

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2019
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NAME OF PROVIDER OR SUPPLIER SENIOR STAR AT ELMORE PLACE MEMORY C	STREET ADDRESS, CITY, STATE, ZIP CODE 4504 ELMORE AVENUE DAVENPORT, IA 52807
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A 000	<p>Initial Comments</p> <p>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.</p> <p>Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 39 Total census of Assisted Living Program for People with Dementia: 39</p> <p>The investigation of Incident #85523-I resulted in the following regulatory insufficiencies:</p>	A 000		
A 003	<p>481-67.2 Program policies and procedures</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the policy regarding bedside positioning bars for 6 of 6 tenants who utilized positioning bars (Tenants #1, #2, #3, #4,</p>	A 003	<p style="text-align: right;">11-15-19</p> <p style="text-align: center;">Plan of Corrective is attached <i>DD</i></p>	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 003	<p>Continued From page 1</p> <p>#5 and #6). Findings follow:</p> <p>1. Review of an incident report dated 7-31-19 revealed Tenant #1 was found deceased in her apartment on 7-31-19 at 10:00 a.m. Her feet were entangled in the sheets with her neck resting on the U bar attached to her bed. The report indicated the nurse on shift/on-call was involved and 911 was called. The main office, Tenant #1's responsible party and the police department were notified. The incident type was indicated as death with an injury.</p> <p>Review of the autopsy report completed on 8/1/19 revealed the tenant died from positional asphyxia. The position the decedent was found in placed significant weight and pressure on her neck in relation to the bed rail.</p> <p>2. Review of the Senior Star Use of Bedside Positioning Bars-Health Services policy and procedure revealed the positioning bar could be used by a tenant to aid in increasing independence and mobility if the criteria below were met.</p> <ul style="list-style-type: none"> - A positioning bar would not be used if it restricted a tenant's movement in any way. Only one positioning bar would be used at one time. - The tenant had submitted a signed written request for the use of a bedside positioning bar. - A physician's order had been obtained for the use of the positioning bar. - A Bedside Positioning Bar Assessment would be completed by a licensed nurse. The results of the assessment indicated the tenant was safe to use the positioning bar. - Education had been provided to the tenant regarding the proper use of the positioning bar. - The service plan would be updated to include 	A 003		

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A 003	<p>Continued From page 2</p> <p>the purpose and use of the repositioning bar, tenant autonomy and "associated needs." - The tenant would be monitored for ability to safely use the positioning bar. Related documents included: Bedside Positioning Bar Assessment Form, Beside Positioning Bar Request and Use of Seclusion or Restraints.</p> <p>The policy indicated the Administrator, Assisted Living Director, Memory Care Director and Move In Coordinator were responsible to educate staff, tenants, families and physicians about the procedures, monitor for compliance, and educate direct care staff about the appropriate use and placement of the positioning bars. Licensed nurses were responsible to inform tenants and family (or responsible parties) of the tenant's need to submit a Bedside Positioning Bar Request Form if they wanted to use a positioning bar. Other responsibilities included obtaining a physician's order, completion and documentation of the initial Bedside Bar Assessment, updating the service plan, documentation of the assessment and service plan in nurse's notes and filing the assessment with the physician's order in the chart. They also completed subsequent Bedside Positioning Bar Assessments and updated the service plan every 90 days which were to be documented in the nurse's notes. If the tenant was no longer able to safely use the positioning bar, a meeting would be held with the tenant and/or responsible party and nurse manager to discuss other options. Licensed nurses would also "communicate use/continued use of positioning bar to the direct care associates and instruct the associates to observe and report any concerns related to the bar including malposition or possible misuse of</p>	A 003		

