DEPARTMENT OF INSPECTIONS AND APPEALS

13/2x/sn

PRINTED: 10/13/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		775543 B. WING		C 08/03/2020	
	PROVIDER OR SUPPLIER AKS ALZHEIMER'S S	PECIAL CARE CE 8525 URI	DDRESS, CITY, BANDALEA DALE, IA 50		00/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE
R 000		encies were cited during the aplaints #88954-C, #89343-C	R 000	On behalf of Glen Oaks Alzheime Special Care Center, I respectfully our Plan of Correction for your app Preparation and/or execution of the corrections does not constitute adm agreement by the provider of the tru	submit roval. plan of ission or
R 373	Orders for medication	nnel medications and treatments. ns and treatments shall be ed by qualified personnel. (I,	R 373	the facts alleged or conclusions set the statement of deficiencies. The p Correction is prepared and/or execu- solely because it is required by the provision of Iowa Law.	forth in lan of
	by: Based on interview a failed to follow prim orders for 1 of 5 form (Resident C-1). Find: Record review reveal admitted to the facilir including dementia, I transient ischemic att atrial fibrillation (Afi anticoagulation medi blood clots. Record C-1 had been taking 8:00 a.m. and 5:00 p Review of Resident 11/24/19 revealed ro APAP 325 mg. two to	led Resident C-1 was try on 3/23/18 with diagnoses hypertension, history of acks (TIAs) and chronic b). The resident was on an cation (Eliquis) to prevent review revealed Resident a 5 mg. tablet of Eliquis at a.m. daily until 2/08/20. C-1's quarterly orders dated utine orders for the following: tablets at 8:00 a.m. and 5:00		R373 The facility will ensure that orders in medications and treatments shall be correctly implemented by qualified personnel. Medications and treatment be entered by community pharmacy personnel. Qualified nursing person review all medication and treatment entered by pharmacy for accuracy a notified HSD and pharmacy with coall medication and treatment orders followed up through Quickmar system Medications will be replaced or remarked from medication cart with each medication cart will be logged into Returned/Destroyed Binder. Returned Medications will go back to the pharmacy and interest will be destroyed and controlled substances will be destroyed by 2 qualified nursing personnel. Qualified personnel will monitor that QA process to ensure accuracy.	ents will mel will torders nd will encerns. s will be em. All hoved dication com the ed rmacy. stroyed
DIVISION OF	HEALTH FACILITIES - S'	8:00 a.m. and 5:00 p.m.; FATE OF IOWA R/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE

12/10/20

FORM APPROVED **DEPARTMENT OF INSPECTIONS AND APPEALS** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ \mathbf{C}

		775542	B. WING		(
		775543	J		08/0	3/2020
	PROVIDER OR SUPPLIER AKS ALZHEIMER'S SI	PECIAL CARE CE 8525 URB	ANDALEA			
	1		ALE, IA 503	322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
	Amlodipine 5mg, at 8:00 a.m.; Lisinopri Furosemide 20mg a 20MEQ ER at 8:00 weekly on Saturday On 7/14/20 review of Administration Reconstruction Reconstruc	8:00 a.m.; Atenolol 50mg.at 1 30mg at 8:00 a.m.; t 8:00a.m.; POT CL Micro a.m.; and Vitamin D2 once at 8:00 a.m. f Resident C-1's Medication rd (MAR) for February 2020 Amlodipine, Atenolol, and opped on 2/8/20. Orders to on of these drugs could not on o	R 373	HSD and/or Administrator will proqualified nursing personnel with a rand education to this process by No 06, 2020.	eview	

