant #5	A 083		

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A 083	Continued From Page 23 reported that she did not want to kill herself or have any plans to do so. The doctor was faxed a condition report. -On 7-31-19 Tenant #5 had no further mention of suicidal ideations. Tenant #5 would remain on 30 minute checks for behaviors with a male tenants to redirect their visits to common areas of the building. -On 9-24-19 (annual review) it was noted in July Tenant #5 had some suicidal ideations and was started on 30 minute checks. for a week. Tenant #5 had sexual behavior noted and monitored. The male tenant was moved to a different house and the behavior subsided. -On 10-15-19 Tenant #5 was crying and thought everyone was talking about her. -On 10-18-19 Tenant #5 had a few incontinent loose stool episodes of the past couple of weeks. -On 10-22-19 it was noted on 10-21-19 Tenant #5 said everyone said mean things about her. -On 10-23-19 Tenant #5 was upset and cried at times. -On 10-31-19 staff reported Tenant #5 had been tearful at times and "clingy." -On 11-3-19 Tenant #5 had loose stool all over the toilet. -On 11-20-19 Tenant #5 was incontinent of stool and it was all over the bathroom wall. Physician's Orders reflected an order dated 11-25-18 for knee high anti-embolism hose, on in the a.m. and off at bedtime.	A 083			

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A 083	Continued From Page 24 Continued record review revealed the service plans were dated 6-26-19 and 9-24-19. The service plans were not updated as needed and did not reflect did not reflect the history of suicidal ideations and behavior with a male tenant and interventions, frequency of checks, loose stools, increased tearfulness or the assistance with anti-embolism hose. 6. When interviewed on 11-21-19 at 12:10 p.m. the DON confirmed all service plan documents requested for the tenants listed above were provided. 7. When interviewed on 11-21-19 at 12:40 p.m. the Administrator confirmed all service plan documents requested for tenants listed above were provided.	A 083		
A 086	481-69.26(3)a Service Plans 481-69.26(231C) 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.	A 086		

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A 086	Continued From Page 25 This Requirement is not met as evidenced by: Based on interview and record review the Program failed to have service plans signed by all parties when a significant change occurred. This pertained to 3 of 5 tenants reviewed (Tenants #2, #3 and #4). Findings follow: 1. Record review on 11-20-19 of Tenant #2's file revealed the service plan was updated on 10-17-19 with significant change for increased incontinence. The service plan was not signed by Tenant #2 or Tenant #2's legal representative as applicable or the health or human service professional. 2. Record review on 11-20-19 of Tenant #3's file revealed the service plan was updated on 10-26-19 with significant change for increased cognitive deficit, needing more cueing from staff to perform cares, refusals of cares and increased incontinence. The service plan was not signed by Tenant #3 or Tenant #3's legal representative as applicable or the health or human service professional. 3. Record review on 11-21-19 of Tenant #4's file revealed the service plan was updated on 10-29-19 with significant change after a hospitalization and skilled care post cerebrovascular accident. The service plan was not signed by Tenant #4 or Tenant #4's legal representative as applicable or the health or human service professional. 4. When interviewed on 11-21-19 at 12:10 p.m. the Director of Nursing confirmed all service plan documents requested for the tenants listed above were provided. 5. When interviewed on 11-21-19 at 12:40 p.m. the Administrator confirmed all service plan	A 086			