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A 003	<p>Continued From page 3</p> <p>the bar." Direct care staffs' responsibilities indicated to observe and "immediately reports any concerns related to a positioning bar to a supervisor."</p> <p>3. When interviewed on 9-11-19 at 5:42 p.m. and 9-16-19 at 2:23 p.m. Nurse #1, previously the Director of Nursing (DON), indicated Tenant #1 was discharged from hospice services in June. When on hospice Tenant #1 had a hospital bed with a half rail she had used at times. When hospice was discontinued, the hospital bed was replaced with a twin bed. The U bar was added, as it was a good transition. The U bar was placed on the side of the bed nearest to the bathroom. Staff B (Nurse Manager at the time) put the U bar on the tenant's bed. Nurse #1 believed the U bar was donated from another tenant. Nurse #1 did not observe placement of the U bar. She was aware there was a policy; however, was not familiar with the specifics of the policy. When shown the policy she confirmed the assessment form was not used; however, the U bar was in the service plan. The use of the U bar had been discussed with Tenant #1's family and there were no questions. Nurse #1 revealed there was not a physician's order for the U bar.</p> <p>When interviewed on 9-16-19 at 9:56 a.m. and on 9-18-19 at 1:32 p.m. Nurse #2 revealed at the time of the incident she was the DON in the Assisted Living Program (AL) and was currently the DON for the Assisted Living Program for People with Dementia (ALP/D). She confirmed a physician's order for the use of the U bar by Tenant #1 had not been obtained. She believed Staff B had placed the bar on the bed for repositioning due to falls and weakness.</p>	A 003		

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A 003	<p>Continued From page 4</p> <p>When interviewed on 9-17-19 at 11:42 a.m., on 9-16-19 at approximately 12:30 p.m. and 9-18-19 at 12:14 p.m., the Health Services Administrator revealed she was the Interim DON in the ALP/D at the time of the incident as Nurse #1 was on leave. During the program's investigation she was made aware of the policy regarding U bars. The U bars were all removed from the program. After the policy was followed including signed releases, physician orders and assessments, U bars were re-installed for the tenants who utilized them. A quote for Halo bars was received on 9-10-19 and they arrived and were installed on 9-13-19, replacing the U bars. The Health Services Administrator revealed she was not aware of the policy regarding bedside positioning bars until after the incident with Tenant #1. The policy provided was a general Senior Star (corporate) policy and was not used at Elmore Place at that time.</p> <p>When interviewed on 9-25-19 at 3:38 p.m. the Director of Corporate Operations indicated the corporation had properties in six states and had different levels of care. She revealed if a Senior Star policy indicated a community name in the title it was specific to that community (program). If the title indicated a level of care it was specific to that level of care. If it was a general policy it applied to all properties.</p> <p>Record review revealed five current tenants utilized U bars at the beginning of the investigation. Those tenants were identified as Tenants #2, #3, #4, #5 and #6. Bedside Positioning Bar Assessments were completed on 8-2-19 for Tenants #2, #3, #4, #5 and #6. Requests for physician orders for the U bars dated 8-2-19 were sent to the primary care</p>	A 003		
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A 003	Continued From page 5 providers for Tenants #2, #3, #4, #5 and #6. The fax indicated they had a "new protocol regarding U BARs." The fax indicated the tenants utilized the U bars to help with transfers out of bed and repositioning while in bed. Signed physician orders were returned for the U bars for Tenants #2, #3, #4, #5 and #6.	A 003		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate for 1 of 1 tenants identified in Incident 85523 (Tenant #1). Findings follow: 1. Review of an incident report dated 7-31-19 revealed Tenant #1 was found deceased in her apartment on 7-31-19 at 10:00 a.m. Her feet were entangled in the sheets with her neck resting on the U bar attached to her bed. The autopsy report completed on 8/1/19 revealed the tenant died from positional asphyxia. The position the decedent was found in placed significant weight and pressure on her neck in relation to the bed rail. Review of Tenant #1's file revealed diagnoses	A 013		

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A 013	<p>Continued From page 6</p> <p>including major neurocognitive disorder, hypertension, insomnia, chronic back pain, recurrent falls and dementia of Alzheimer type with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale at the time of the incident, which indicated severe cognitive decline.</p> <p>A Change in Condition document dated 6-17-19 reflected Tenant #1 had been discharged from hospice. The hospital bed was removed from her apartment and a "regular bed" was brought in. A U bar had been placed on the bed to help with repositioning. Memory care staff were to ensure it was in the correct position at all times.</p> <p>Tenant #1's service plan dated 6-17-19 reflected a history of frequent falls. The interventions in place were unsuccessful; however, staff were to provide redirection and supervision to minimize falls. Due to "significant cognitive deficits" she was unable to understand her risk taking behaviors. Staff were to ensure Tenant #1's door was open at all times for frequent supervision while in her apartment. If Tenant #1 slept late staff were to check on her frequently and, once awake, assist her with getting up for the day promptly to minimize falls in her room. The service plan reflected when Tenant #1 went to bed she typically slept through the night without waking. Tenant #1 had a U bar placed on the bed to aid in positioning. Memory care staff were to ensure the U bar was in the correct position at all times. Staff provided toileting assistance twice per night and every two hours during the day.</p> <p>2. When interviewed on 9-11-19 at 5:42 p.m. and 9-16-19 at 2:23 p.m. Nurse #1, previously the Director of Nursing (DON), indicated Tenant #1</p>	A 013		