DEPARTMENT OF INSPECTIONS AND APPEALS

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		<u> </u>	_
		775543	B. WING		08/0	3/2020
	PROVIDER OR SUPPLIER AKS ALZHEIMER'S S	PECIAL CARE CE 8525 URB.	oress, city, s ANDALEAV ALE, IA 5032			
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
R 373	Continued From pa	age 2	R 373			
	conducted with the meant by medicatic as documented on I PCP reported she horders on her comp 11/24/19 and made review the Februar no idea the drugs he confirmed she had discontinue any of Eliquis, that were s reported that if the accident (CVA) was stopping the Eliquis cause.	PCP to clarify what was ons "reviewed and unchanged" her note dated 2/13/20. The ad reviewed her last set of outer which were dated no changes. She did not y MAR. She reported she had ad been stopped and not written orders to the medications, including topped on 2/8/20. She resident's cerebral vascular is the result of a blood clot then is might have been a possible				
	computer program QuickMAR for med review revealed the C-1's scripts for Elic Lisinopril on 2/8/19 dated 3/23/18. Then the scripts. When e into the computer of RN) inadvertently of for those medication automatically stopp 2/8/20 and marked On 7/21/20 at 11:12 former Administrat system required the each script as it was standard of practice medication end date to ensure the system.	evealed the facility utilized a called Care Suite by lication administration. Record a pharmacy renewed Resident quis, Amlodipine, Atenolol and D. The original scripts were re were no stop dates listed on intering the updated scripts on 2/8/19 former Staff D (an entered a stop date of one year ins. As a result, the computer oed those meds on the MAR on them as discontinued. 2 a.m. interview with the cor revealed the computer in user to put in an end date for sentered. The established exconsisted of entering the established in the correct of the several years out in order in did not stop any scripts of Scripts had to be renewed mually.				

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		775543	B. WING		08/0	C 03/2020
NAME O	F PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	00/0	
GLEN	OAKS ALZHEIMER'S S	\$525 LIDB	ANDALEAV			
			ALE, IA 503	22		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
R 37	Continued From pa	ge 3	R 373			
	Staff D, who had be Director in February	o.m. interview with former en the Health Services 2019, revealed he could not a why he had put in a one meds that were				
	revealed she admin Atenolol and Lisino She reported the co alerted the user who 3 to 4 days in advar computer alerted he that morning were of understand why the	is a.m. interview with Staff G istered Eliquis, Amlodipine, pril to Resident C-1 on 2/7/20. mputer system automatically en a medication was expiring acc. Staff G confirmed the er the drugs she was passing expiring. She could not see meds were expiring and				
	(LPN) who was sea nurses' office at the E told her she "wou documented this con and reported there v	supervisor, former Staff E ted at the computer in the time. She stated former Staff ald get to it." Staff G had not inversation with former Staff E were no witnesses in the area. ersation, Staff G returned to				
	passing medications authorized to check computer system. S medications the conthe paper MARs, and	s. Staff G said she was not or enter orders into the he only administered nputer told her to give. Unlike medication discontinued in the				
		o longer showed up on the passers could not see when scontinued or why.				
	p.m. revealed she co C-1 having disconting 2020 or pulling any of the cart for return to	er Staff E on 7/22/20 at 3:15 uld not remember Resident nued medications in February discontinued medication from the pharmacy. She denied th Staff G took place and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY	
		IDEATH TOTAL NORMER.	A. BUILDIN	G:	COMPLETED
		775543	B. WING		C 08/03/2020
	PROVIDER OR SUPPLIER AKS ALZHEIMER'S SI	PECIAL CARE CE 8525 URE	DRESS, CITY, BANDALEA DALE, IA 50		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETE
R 373	Continued From page	ge 4	R 373		
R 642	On 7/30/20 at 11:30 Operations confirmed suggested talking with she recalled seeing lacards in the medicards in the medicards at 3:00 precalled seeing Resignation the medicart but the prompts to pass the would have been in give a specific date. The reported this to form documented it and confirmed the conversation. Observation of the middle medications for Resignal of the seeing Resignation.	dent C-1. No documentation o who removed them. The nedications discontinued on determined.	R 642	R642	
	481-57.17(3)e Recoi			This facility will complete an incide report for every accident incident or	nt
	57.17(3) Incident rece. An incident report s	ord. shall be completed for every musual occurrence within bremises that affects a		unusual occurrence that affects a res visitor or employee. All Qualified N personnel will be provided review as education of Accident, Incident and Unusual occurrence JEA policy by November 30, 2020	ident, ursing

FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CL1A STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \mathbf{C} B. WING __ 08/03/2020 775543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8525 URBANDALEAVENUE GLEN OAKS ALZHEIMER'S SPECIAL CARE CE URBANDALE, IA 50322 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 642 Continued From page 5 R 642 This REQUIREMENT is not met as evidenced bv: Based on interview and record review the facility failed to ensure an incident report was completed regarding an accident involving 1 of 5 former residents reviewed (Resident C-2). Findings include: On 7/14/20 record review revealed a progress note dated 1/31/20 (late entry for 1/23/20) indicating that at approximately 6:00 p.m. on 1/23/20, Resident C-2 was found by Staff M sitting in a bookshelf with shattered glass around her. An open wound was observed on her right forehead. The epidermis and dermal layers were open. She had a dried stream of blood on her face. There was no active bleeding. The resident's PCP (primary care provider) was contacted agreed to not send her to the emergency room due to her current status (transitioning, hallucinations, panic from sounds and touch) and the POA's (power of attorney) wishes. The nurse cleaned the wound and applied steri-strips. On 1/24/20, the resident's PCP completed an established patient visit at the facility. The Metro Geriatric Services encounter note dated 1/24/20 documented the previous day the resident had multiple falls including one where she shattered glass on a cabinet she pulled on herself. The resident had a "large open wound on forehead, scalp open skull exposed. Blood controlled with intervention. She is now in bed, apnea episodes."

On 7/15/20 at 1:19 p.m. the interim Administrator DIVISION OF HEALTH FACILITIES - STATE OF IOWA

located.

