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
	775543	A. BUILDING: _____ B. WING _____	C 08/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS ALZHEIMER'S SPECIAL CARE CE	8525 URBANDALE AVENUE URBANDALE, IA 50322

(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
R 000	Initial Comments The following deficiencies were cited during the investigation of Complaints #88954-C, #89343-C and #89937-C.	R 000	On behalf of Glen Oaks Alzheimer's Special Care Center, I respectfully submit our Plan of Correction for your approval. Preparation and/or execution of the plan of corrections 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 Iowa Law.	
R 373	481-57.11(7) Personnel 57.11(7) Orders for medications and treatments. Orders for medications and treatments shall be correctly implemented by qualified personnel. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow primary care provider (PCP) orders for 1 of 5 former residents reviewed (Resident C-1). Findings include: Record review revealed Resident C-1 was admitted to the facility on 3/23/18 with diagnoses including dementia, hypertension, history of transient ischemic attacks (TIAs) and chronic atrial fibrillation (Afib). The resident was on an anticoagulation medication (Eliquis) to prevent blood clots. Record review revealed Resident C-1 had been taking a 5 mg. tablet of Eliquis at 8:00 a.m. and 5:00 p.m. daily until 2/08/20. Review of Resident C-1's quarterly orders dated 11/24/19 revealed routine orders for the following: APAP 325 mg. two tablets at 8:00 a.m. and 5:00 p.m.; Eliquis 5mg. at 8:00 a.m. and 5:00 p.m.;	R 373	R373 The facility will ensure that orders for medications and treatments shall be correctly implemented by qualified personnel. Medications and treatments will be entered by community pharmacy personnel. Qualified nursing personnel will review all medication and treatment orders entered by pharmacy for accuracy and will notified HSD and pharmacy with concerns. All medication and treatment orders will be followed up through Quickmar system. All Medications will be replaced or removed from medication cart with each medication change. All medications removed from Medication cart will be logged into the Returned/Destroyed Binder. Returned medications will go back to the pharmacy. All controlled substances will be destroyed by 2 qualified nursing personnel. Qualified personnel will monitor through QA process to ensure accuracy.	

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R 373	Continued From page 1 Amlodipine 5mg, at 8:00 a.m.; Atenolol 50mg.at 8:00 a.m.; Lisinopril 30mg at 8:00 a.m.; Furosemide 20mg at 8:00a.m.; POT CL Micro 20MEQ ER at 8:00 a.m.; and Vitamin D2 once weekly on Saturday at 8:00 a.m. On 7/14/20 review of Resident C-1's Medication Administration Record (MAR) for February 2020 revealed the Eliquis, Amlodipine, Atenolol, and Lisinopril were all stopped on 2/8/20. Orders to stop the administration of these drugs could not be located. On 7/14/20 a review of Progress Notes review revealed on the morning of 3/05/20 at 8:20 a.m. staff called the nurse into the dining room as Resident C-1 was having trouble speaking. The nurse's evaluation noted left side facial droop, word salad and left sided weakness. The resident's family agreed to have her sent to the emergency room by ambulance for evaluation. The emergency room's medical records revealed Resident C-1 suffered an Ischemic Stroke - precerebral occlusion. The emergency room physician noted the resident was prescribed Eliquis but had not been getting it at the facility. While in the emergency room Resident C-1 was given a tissue plasminogen activator (TPA) treatment. She started to have acute neurological changes such as not being able to follow commands and having a right upward gaze. ACT scan of her head showed a new small bleed. Resident C-1 passed away on 3/07/20. On 2/13/20 Resident C-1 had been seen by her PCP who documented her medications "reviewed and unchanged." This documentation came days after Resident C-1's medications had been discontinued as noted on the February MAR.	R 373	HSD and/or Administrator will provide all qualified nursing personnel with a review and education to this process by November 06, 2020.	