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A 013	<p>Continued From page 7</p> <p>was discharged from hospice services in June. When on hospice Tenant #1 had a hospital bed with a half rail she used at times. When hospice was discontinued, the hospital bed was replaced with a twin bed. The U bar was added, as it was a good transition. The U bar was placed on the side of the bed nearest to the bathroom. Staff B (Nurse Manager at the time) put the U bar on the tenant's bed. Nurse #1 believed the U bar was donated from another tenant. Nurse #1 did not observe placement of the U bar.</p> <p>When interviewed on 9-16-19 at 9:56 a.m. and on 9-18-19 at 1:32 p.m. Nurse #2 revealed at the time of the incident she was the DON in the Assisted Living Program (AL) and was currently the DON for the Assisted Living Program for People with Dementia (ALP/D). She stated she did not develop Tenant #1's service plan but confirmed it stated memory care staff were to check placement of the U bar. She assumed it meant front line staff and said checking for correct placement was most likely not done. Direct care staff did not receive any training on the U bar. Nurse #2 revealed she was not made aware of the policy regarding bedside positioning bars until after the fact. The service plan reflected the bed rail and the restraint policy was followed.</p> <p>Staff A's Incident Witness Statement indicated on 7-31-19 between 10:00 a.m. and 10:15 a.m. she went to Tenant #1's apartment to get her ready for the day and saw her on the floor with her neck on the bar. She immediately radioed for a nurse.</p> <p>When interviewed on 9-17-19 at 10:32 a.m. and 1:41 p.m. Staff A stated she checked on Tenant #1 at approximately 6:45 a.m. and she was lying</p>	A 013		

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A 013	<p>Continued From page 8</p> <p>in bed on her back sleeping. Tenant #1's door was closed which was usual due to wandering tenants. Between 10:00 a.m. and 10:15 a.m. Staff A went to the apartment, turned on the light and observed the tenant from the back. Her neck was on the bar and her arms were out to the side. She called for help and staff responded. She didn't notice anything unusual about the placements of the U bar; however, she did not pay attention to it.</p> <p>On 9-18-19 at 10:45 a.m. Staff C said Tenant #1 had scheduled checks a couple of times per shift on third shift. On the night before the incident, she believed Tenant #1 slept through the night. She checked her to see if she was incontinent. One time she was incontinent and was changed in bed. When Tenant #1 was asleep her apartment door was closed. She did not observe the position of the bar and the bar was not touched on third shift.</p> <p>On 9-18-19 at 9:48 a.m. Staff D revealed certified nursing assistants did not check the placement of any bed rails utilized by tenants. Staff D had not observed the bed rail on Tenant #1's bed. She recalled Tenant #1's door being closed that morning when she walked by to get towels.</p> <p>When interviewed on 9-18-19 at 1:00 p.m. Staff E revealed she was by the dining room when Staff A called for help in Tenant #1's apartment. She responded and observed Tenant #1 face down on the U bar. Staff E was not familiar with the tenant as she normally worked in the other program on campus (assisted living). She occasionally assisted in this program (memory care). She had never checked the placement of bars.</p>	A 013		