No incident report for this fall with injury could be

DEPARTMENT OF INSPECTIONS AND APPEALS

AND PLAN OF CORRECTION DENTIFICATION NUMBERS R. WING C. C. C. OR/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2P. CODE S25.2 SURBANDALE A NUMBER S25.2 SURBANDALE A S03.22		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY		
AMAGE OF PROVIDER OR SUPPLIER GLEN OAKS ALZHEIMER'S SPECIAL CARE CE CX4) ID SUMMARY STATEMANT OF DEPICIENTIS GRACH DEFICIENCY MINT BE PRECEDED BY PULL REGICLATORY OR LSC IDENTIFYING INFORMATION) R 642 Continued From page 6 confirmed these findings. R 710 481-57.19(2) Drugs 481-57.19(2) Drugs 481-57.19(2) Drugs asfiguards. i. Discontinued medication shall be destroyed within a specified time by a responsible person, in the presence of a witness, and with a notation made to that effect or shall be returned to the pharmacist for destruction. Drugs listed under the Schedule II drugs shall be destroyed in accordance with the requirements established by the lowa board of pharmacy. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to document the disposition of discontinued medications for 1 of 5 former residents reviewed (Resident C-1). Findings include: On 7/14/20 review of Resident C-1's Medication amistration Record for February 2020 revealed the following were discontinued and 28/20 in the computer system: Eliquis 5mg, at 8:00 a.m.; Atenolol 50mg, at 8:00 a.m., Atenolol 50mg, at 8:00 a.m. and 5:00 p.m., Amilotipine 5mg, at 8:00 a.m., Atenolol 50mg, at 8:00 a.m., and 5:00 p.m., Amilotipine 5mg, at 8:00 a.m., Control of the discontinued on the rediscontinued on the redi	AND PLAI	N OF CORRECTION	TION I IDENTIFICATION NUMBER I CON		СОМР	LETED			
AMAGE OF PROVIDER OR SUPPLIER GLEN OAKS ALZHEIMER'S SPECIAL CARE CE CX4) ID SUMMARY STATEMANT OF DEPICIENTIS GRACH DEFICIENCY MINT BE PRECEDED BY PULL REGICLATORY OR LSC IDENTIFYING INFORMATION) R 642 Continued From page 6 confirmed these findings. R 710 481-57.19(2) Drugs 481-57.19(2) Drugs 481-57.19(2) Drugs asfiguards. i. Discontinued medication shall be destroyed within a specified time by a responsible person, in the presence of a witness, and with a notation made to that effect or shall be returned to the pharmacist for destruction. Drugs listed under the Schedule II drugs shall be destroyed in accordance with the requirements established by the lowa board of pharmacy. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to document the disposition of discontinued medications for 1 of 5 former residents reviewed (Resident C-1). Findings include: On 7/14/20 review of Resident C-1's Medication amistration Record for February 2020 revealed the following were discontinued and 28/20 in the computer system: Eliquis 5mg, at 8:00 a.m.; Atenolol 50mg, at 8:00 a.m., Atenolol 50mg, at 8:00 a.m. and 5:00 p.m., Amilotipine 5mg, at 8:00 a.m., Atenolol 50mg, at 8:00 a.m., and 5:00 p.m., Amilotipine 5mg, at 8:00 a.m., Control of the discontinued on the rediscontinued on the redi						,	~		
MAME OF PROVIDER OR SUPPLIER GLEN OAKS ALZHEIMER'S SPECIAL CARE CE STREET ADDRESS, CITY, STATE, 2P CODE 8252 URBANDALE AVENUE URBANDALE, IA 503322 SUBMANDALE, IA 503322 RADIA GLEACH DEPICTION VOILST OF PREADMENTS OF PROVIDERS PLAN OF CORRECTION REGULATORY OR LISC IDENTIFYING INFORMATION) R 642 Continued From page 6 confirmed these findings. R 710 481-57.19(2) i Drugs 481-57.19(2) Drug safeguards. i. Discontinued medications shall be destroyed within a specified time by a responsible person, in the presence of a witness, and with a notation made to that effect or shall be returned to the pharmacist for destruction. Drugs listed under the Schedule II drugs shall be destroyed in accordance with the requirements established by the lowa board of pharmacy. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to document the disposition of discontinued medications for 1 of 5 former residents reviewed (Resident C-1). Findings include: On 7/14/20 review of Resident C-1's Medication and conductions for 1 of 5 former residents reviewed (Resident C-1). Findings include: On 7/14/20 review of Resident C-1's Medication and also pour, Ambidopine Smg. at 8:00 a.m. and 5:00 p.m.; Ambidopine Smg. at 8:00 a.m. and 5:00 a.m.; Ambidopine Smg. at 8:00 a.m. and 5:00 a.m			775543	B. WING					
GLEN OAKS ALZHEIMER'S SPECIAL CARE CE VRBANDALE, IA 50322 VRB SUMMARY STATEMENT OF DESICIENCIES DESTRICT OF DESICIENCIES CREATI DESICIENCY MUST BE PRECEDED BY FULL TAG CREATI CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE R 642 Continued From page 6 Confirmed these findings. R 710 481-57.19(135C) Drugs. \$57.19(2) Drug safeguards. i. Discontinued medications shall be destroyed within a specified time by a responsible person, in the presence of a witheas, and with a notation made to that effect or shall be returned to the pharmacist for destruction. Drugs listed under the Schedule II drugs shall be destroyed in accordance with the requirements established by the Iowa board of pharmacy. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to document the disposition of discontinued medications for 1 of 5 former residents reviewed (Resident C-1) Findings include: On 7/14/20 review of Resident C-1's Medication Administration Record for February 2020 revealed the following were discontinued on 2/8/30 in the computer system: Eliquis Smg. at 8:00 a.m.; Atenolol 50mg, at 8:00 a.m. and Lisinopril 30mg at 8:00 a.m. and 100 a.m. an	NAME OF	Dr. O. H. Dr. Co. C. L.	****	L		06/0	1312020		
URBANDALE, IA 50322 Continued From page 6 Confirmed these findings. R 642 Continued From page 6 Confirmed these findings. R 710 A81-57.19(2)) Drugs R 770 Confirmed these findings. R 710 Confirmed these findings. R 710 R 710 Continued medications shall be destroyed within a specified time by a responsible person, in the presence of a witness, and with a notation made to that effect or shall be returned to the pharmacist for destruction. Drugs listed under the Schedule II drugs shall be destroyed in accordance with the requirements established by the lowa board of pharmacy. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to document the disposition of discontinued medications for 1 of 5 former residents reviewed (Resident C-1) Findings include: On 7/14/20 review of Resident C-1's Medication Administration Record for February 2020 revealed the following were discontinued on 2/8/20 in the computer system: Eliquis 5mg, at 8:00 a.m.; Attendol 30mg, at 8:00 a.m. and 5:00 p.m.; Amilotipine 5mg, at 8:00 a.m.; Attendol 30mg, at 8:00 a.m. and Lisinopril 30mg at 8:00 a.m. and surveyers the discontinued on reviewed the without the medication of the pharmacy. (II, III) Confirmed the pharmacy and present the requirements of the pharmacy and control substances will be destroyed by 2 Qualified nursing personnel.	NAME OF	PROVIDER OR SUPPLIER							
SUMMARY STATEMENT OF DESICIENCES TAG PROVIDERS LAD DECRESE CENTED N PROFITE TAG PROVIDERS LAD OF CORRECTION CONCEPT PATE	GLEN O	AKS ALZHEIMER'S SI	PECIAL CARE CE						
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revealed he was not sure where the discontinued									
medications went. He called the pharmacy but									
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DEPARTMENT OF INSPECTIONS AND APPEALS