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A 086	Continued From Page 26	A 086		
	documents requested for the tenants listed above were provided.			
A 104	481-69.28(5) Food Service 481-69.28(231C) 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 Program failed to ensure staff responsible for serving food had an orientation on sanitization and safe food handling prior to handling food. This pertained 5 of 8 staff reviewed (Staff A, D, E, F and G). Findings follow: 1. Record review on 11-19-19 of Staff A's training documents revealed a hire date of 10-2-18. Staff A switched from a dietary aide to a universal worker (UW) on 10-20-19. Staff A completed a New Staff Dietary Training on 2-18-19; which was completed more than four months after hire. The course listing did not indicate it was a food safety and sanitation course. 2. Record review on 11-19-19 of Staff D's training documents revealed a hire date of 7-9-19. Staff D completed a New Staff Dietary Training on 9-28-19; which was completed more than two months after hire. The course listing did not indicate it was a food safety and sanitation course. 3. Record review on 11-19-19 of Staff E's training	A 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALPD365	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER GRAND MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 104	Continued From Page 27 documents revealed a hire date of 7-9-19. Staff E had a New Staff Dietary Training on 7-11-19. The course listing did not indicate it was a food safety and sanitation course. Staff E completed a Food Safety Fundamentals course dated 11-16-19; however, it was completed more four months after hire. 4. Record review on 11-19-19 of Staff F's training documents revealed a hire date 3-5-19. Staff F changed from dietary aide to a UW on 9-14-19. Staff F completed a Food Safety Fundamentals course dated 11-17-19; however, it was completed more than eight months after hire and more than two months after the change to a UW. 5. Record review on 11-19-19 of Staff G's training documents revealed a hire date of 3-19-19. Staff G had a New Staff Dietary Training on 3-25-19. The course listing did not indicate it was food safety and sanitation course. 6. When interviewed on 11-21-19 at 12:40 p.m. the Administrator confirmed all staff listed above served food and all food safety training requested was provided.	A 104			
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.	A 121			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALPD365		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2019	
NAME OF PROVIDER OR SUPPLIER GRAND MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 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 121	Continued From Page 28 This Requirement is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completion eight hours of dementia-specific education within 30 days of employment. This pertained to 7 of 8 staff reviewed (Staff A, B, C, D, E, F and G). Findings follow: 1. Record review of Staff A's training documents revealed a date of hire of 10-2-18. Staff A switched from a dietary aide to a universal worker (UW) on 10-20-19. Staff A did not have eight hours of dementia-specific training within 30 days of employment. 2. Record review of Staff B's training documents revealed a date of hire of 10-1-19. Staff B had seven hours of dementia training within 30 days of employment; however, a two hour hands on training course was documented as completed on 11-7-19. 3. Record review of Staff C's training documents revealed a date of hire of 10-1-19. Staff C had six hours of dementia training completed within 30 days of employment; however a two hour hands on training course was documented as completed on 11-3-19. An additional hour of training was documented as completed on 11-17-19. 4. Record review of Staff D's training documents revealed a date of hire of 7-9-19. Staff D did not complete eight hours of dementia-specific training within 30 days of employment. 5. Record review of Staff E's training documents revealed a date of hire as 7-9-19. Staff E did not complete eight hours of dementia-specific training within 30 days of employment. 6. Record review of Staff F's training documents			A 121			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALPD365	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER GRAND MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 121	Continued From Page 29 revealed a date of hire as 3-5-19. Staff F changed from dietary aide to a UW on 9-14-19. Staff F did not complete eight hours of dementia training within 30 days of employment. 7. Record review of Staff G's training documents revealed a date of hire as 3-19-19. Staff G did not complete eight hours of dementia training within 30 days of employment. 8. When interviewed on 11-21-19 at 12:40 p.m. the Administrator confirmed all dementia education for the staff listed above was provided. She said staff completed the two hour hands on training in the first two days of employment during orientation; however, the the date on the training grid listed the date staff checked the box that it was completed.	A 121		



LUTHERMANOR

COMMUNITIES

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1/29/2020

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2/3/20

January 6, 2020

Department of Inspections and Appeals

Attn: Catie Campbell

Lucas State Office Building

321 East 12th Street

Des Moines, Iowa 50319

Dear Ms. Campbell:

On behalf of Grand Meadows, Asbury, Iowa, I respectfully submit our Plan of Correction for your approval. Our response is specific to the onsite certification visit on November 12-21, 2019. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Life Safety-Emergency Policies

Elements detailing how the program will correct each regulatory insufficiency.

- *Grand Meadows applied for dual certification. All exit doors will be alarmed as required by regulation for Dementia Specific programs.*

What measures will be taken to ensure the problem does not recur.

- *Staff were educated on regulatory requirements related to door alarms for dementia specific programs.*

How the program plans to monitor performance to ensure compliance.

- *Staff will be re-educated on an annual basis on regulatory requirement for door alarms in a dementia specific environment.*
- *Maintenance and or designee will conduct door alarm checks at least monthly.*

The date by which the regulatory insufficiency will be corrected.

- *This insufficiency will be corrected by January 30, 2020.*

Criteria for Admission and Retention of Tenants

Elements detailing how the program will correct each regulatory insufficiency.