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A 013	Continued From page 9 When interviewed on 9-17-19 at 11:50 a.m. Staff F revealed she did not usually make beds and had never checked the placement of the U bar on Tenant #1's bed. Tenant #1's apartment door was usually closed as other tenants wandered. If Tenant #1 was resting staff were to check on her and let her rest. On 9-18-19 at 1:57 p.m. Staff G stated she couldn't speak for other staff, but if she noticed a U bar pulled out on a bed, she pushed it back in. She had not noted any issues with Tenant #1's bar. When interviewed on 9-18-19 at 1:46 p.m. Staff H revealed Tenant #1's apartment door was closed at night due to wandering tenants; however, if lying in bed during the day the door was kept open. Staff H had not observed a bed positioning bar; however, if there was as issue it would be reported to the nurse. 3. In summary, when discharged from hospice services the tenant's hospital bed was replaced by a twin bed with an attached U bar. The tenant's service plan indicated staff were to check for correct placement of the U bar. Interviews confirmed staff did not check U bars for correct placement and Nurse #2 indicated staff were not trained on U bar placement. The service plan stated the tenant's door was to remain open at all times in order to provide frequent supervision. Staff present at the time of the incident confirmed the door was shut that morning and in fact was often shut at night due to wandering behaviors of other tenants. In addition, Tenant #1 did not receive appropriate services related to the installation of the U bar on her bed.	A 013		

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A 013	Continued From page 10 Please refer to the regulatory insufficiency related to Structural Requirements/Safety for further details.	A 013		
A 089	<p>481-69.26(4)a Service Plans</p> <p>481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum:</p> <p>a. The tenant's identified needs and preferences for assistance</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop a service plan that reflected the identified needs of 1 of 1 tenants identified in Incident #85523 (Tenant #1). Findings follow:</p> <p>1. Review of Tenant #1's file revealed diagnoses including major neurocognitive disorder, hypertension, insomnia, chronic back pain, recurrent falls and dementia of Alzheimer type with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale at the time of the incident, which indicated severe cognitive decline.</p> <p>2. When interviewed on 9-11-19 at 5:42 p.m. Nurse #1, previously the Director of Nursing (DON), indicated Tenant #1 needed assistance with activities of daily living (ADLs). Tenant #1 sometimes pocketed food, however it was not consistent.</p>	A 089		

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A 089	<p>Continued From page 11</p> <p>On 9-17-19 at 10:32 a.m. Staff A revealed Tenant #1 needed help with ADLs, including eating with hand over hand to full assist. Tenant #1 required hands on assistance to ambulate. She did not use an assistive device.</p> <p>When interviewed on 9-18-19 at 10:45 a.m. Staff C said Tenant #1 had scheduled checks a couple of times per shift on third shift. On the night before the incident, she believed Tenant #1 slept through the night. She checked her to see if she was incontinent. One time she was incontinent and was changed in bed.</p> <p>On 9-18-19 at 1:57 p.m. Staff G revealed Tenant #1 was a total assist with all ADLs and was on a two hour toileting schedule. With ambulation and mobility Tenant #1 was a stand by assist with a gait belt. Staff assisted with feeding Tenant #1 at meals.</p> <p>3. Further record review of a Hospice Visit Note Report (visit date 6-12-19) revealed the tenant was being discharged from hospice services. The Visit Note Report indicated Tenant #1 was a total assist with feeding and pocketed food. Tenant #1 had decreased strength in the lower bilateral extremities. Tenant #1 ambulated with "human assistance."</p> <p>Tenant #1's service plan dated 6-17-19 reflected a history of frequent falls. The interventions in place were unsuccessful; however, staff were to provide redirection and supervision to minimize falls. Due to "significant cognitive deficits" she was unable to understand her risk taking behaviors. Tenant #1 ambulated independently without assistive devices and transferred independently. Tenant #1 liked to "stay on the</p>	A 089		