DEPAR	I MENT OF INSPEC	HUNSANDAPPEALS			CVAN DATE S	LIDATEN
	IT OF DEFICIENCIES	CIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NOVIDER.	A. BUILDING:			
					C	İ
		775543	B. WING		08/03	7/2020
	PROTUDED OF CLIPPLIED	STREET AID	PESS CITY ST	ATE, ZIP CODE		
	PROVIDER OR SUPPLIER	8525 URBA	NDALEAV			
GLEN OA	AKS ALZHEIMER'S S	PECIAL CARE CE				
		URBANDA	LE, IA 5032			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
170				DEFICIENCY)		
D 710	G 1: 1F	7	R 710			
R 710	Continued From pa	ige /	10 / 10			
	they had no record of	of receiving them.				
	O = 7/22/20 at 11:25	a.m. interview with Staff G				
		mbered the drugs expiring				
	and telling former	Staff E (LPN) about it. Staff G			İ	į
	denied removing the	e meds from the medication			1	
	cart following their	discontinuation. She thought				
	they may have been	placed in the plastic tote for				
	return to pharmacy	but could not say for certain.			İ	
	_					
	On 7/22/20 at 3:15	p.m. former Staff E (LPN)				
		ntion with Staff G and stated				
	she did not rememb	per any of the resident's meds				
	expiring or pulling	any off of the cart.				
	On 7/23/20 at 10:33	Sam the Interim			İ	
	Administrator confi	irmed the facility could not find				
		urns or destruction for			į	
	Resident C-1's med					
	discontinued on 2/	08/20.			İ	
R 834	481-57.22(3)c Orio	entation and Service Plan		R834	_	
				This facility will develop a written		
		an. Within 30 days of		Plan for each resident within 30 da		
	admission, the adr	ministrator or the		admission. The Service Plan will		
	administrator's desi	gnee, in conjunction with the		individualized based on resident no	eeds to	
	resident, the residen	nt's responsible party, the		ensure quality of over all health.		
	interdisciplinary tea	am, and any organization that		Current residents Service Plans wi	ll be	
	works with or serve	es the resident, shall develop a		reviewed/updated to reflect require	ements	
		zed, and integrated service plan		stated above by January 15, 2021.		
		e service plan shall be lemented to address the		forward Administrator and/or desi	gnee will	
		and assessed needs, such as		utilize tacking system to ensure co		
	activities of daily li	iving, rehabilitation, activity, and		of Service Plans are met.		1
	social behavioral	emotional, physical and mental				
	health. (I, II, III)				ļ	
	c. The service plan	n should be modified to add or				
	delete goals and o	bjectives as the resident's				

MO9B11

DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 08/03/2020 775543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8525 URBANDALEAVENUE GLEN OAKS ALZHEIMER'S SPECIAL CARE CE URBANDALE, IA 50322 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 834 R 834 Continued From page 8 needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced Based on interview and record review the facility failed to modify service plans as needs changed for 2 of 5 former residents reviewed (Resident C-2 and C-3). Findings include: 1. On 7/14/20 record review revealed Resident C-2 was admitted on 6/14/19 and passed away at the facility on 1/27/20. Progress notes review revealed Resident C-2 had falls on 12/21/19, 12/24/19, 1/21/20 (twice) and 1/23/20 (twice, one of which resulted in serious injury). As a result of the increased number of falls a fall mat had been positioned at the edge of the resident's bed. Intermittent 1:1 supervision was provided depending on the resident's level of anxiety. Hospice services were started on 12/19/19. On the morning of 1/23/20 Resident C-2's hospice nurse documented he had spent quite a bit of 1:1 time with the resident to keep her safe as she made multiple attempts to get up from her chair. A progress note dated 1/21/20 documented

increased anxiety and agitation most of the 6:00 DIVISION OF HEALTH FACILITIES - STATE OF IOWA