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 373	Continued From page 2 On 7/16/20 at 10:21 a.m. an interview was conducted with the PCP to clarify what was meant by medications "reviewed and unchanged" as documented on her note dated 2/13/20. The PCP reported she had reviewed her last set of orders on her computer which were dated 11/24/19 and made no changes. She did not review the February MAR. She reported she had no idea the drugs had been stopped and confirmed she had not written orders to discontinue any of the medications, including Eliquis, that were stopped on 2/8/20. She reported that if the resident's cerebral vascular accident (CVA) was the result of a blood clot then stopping the Eliquis might have been a possible cause. The investigation revealed the facility utilized a computer program called Care Suite by QuickMAR for medication administration. Record review revealed the pharmacy renewed Resident C-1's scripts for Eliquis, Amlodipine, Atenolol and Lisinopril on 2/8/19. The original scripts were dated 3/23/18. There were no stop dates listed on the scripts. When entering the updated scripts into the computer on 2/8/19 former Staff D (an RN) inadvertently entered a stop date of one year for those medications. As a result, the computer automatically stopped those meds on the MAR on 2/8/20 and marked them as discontinued. On 7/21/20 at 11:12 a.m. interview with the former Administrator revealed the computer system required the user to put in an end date for each script as it was entered. The established standard of practice consisted of entering the medication end dates several years out in order to ensure the system did not stop any scripts before they were up. Scripts had to be renewed by PCPs at least annually.	R 373		

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R 373	Continued From page 3 On 7/22/20 at 7:00 p.m. interview with former Staff D, who had been the Health Services Director in February 2019, revealed he could not remember or explain why he had put in a one year end date for the meds that were discontinued. On 7/22/20 at 11:25 a.m. interview with Staff G revealed she administered Eliquis, Amlodipine, Atenolol and Lisinopril to Resident C-1 on 2/7/20. She reported the computer system automatically alerted the user when a medication was expiring 3 to 4 days in advance. Staff G confirmed the computer alerted her the drugs she was passing that morning were expiring. She could not understand why these meds were expiring and reported this to her supervisor, former Staff E (LPN) who was seated at the computer in the nurses' office at the time. She stated former Staff E told her she "would get to it." Staff G had not documented this conversation with former Staff E and reported there were no witnesses in the area. Following the conversation, Staff G returned to passing medications. Staff G said she was not authorized to check or enter orders into the computer system. She only administered medications the computer told her to give. Unlike the paper MARs, a medication discontinued in the computer system no longer showed up on the pop up screen. Med passers could not see when medications were discontinued or why. Interview with former Staff E on 7/22/20 at 3:15 p.m. revealed she could not remember Resident C-1 having discontinued medications in February 2020 or pulling any discontinued medication from the cart for return to the pharmacy. She denied the conversation with Staff G took place and indicated Staff G "had it out" for her.	R 373		

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 373	Continued From page 4 Review of former Staff E's time card revealed she did not work on 2/7/20, 2/8/20, 2/9/20 or 2/10/20. On 7/30/20 at 11:30 a.m. the Director of Operations confirmed these findings and suggested talking with Staff M who had reported she recalled seeing Resident C-1's medication cards in the med cart when there were no computer prompts to pass the medication. On 7/30/20 at 3:00 p.m. Staff M stated she recalled seeing Resident C-1's medication cards in the med cart but there were no computer prompts to pass the meds. She thought this would have been in the morning, but could not give a specific date. Staff M said she also reported this to former Staff E but had not documented it and could not recall specifics of the conversation. Observation of the med cart revealed no medications for Resident C-1. No documentation could be located as to who removed them. The whereabouts of the medications discontinued on 2/8/20 could not be determined.	R 373		
R 642	481-57.17(3)e Records 481-57.17(135C) Records. 57.17(3) Incident record. e. An incident report shall be completed for every accident, incident or unusual occurrence within the facility or on the premises that affects a resident, visitor, or employee. (II, III)	R 642	R642 This facility will complete an incident report for every accident incident or unusual occurrence that affects a resident, visitor or employee. All Qualified Nursing personnel will be provided review and education of Accident, Incident and Unusual occurrence JEA policy by November 30, 2020	

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R 642	Continued From page 5 This REQUIREMENT is not met as evidenced by: 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." No incident report for this fall with injury could be located. On 7/15/20 at 1:19 p.m. the interim Administrator	R 642		

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R 642	Continued From page 6 confirmed these findings.	R 642		
R 710	481-57.19(2)i Drugs 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 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 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 2/8/20 in the computer system: Eliquis 5mg. at 8:00 a.m. and 5:00 p.m.; Amlodipine 5mg. at 8:00 a.m.; Atenolol 50mg.at 8:00 a.m. and Lisinopril 30mg at 8:00 a.m. On 7/22/20 at 10:43 a.m. interview with former Staff C (Health Services Director at that time) revealed he was not sure where the discontinued medications went. He called the pharmacy but	R 710	R710 This facility will ensure all medications will be placed or removed from the medication cart with each medication change. All medications removed from the medication cart will be logged into the Returned/Destroyed Binder. Medications pulled from the medication cart will be returned to the pharmacy. All control substances will be destroyed by 2 Qualified nursing personnel.	