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(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 089	<p>Continued From page 12</p> <p>move" and would not wait for staff assistance. Tenant #1 walked around the building much of the day and went in and out of rooms. Staff was to provide redirection out of other tenants' apartments and keep her in the common areas with increased supervision. When she was tired she would start to lean to one side. When staff observed her leaning or appearing fatigued they were to assist her to a recliner and provide an item for her to "tinker" with in her hands. It provided comfort and distraction and allowed her to rest. She fell on occasion when sitting down due to poor depth perception. Staff were to assist her when she attempted to sit down. Staff were to notify the nurse of any new concerns with her mobility or gait. The service plan reflected Tenant #1 required routine prompting/cueing to eat. Staff assisted at meals, including set up, and encouraged and reminded her to attend meals. Tenant #1 fed herself with prompting and cueing. She occasionally needed hands on assist with eating. The service plan also included hospice services such as nursing visits and bathing aides.</p> <p>4. The service plan did not reflect the identified needs of assistance provided with meals and pocketing of food, assistance provided with ambulation or checks at night regarding toileting assistance. The service plan also did not reflect the discontinuation of the hospice services.</p> <p>When interviewed on 9-18-19 at 1:32 p.m. Nurse #2 confirmed this was the tenant's most recent service plan.</p>	A 089		
A 154	<p>481-69.35(1)b Structural Requirements</p> <p>481-69.35(231C) Structural requirements. 69.35(1) General requirements.</p>	A 154		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2019
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NAME OF PROVIDER OR SUPPLIER SENIOR STAR AT ELMORE PLACE MEMORY C	STREET ADDRESS, CITY, STATE, ZIP CODE 4504 ELMORE AVENUE DAVENPORT, IA 52807
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A 154	<p>Continued From page 13</p> <p>b. The buildings and grounds shall be well-maintained, clean, safe and sanitary.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to maintain a building that was safe regarding the placement and installation of assistive bed positioning bars for 1 of 1 tenants identified in Incident #85523 (Tenant #1). Findings follow:</p> <p>1. Review of an incident report dated 7-31-19 revealed Tenant #1 was found deceased in her apartment on 7-31-19 at 10:00 a.m. Her feet were entangled in the sheets with her neck resting on the U bar attached to her bed. The report indicated the nurse on shift/on-call was involved and 911 was called. The main office, Tenant #1's responsible party and the police department were notified. The incident type was indicated as death with an injury.</p> <p>Review of the autopsy report completed on 8/1/19 revealed the tenant died from positional asphyxia. The position the tenant was found in placed significant weight and pressure on her neck in relation to the bed rail. The report indicated "the decedent was found face down with her neck apparently stuck on black bed rail which was not a part of the original bed. In addition, it was noted that her legs were wrapped and intertwined with the bed sheets and blankets. Apparently, the blankets were tucked tightly into the corners of the bed. The patient was last seen alive approximately two hours prior at 0800 am when staff saw her sleeping in bed and decided to let her sleep a little longer."</p>	A 154		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2019
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NAME OF PROVIDER OR SUPPLIER SENIOR STAR AT ELMORE PLACE MEMORY C	STREET ADDRESS, CITY, STATE, ZIP CODE 4504 ELMORE AVENUE DAVENPORT, IA 52807
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A 154	<p>Continued From page 14</p> <p>Review of Tenant #1's file revealed diagnoses including major neurocognitive disorder, hypertension, insomnia, chronic back pain, recurrent falls and dementia of Alzheimer type with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale at the time of the incident, which indicated severe cognitive decline.</p> <p>A Change in Condition document dated 6-17-19 reflected Tenant #1 had been discharged from hospice. The hospital bed was removed from her apartment and a "regular bed" was brought in. A U bar had been placed on the bed to help with repositioning. Memory care staff were to ensure it was in the correct position at all times.</p> <p>2. When interviewed on 9-11-19 at 5:42 p.m. and 9-16-19 at 2:23 p.m. Nurse #1, previously the Director of Nursing (DON), indicated Tenant #1 was discharged from hospice services in June. When on hospice Tenant #1 had a hospital bed with a half rail she had used at times. When hospice was discontinued, the hospital bed was replaced with a twin bed. The U bar was added, as it was a good transition. The U bar was placed on the side of the bed nearest to the bathroom. Staff B (Nurse Manager at the time) put the U bar on the tenant's bed. Nurse #1 believed the U bar was donated from another tenant. Nurse #1 did not observe placement of the U bar.</p> <p>Nurse #2's typed statement indicated on 7-31-19 she was asked to come to Tenant #1's apartment by Staff A. When she entered the apartment she observed Tenant #1's neck was resting on the U bar, which was partially pulled out from the bed and her feet were wrapped up in the blankets. She immediately asked staff to leave the</p>	A 154		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2019
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A 154	<p>Continued From page 15</p> <p>apartment and called for Health Services Administrator to come to the apartment and then called medics. After the medics and medical examiner left, the Health Services Administrator and Nurse #2 entered Tenant #1's apartment to check the placement and type of the U bar. It was noted the U bar was not properly leveled and had no strap.</p> <p>When interviewed on 9-16-19 at 9:56 a.m. and on 9-18-19 at 1:32 p.m. Nurse #2 revealed at the time of the incident she was the DON in the Assisted Living Program (AL) and was currently the DON for the Assisted Living Program for People with Dementia (ALP/D). Staff A radioed for assistance to Tenant #1's apartment. She immediately responded to Tenant #1's apartment and observed Tenant #1 with her neck resting on the U bar. Her feet were wrapped up in blankets on the floor and her arms were dangling down. Tenant #1 was deceased when observed and the U bar was pulled out from the mattress. The bar was out far enough the tenant's head was resting on it. Nurse #2 indicated after the medical examiner moved Tenant #1's body, she observed a laceration on her neck. It appeared as if she tried to get up but her feet were tangled in the blankets and she fell. There was blood on the side where the neck was resting. Tenant #1's face was not against the bed. The police and medical examiner thought she rolled and suffocated; however, they possibly misunderstood that she was not bed bound and could get up and move on her own. She noted the U bar was not level, the feet of the bar were not touching the floor, and neither black stopper was on the floor. There were also no straps attached to the bar. She said Staff B had placed the bar on the bed for repositioning due to falls</p>	A 154		

