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
	S0265	A. BUILDING: _____ B. WING _____	R-C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments Assisted Living Programs 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: 15 Number of tenants with cognitive disorder: 3 Total of General Population: 18 Memory Care Unit Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 8 Total of Memory Care: 9 Total Census of Assisted Living Program for People with Dementia : 27 The following regulatory insufficiencies were cited during the revisit conducted to determine progress toward correcting violations identified during a complaint investigation completed on 4/9/18.	{A 000}		
A 094	481-67.13(4) Exit Interview, Final Report and POC 481-67.13(17A,231C,85GA,SF394) Exit interview, final report, plan of correction. 67.13(4) Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of	A 094	1. Administrator will review prior plan of correction and make any updates related to the re-survey 2. Administrator will provide an Inservice to staff regarding survey results and plan of correction	4/15/19

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Krista M Ward — TITLE: administrator — (X6) DATE: 3-15-19

revised POC date

DD 3/18/19

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A 094	Continued From page 1 correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the Plan of Correction (POC) regarding a regulatory insufficiency from the complaint investigation completed on 4/9/18. Findings include: Review of the POC revealed the plan was not implemented or corrected by the effective date of 5/9/18 regarding updated service plans. This was confirmed by the Administrator on 2/6/19 at 2:00 PM. Please see 69.26(1) for details.	A 094	3. Administrator will document efforts on the Corrective Action Plan (CAP), weekly until completion date 4. Administrator will continue to audit compliance efforts monthly for three months	
{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:	{A 083}	1. The service plan for the identified tenant #4 has been audited and updated 2. Service plans will be audited for all affected tenants (all current tenants) to identify service plan deficiencies 3. Service plans identified as noncompliant will be updated to meet state standards 4. Service plans will be updated at a minimum of annually or with change in condition	4/15/19

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{A 083}	Continued From page 2 Based on interview and record review, the Program failed to update service plans when needs changed or at least annually for 1 of 4 tenants reviewed (Tenant #4). Findings include: Record review revealed Tenant #4 was admitted to the Program on 9/30/16. An initial service plan was implemented on 9/29/16. A second (undated) service plan was found in the record which was believed to be from 2017. A fax to Tenant #4's physician in October 2018 revealed the following: "[tenant] has been refusing meds and care services from multiple staff and having negative behaviors towards staff and other tenants." No service plan for the year 2018 could be located in the tenant's record. On 2/6/19 at 2:00 PM, the Administrator confirmed no updated service plan for Tenant #4 could be found. The last service plan updated was believed to be from 2017 (due to it not having signatures or a date of implementation). The Administrator confirmed Tenant #4 continued to have behavioral issues.	{A 083}	5. Audits will be conducted monthly for three months then quarterly for one year to ensure compliance	