- *Tenant #3 no longer resides at Grand Meadows.*

What measures will be taken to ensure the problem does not recur.

- *The RN and nurse designee will be re-educated on regulatory criteria for admission and retention of tenants.*

How the program plans to monitor performance to ensure compliance.

- *The RN and/or designee will review appropriate for assisted living when completing a 90 day nurse review or evaluation of tenant.*

The date by which the regulatory insufficiency will be corrected.

- *This insufficiency will be corrected by January 30, 2020.*

Program Policies and Procedures

Elements detailing how the program will correct each regulatory insufficiency.

- *Incident reports will be completed as required by regulation and Grand Meadows' policy.*
- *Incident reports will be completed for Tenants #2, #3, #4, and #5 when applicable.*

What measures will be taken to ensure the problem does not recur.

- *Staff will be re-educated for policies/procedures for incident reporting.*
- *The RN and nurse designee will be re-educated on policies/procedures for incident reporting.*

How the program plans to monitor performance to ensure compliance.

- *The RN, Administrator, or Designee will monitor for compliance at least every 90 days to ensure incident reports are being completed as required by regulation and policy.*

The date by which the regulatory insufficiency will be corrected.

- *This insufficiency will be corrected by January 30, 2020.*

Evaluation of Tenant

Elements detailing how the program will correct each regulatory insufficiency.

- *The RN will complete a health/functional and cognitive evaluation for Tenants #2, and #3.*
- *Tenant #1 no longer resides at Assisted Living Program.*
- *Evaluations will be completed as required by regulation.*

What measures will be taken to ensure the problem does not recur.

- The RN and nurse designee will be re-educated on regulatory requirements for completing an evaluation of tenant.

How the program plans to monitor performance to ensure compliance.

- The Administrator, RN, or designee will monitor for compliance at least two times per year.

The date by which the regulatory insufficiency will be corrected.

- This insufficiency will be corrected by January 30, 2020.

Staffing

Elements detailing how the program will correct each regulatory insufficiency.

- Staff D, E, and G will be appropriately delegated by the RN.
- All staff will be appropriately trained and/or delegated by the RN within 30 days of hire or before completing task, as appropriate.

What measures will be taken to ensure the problem does not recur.

- The RN will be re-educated on training/delegation regulatory requirements.
- The Administrator will be re-educated on training/delegation requirements with new hires and when there is a change in the Delegating RN.

How the program plans to monitor performance to ensure compliance.

- The Administrator, RN, or designee will monitor staff files at least annually to ensure staff has documentation for trained/delegated tasks.

The date by which the regulatory insufficiency will be corrected.

- This insufficiency will be corrected by January 30, 2020.

Service Plans

Elements detailing how the program will correct each regulatory insufficiency.

- Tenants #2, #3, #4, and #5 will have service plans developed by the RN to meet the tenant's identified needs and preferences.
- Tenant #1 no longer residents at the Assisted Living Program.
- Service Plans will be completed as required by regulation.

What measures will be taken to ensure the problem does not recur.

- The RN and nurse designee will be re-educated on regulatory requirements for service plan development.

How the program plans to monitor performance to ensure compliance.

- The Administrator, RN, or designee will monitor for compliance at least two times per year.

The date by which the regulatory insufficiency will be corrected.

- This insufficiency will be corrected by January 30, 2020.

Dementia Specific Education for Personnel

Elements detailing how the program will correct each regulatory insufficiency.

- *Staff A, B, C, D, E, F, and G will have dementia specific training as required by regulation.*
- *All new hires will receive 8 hours of dementia specific education within 30 days of hire.*
- *All staff will receive 8 hours of dementia specific education annually.*

What measures will be taken to ensure the problem does not recur.

- *The Administrator will be re-educated on regulatory requirements for dementia training.*

How the program plans to monitor performance to ensure compliance.

- *The Administrator or designee will monitor for compliance at least two times per year.*

The date by which the regulatory insufficiency will be corrected.

- *This insufficiency will be corrected by January 30, 2020.*

If you have any questions regarding this plan of correction, please feel free to contact me at 563-690-7179. Thank you.

Sincerely,

Rachel Ferguson

Administrator – Grand Meadows Campus