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A 154	<p>Continued From page 16</p> <p>and weakness. Nurse #2 did not think she had ever installed a U bar without straps secured to the frame. When it was leveled it was normally very secure. (Tenant #1's U bar had been thrown away; however, Nurse #2 was shown a picture of the bed repositioning bar that the Program had provided and she said it was similar to the bar shown).</p> <p>The Health Services Administrator typed statement indicated on 7-31-19 she was called to the Program by Nurse #2 due to Tenant #1 being found on the floor deceased. After the investigators and the medical examiner left she went to the tenants' apartments that had U bars to ensure proper placement and security.</p> <p>When interviewed on 9-17-19 at 11:42 a.m., 9-16-19 at approximately 12:30 p.m. and 9-18-19 at 12:14 p.m. the Health Services Administrator revealed she was the Interim DON in memory care as Nurse #1 was on leave. On 7-31-19 around 10:00 a.m. she was notified by staff that Nurse #2 was trying to reach her. When she arrived at Tenant #1's apartment she observed Tenant #1 with her feet tangled in the bed sheets and her neck was resting on the U bar with her hands at her side. The U bar was still under the mattress and was pushed out some. She was not sure how far it was pushed out. After the investigators were done she and Nurse #2 went to the apartment. The medical examiner said Tenant #1 rolled out of bed and she disagreed due to Tenant #1's foot placement. She thought Tenant #1 went to stand up, her feet were tangled and she fell forward. Nurse #2 had mentioned the foot posts were not level. When the Health Services Administrator observed the U bar she noted the strap was not in place (it had</p>	A 154		

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A 154	<p>Continued From page 17</p> <p>been pointed out from investigators) and it was not level with the ground. She stated if the bar isn't level it is not as sturdy when pushed down. Tenant #1 had a twin size bed with box springs and mattress, which belonged to the Program. She had been told by Nurse #1 the U bar was provided by the Program and Staff B installed it on the bed. At times there was extra equipment stored in the Assisted Living. Direct care staff did not place bars on beds, only licensed personnel did.</p> <p>When interviewed on 9-16-19 at 10:38 a.m. the Executive Director said he was alerted to the incident with Tenant #1. He went into Tenant #1's apartment and observed her on the floor. Her head was postured on the bar and the rest of her body was on the floor. The bar had pulled away from the bed, perhaps a foot or so. He did not look at the exact position. He was told Tenant #1's bar was not secured to the bed and straps were not utilized. The Program took immediate action and ordered Halo bars for the tenants with the bars.</p> <p>On 9-16-19 at 1:57 p.m. the Environmental Services Director said he had been walking in the lobby when the Executive Director said he was on his way to a death in memory care. He went to Tenant #1's apartment and secured it as it was an unexpected death. When he was in the apartment he noted the bar was pulled out from the bed 16 to 18 inches. He did not know where the bar came from. Environmental staff generally did not install medical equipment.</p> <p>On 9-17-19 at 4:05 p.m. Staff B said she currently worked as a floor nurse on an as-needed basis. She had been the Nurse</p>	A 154		