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 710	Continued From page 7 they had no record of receiving them. On 7/22/20 at 11:25 a.m. interview with Staff G revealed she remembered the drugs expiring and telling former Staff E (LPN) about it. Staff G denied removing the meds from the medication 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. On 7/22/20 at 3:15 p.m. former Staff E (LPN) denied the conversation with Staff G and stated she did not remember any of the resident's meds expiring or pulling any off of the cart. On 7/23/20 at 10:33 a.m. the Interim Administrator confirmed the facility could not find a record of drug returns or destruction for Resident C-1's medications that were discontinued on 2/08/20.	R 710		
R 834	481-57.22(3)c Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's	R 834	R834 This facility will develop a written Service Plan for each resident within 30 days of admission. The Service Plan will be individualized based on resident needs to ensure quality of over all health. Current residents Service Plans will be reviewed/updated to reflect requirements stated above by January 15, 2021. Going forward Administrator and/or designee will utilize tacking system to ensure compliance of Service Plans are met.	

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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 by: 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	R 834		

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R 834	Continued From page 9 p.m. to 6:00 a.m. shift requiring 1:1 supervision most of the shift. The resident experienced increased hallucinations. Further review revealed Resident C-2 experienced weight loss since admission on 6/14/19. On 9/12/19 a Metro Geriatric Services encounter note documented Resident C-2's weight as 181 pounds. On 12/26/2019 the Metro Geriatric Services encounter note indicated her weight was 165 pounds. Progress notes review revealed the dietary supplement Ensure was offered and consumed. Review of the resident's service plan last reviewed on 10/18/19 revealed no indication it had been modified to reflect the falls, the fall mat, the need for 1:1 supervision, the weight loss, the introduction of the ensure supplements, or the start of hospice services. 2. On 7/15/20 record review revealed Resident C-3 was admitted on 10/22/19 and passed away at the facility on 2/12/20. A progress note dated 12/12/19 revealed hospice services were started. A Metro Geriatric Services encounter note dated 12/10/19 documented a wound to the resident's buttocks. A progress note dated 12/18/19 revealed new orders to cleanse the wound and apply Baza cream to the coccyx and buttocks twice a day. There was also an order to obtain an equalgel or roho cushion for the resident's wheelchair. Review of the resident's service plan last reviewed on 11/19/19 revealed no indication it was modified to include hospice services or the wound to the buttocks and subsequent treatment. The plan documented Resident C-3 did not have	R 834		

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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.	R 834		
R 836	481-57.22(3)d Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as 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) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure service plans were reviewed	R 836	R836 This facility will develop a written Service Plan for each resident within 30 days of admission. The Service Plan will be individualized based on resident needs to ensure quality of over all health. Current residents Service Plans will be reviewed/updated to reflect requirements stated above by January 15, 2021. Going forward Administrator and/or designee will utilize tacking system to ensure compliance of Service Plans are met.	

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R 836	Continued From page 11 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.	R 836		
R1024	481-57.34(3)c Safety 481-57.34(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III) 57.34(3) Resident safety. c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review record 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,	R1024	R1024 This facility will ensure that all resident have adequate supervision by making all attempts to have residents located in the appropriate area based on level of care. Staff will assist/monitor and report increase of care needs to supervisor. Community personnel will be educated on Change of Condition reporting by November 11, 2020 Moving forward, Residents will be monitored for Significant Change of Condition and re-evaluated quarterly as per policy to ensure resident continue to meet RCF regulations for Level Of Care. This will be monitored by the HSD or designee.	

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GLEN OAKS ALZHEIMER'S SPECIAL CARE CE	8525 URBANDALE AVENUE URBANDALE, IA 50322

(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
R1024	Continued From page 12 12/24/19, 1/21/20 (twice) and 1/23/20 (twice, one of which resulted in 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. A progress note dated 1/31/20 (late entry for 1/23/20) revealed 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 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 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.	R1024		

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
	775543	A. BUILDING: _____ B. WING _____	C 08/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 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 family. The facility did not include the need for 1:1 supervision in the resident's service plan to assist	R1024		

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
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R1024	Continued From page 14 in fall prevention. The facility had not provided for 1:1 supervision as needed to prevent injury on 1/23/20. On 7/30/20 at 11:30 a.m. the Regional Director of Operations confirmed these findings.	R1024		