DEPARTMENT OF INSPECTIONS AND APPEALS
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI

		IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION G:	(X3) DATE COMP	E SURVEY PLETED
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R 834	Continued From pa	ge 9	R 834			
	most of the shift. The increased hallucinate Further review reve					
	6/14/19. On 9/12/19 encounter note docu	9 a Metro Geriatric Services umented Resident C-2's			i	
		ds. On 12/26/2019 the Metro ncounter note indicated her				
	weight was 165 pou	ands. Progress notes review				:
	revealed the dietary offered and consum	supplement Ensure was ed.				
	reviewed on 10/18/1 had been modified to the need for 1:1 sup-	ent's service plan last 19 revealed no indication it to reflect the falls, the fall mat, ervision, the weight loss, the ensure supplements, or the rices.				
	C-3 was admitted or at the facility on 2/1	d review revealed Resident n 10/22/19 and passed away 2/20. A progress note dated ospice services were started.				
	12/10/19 documente buttocks. A progress revealed new orders apply Baza cream to twice a day. There w	ervices encounter note dated and a wound to the resident's note dated 12/18/19 to cleanse the wound and the coccyx and buttocks was also an order to obtain an hion for the resident's				
	was modified to incl wound to the buttock	ont's service plan last 9 revealed no indication it ude hospice services or the cs and subsequent treatment. d Resident C-3 did not have				

PRINTED: 10/13/2020 FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ 08/03/2020 775543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8525 URBANDALEAVENUE GLEN OAKS ALZHEIMER'S SPECIAL CARE CE URBANDALE, IA 50322 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 834 R 834 Continued From page 10 any current or active skin issues. 3. On 7/16/20 at 10:14 a.m. the Regional Director of Operations confirmed these findings. R836 R 836 R 836 481-57.22(3)d Orientation and Service Plan This facility will develop a written Service Plan for each resident within 30 days of 57.22(3) Service plan. Within 30 days of admission. The Service Plan will be admission, the administrator or the individualized based on resident needs to administrator's designee, in conjunction with the ensure quality of over all health. resident, the resident's responsible party, the interdisciplinary team, and any organization that Current residents Service Plans will be works with or serves the resident, shall develop a reviewed/updated to reflect requirements written, individualized, and integrated service plan stated above by January 15, 2021. Going for the resident. The service plan shall be forward Administrator and/or designee will developed and implemented to address the utilize tacking system to ensure compliance resident's priorities and assessed needs, such as of Service Plans are met. activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) d. The service plan shall be reviewed at least quarterly by relevant staff, the resident and appropriate others, such as the resident's family, case manager and responsible party. The review shall include a written report which addresses a summary of the resident's progress toward goals and objectives and the need for continued services. (I, II, III)

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

This REQUIREMENT is not met as evidenced

Based on interview and record review the facility failed to ensure service plans were reviewed

by:

DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ \mathbf{C} 08/03/2020 B. WING 775543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8525 URBANDALEAVENUE GLEN OAKS ALZHEIMER'S SPECIAL CARE CE URBANDALE, IA 50322 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 836 Continued From page 11 R 836 quarterly for 1 of 5 former residents reviewed (Resident C-1). Findings include: On 7/14/20 record review revealed Resident C-1 was admitted to the facility on 3/23/18 and discharged on 3/05/20. The most recent quarterly review of the service plan located was dated 9/10/19. On 7/15/20 at 12:15 p.m. the Regional Director of Operations confirmed 9/10/19 was the last review of the service plan. R1024 R1024 481-57.34(3)c Safety R1024 This facility will ensure that all resident 481-57.34(135C) Safety. The licensee of a have adequate supervision by making all residential care facility shall be responsible for the attempts to have residents located in the provision and maintenance of a safe environment appropriate area based on level of care. for residents and personnel. (I, II, III) Staff will assist/monitor and report increase of care needs to supervisor. 57.34(3) Resident safety. Community personnel will be educated on Change of Condition reporting by c. Residents shall receive adequate supervision to ensure against hazard from themselves, November 11, 2020 others, or elements in the environment. (I, II, III) Moving forward, Residents will be monitored for Significant Change of Condition and re-evaluated quarterly as per This REQUIREMENT is not met as evidenced policy to ensure resident continue to meet by: RCF regulations for Level Of Care. This Based on interview and record review record will be monitored by the HSD or designee. review the facility failed to provide adequate supervision to ensure against hazards for 1 of 5 former residents reviewed (Resident C-2). Findings include: On 7/14/20 record review revealed Resident C-2 was admitted on 6/14/19 and passed away at the facility on 1/27/20. Progress notes review revealed Resident C-2 had falls on 12/21/19,

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DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

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B. WING

08/03/2020

		775543	B. WING		08/03/2020
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R1024	Continued From page	ge 12	R1024		
	of which resulted in increased number of positioned at the edg Intermittent 1:1 supe depending on the res Hospice services we A progress note date 1/23/20) revealed the on 1/23/20. Resident sitting in a bookshel her. An open wound forehead. The epide open. She had a drieface. There was no a resident's PCP (print contacted agreed to emergency room du (transitioning, hallus and touch) and the F	ary care provider) was			
	established patient v Geriatric Services en documented the prev multiple including o on a cabinet she pull had a "large open we skull exposed. Blood She is now in bed, a On the morning of 1 hospice nurse docum bit of 1:1 time with the	dent's PCP completed an isit at the facility. The Metro accounter note dated 1/24/20 vious day the resident had ne where she shattered glass and on herself. The resident bund on forehead, scalp open a controlled with intervention. pnea episodes." 1/23/20 Resident C-2's mented he had spent quite a she resident to keep her safe attempts to get up from her			

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

STATE FORM 6899 MO9B11 If continuation sheet 13 of 15

PRINTED: 10/13/2020 FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ____ \mathbf{C} 08/03/2020 775543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8525 URBANDALEAVENUE GLEN OAKS ALZHEIMER'S SPECIAL CARE CE URBANDALE, IA 50322 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R1024 R1024 Continued From page 13 A progress note dated 1/21/20 documented increased anxiety and agitation most of the 6:00 p.m. to 6:00 a.m. shift requiring 1:1 supervision most of the shift. The resident experienced increased hallucinations. She continually tried to stand and walk and called out to her mom and dad for help. On 7/22/20 at 9:15 a.m. former Staff C (Health Services Director) confirmed Resident C-2 needed 1:1 care before the fall on 1/23/20 but the former administrator did not want to pay for it. On 7/22/20 at 3:15 p.m. former Staff E (LPN) also confirmed the need for 1:1 supervision for Resident C-2 but said it was too much money. On 7/30/20 at 3:00 p.m. interview with Staff M who found Resident C-2 on the evening 1/23/20 stated if Resident C-2 would have had 1:1 supervision at the time she wouldn't have fallen that hard. Staff could have eased her to the floor

with the POA after the increase in falls and several different attempts at medication adjustments that were ineffective. The family did not want Resident C-2 to leave the facility and agreed to the start of hospice service to get more needed help. The PCP confirmed she hadn't informed the facility of this discussion with the

or redirected her and called on the 2 way radios for assistance. Staff M reported Resident C-2's husband was often with her during the day but when he left, the resident was known to fall.

On 7/16/20 at 10:20 a.m. Resident C-2's PCP stated she had discussed level of care concerns

The facility did not include the need for 1:1 supervision in the resident's service plan to assist

family.

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DEPARTMENT OF INSPECTIONS AND APPEALS

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R1024	Continued From pa	ge 14	R1024			
		he facility had not provided for eeded to prevent injury on				
	On 7/30/20 at 11:30 Operations confirm	a.m. the Regional Director of the these findings.				