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A 154	<p>Continued From page 18</p> <p>Manager until 7-1-19. When Tenant #1 graduated from hospice in June the hospital bed was replaced by a twin bed. She recalled the hospital bed had one side rail on it. She wasn't positive but thought the twin bed may have had a U bar attached. If there was a bar put on it would have been at the direction of the DON. She denied changing out the bed or placing the U bar on the twin bed for Tenant #1. She noted there were extra U bars stored and utilized by the Program. She recalled she had been verbally trained on how to apply bars to beds and had done so during the time she was Nurse Manager. There were different types of bars available, some of which slid under the mattress and used straps. She was aware Tenant #1 had passed away but was provided vague details.</p> <p>When interviewed on 9-18-19 at 12:36 p.m. Staff I (maintenance) said sometimes work orders were generated to set up beds, and other times there were no work orders. Maintenance staff installed bed rails at times if there were a lot of pieces to deal with. If it slipped under the mattress nursing might do it. Staff I said he had not put many beds together in memory care when asked about Tenant #1's bed and the positioning bar.</p> <p>When interviewed on 9-19-19 at 1:03 p.m. Staff J (maintenance) said beds were stored in the garage in independent living and maintenance would set them up. Housekeeping might help. The bed positioning bars that slipped under the bed were installed by nursing. Maintenance staff installed the Halo bars as they were kind of complicated to put together. Staff J did not have any knowledge of the equipment for Tenant #1.</p>	A 154		

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A 154	<p>Continued From page 19</p> <p>3. The bar installed on Tenant #1's bed was not available for observation as it had been discarded by the Program. The Health Services Administrator provided an online picture of a bed positioning bar similar to the bed positioning bar used in Tenant #1's apartment. The manufacture's User Guide for that bar included assembly instructions, general warnings and warranty information.</p> <p>Assembly instructions included:</p> <ul style="list-style-type: none"> - Assemble the brace bar to the two support frame pieces. Ensure the arrow on the two support frame pieces is pointing up. - Attached the base frame to the support frame pieces. - Attach the legs to the support frame pieces. - Attach the assist bar to the other side of the support frame pieces. The clips on the assist bar should face outward (storage packet hangs on). - Attach the storage pocket to assist bar (outside). - Remove the mattress from the bed. Put the assembled bed assist at location on the bed, the bed assist would sit between the bed frame and mattress or between the box spring and the mattress. The legs would be need be adjusted dependent on the height of the bed frame. Make sure the legs are firmly touching the ground. When in place thread the strap through two loops on the base (dependent on the size of the bed might reach only one loop), - Secure the strap around the bed frame on the opposite side of the bed and tighten. - Put the mattress back on the bed and the top of the assist bar could need a height adjustment dependent on the width of the mattress. <p>General warnings indicated:</p>	A 154		

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A 154	<p>Continued From page 20</p> <ul style="list-style-type: none"> - Before use ensure that all push buttons and clips are securely in place and that the legs are leveled and are securely touching the ground." - The unit is not meant to support full body weight but to assist with stability when getting in or out of bed. - The unit is not meant to be used as a restraint for preventing people from rolling out of bed. <p>A video tutorial of the product was observed on 9-12-19 (the date the video was posted was 6-21-14). The video tutorial indicated the bed assist bar could be used for a home care mattress/framework or a residential bed. The individual demonstrated the assembly of the product. It was then indicated the bar would be slid between the mattress and box springs, which should hold into place without problem. However, if there was a very light individual, if wanted, although not necessary, straps could be used. It was then demonstrated how the straps would be applied. To ensure it was properly set up, while sitting on the bed, grab a hold of the bar, and it should not flex away or out from the bed. It referred to the owner's manual or tech support desk for questions.</p> <p>A Monthly V/S (vital signs) and Weight document indicated Tenant #1's weight in June 2019 was 97.8 and 101 in July 2019.</p> <p>4. In summary, when Tenant #1 was discharged from hospice her hospital bed was replaced with a twin bed with an attached U bar both provided by the Program. It could not be determined who attached the U bar to the bed. When Tenant #1 was found deceased in her apartment on 7-31-19 with her neck on the U bar, the U bar was not secured with a strap and was not leveled. The</p>	A 154		

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A 154	Continued From page 21 bar on Tenant #1's bed was discarded by the Program; however, an online picture of a similar bar was provided by the Program. The bar provided by the Program was not installed per owner's manual instructions regarding the placement of the strap and the leveling of the bar.	A 154		

Plan of Correction – Senior Star at Elmore Place

11-15-19

Date: 10/17/19

To: Iowa Department of Inspections & Appeals (DIA)

From: Amanda Buchholz, Health Service Administrator

RE: DIA Visit on September 11th, 2019 through September 26th, 2019

Enclosed is the Plan of Correction (POC) in response to on-site monitoring visit by DIA monitor Stephanie Cummings on September 11th, 2019 through September 26th, 2019, to Senior Star at Elmore Place Memory Care. Regulatory Insufficiencies in the area(s) of: Structure/life safety, policies and procedures, tenant rights, and service plans. Each area of regulatory Insufficiency is noted in this document including a detailed POC.

PLAN OF CORRECTION

Area: Structure/ Life Safety

Regulatory Insufficiency #1: 481-69.35(231C) The buildings and grounds shall be well-maintained, clean, safe and sanitary. 69.35(1)

POC:

- 1. The Program will correct the regulatory insufficiency by:** Updating the policy to reflect changes in bed side repositioning, Staff will receive notification and training on the updated Policy and Procedure.
- 2. The following measures will be taken to ensure the problem does not recur:** The Program will implement the updated policy changes as soon as the policy is reviewed and approved by the corporate office. The Program will ensure every tenant that has the bedside repositioning devices is installed correctly in accordance to the manufacturer guidelines.
- 3. The Program plans to monitor performance to ensure compliance by:** periodic checks will be performed by the Director, Assistant Director or designee for proper placement of bed side positioning bar.
- 4. The regulatory insufficiency will be corrected by:** November 16, 2019

Area: Program policies and procedures

Regulatory Insufficiency #2: 481-67.2(1)e Program Policies and Procedures, including those for incident reports. A programs 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

11/11/19

Plan of Correction – Senior Star at Elmore Place

and procedures related to the reporting of incidents including allegations of dependent adult abuse. 67.2(2)

POC:

1. **The Program will correct the regulatory insufficiency by:** Senior Star at Elmore Place will follow the senior star policies in accordance to Iowa regulations. Senior Star Corporate office will notify property of any updated policies to ensure policies are being followed.
2. **The following measures will be taken to ensure the problem does not recur:** The registered Nurses and or designee will continue ongoing training with policies/procedures as deemed necessary. The program nurses have been reeducated on the bedside positioning bars.
3. **The Program plans to monitor performance to ensure compliance by:** The registered nurses and or designee will communicate any changes to the front line associates.
4. **The regulatory insufficiency will be corrected by:** November 16, 2019

Area: Tenant Rights

Regulatory Insufficiency #3: 481-67.3(2) tenant rights. All tenants have the following rights: 67.3(2), to receive care, treatment and services which are adequate and appropriate.

POC:

1. **The Program will correct the regulatory insufficiency by:** Senior Star at Elmore Place will assess all residents annually and with significant change as required by Iowa regulatory requirements for assisted living.
2. **The following measures will be taken to ensure the problem does not recur:** The registered Nurses and or designee responsible for assessment will be retrained on the assessment requirements and frequency. Training will continue annually for existing associates and upon hire for new associates.
3. **The Program plans to monitor performance to ensure compliance by:** The registered nurses and or designee will review service plans annually and with significant change to validate compliance.
4. **The regulatory insufficiency will be corrected by:** November 16th, 2019

Area: Service Plans

Plan of Correction – Senior Star at Elmore Place

Regulatory Insufficiency #4: 481-69.26(4) service plans. The service plan shall be individualized and shall indicate; at a minimum a. the tenants identified needs and preferences for assistance.

POC:

- 1. The Program will correct the regulatory insufficiency by:** Senior Star at Elmore Place will correct any service plan to reflect the resident needs to ensure services are adequate and appropriate. The community will ensure all staff is following individual service plans.
- 2. The following measures will be taken to ensure the problem does not recur:** The registered Nurses and or designee will continue ongoing training regarding service plans review.
- 3. The Program plans to monitor performance to ensure compliance by:** The registered nurses and or designee will review service plans annually to ensure the service plans accurately reflect the care, treatment and services appropriate for the tenant.
- 4. The regulatory insufficiency will be corrected by:** November 16th, 2019