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
	S0243	A. BUILDING: ______ B. WING ______	C 07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	**1701 13TH AVENUE NORTH CLINTON, IA 52732**

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population program: Number of tenants without cognitive disorder: 36 Number of tenants with cognitive disorder: 4 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 16 Total census of Assisted Living Program for Persons with Dementia: 56 No regulatory insufficiencies were cited during the investigation of Incident #83495-I. The following regulatory insufficiencies were cited during the investigation of Complaint #84025-C.	A 000		
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 interview and record review, the Program failed to ensure adequate and	A 013	Plan of Correction is attached [signature] 9/4/19	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 013	Continued From page 1	A 013		

appropriate care was provided to 2 of 6 tenants reviewed (Tenant #1,#4). Findings follow:

1. Review on 7/3/19 of a Documentation Survey Report for Tenant #1 revealed she was to be checked by staff sixteen times per shift (once every thirty minutes). There was no documentation of checks being conducted for Tenant #1 at the following times: 5/13/19 from 3:00 AM - 7:00 AM, 5/15/19 from 1:00 AM - 4:00 AM and 5/24/19 from 12:00 AM - 6:00 AM. There were 1-2 hour gaps in checks on 5/1/19, 5/3/19, 5/6/19, 5/11/19, 5/12/19, 5/16/19, 5/18/19, 5/22/19, 5/26/19 and 5/31/19.

On 5/26/19, the Documentation Survey Report reflected Tenant #1 was checked at 5:00 AM but not again until 6:55 AM at which time a Progress Note reflected she was heard yelling and found on the floor by her sink with an abrasion to her right elbow.

2. Record review on 7/3/19 revealed Tenant #4 was admitted to the program on 2/21/19. He was diagnosed with Lewy Body Dementia. A note from Tenant #4's physician dated 2/27/19 noted Tenant #4 had worsened over the past month. There were several days when Tenant #4 was barely able to function. The doctor noted Tenant #4 was having more difficulty walking and was shaky. The Health Care Coordinator sent a fax to Tenant #4's doctor on 3/1/19 notifying him Tenant #4 had three falls since admission and seemed somewhat weaker.

A service plan dated 3/21/19 noted Tenant #4 was at risk for falls due to his history and was to receive safety checks for falls 16 times per shift (every 30 minutes).

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A 013	Continued From page 2 A progress note dated 4/3/19 reflected Tenant #4 fell at 2:50 AM without injury. Tenant #4 suffered another fall on 4/3/19 at 5:50 PM during which time he was transported to the hospital by EMTs. He returned to the Program on 4/4/19 with no new orders. Tenant #4 fell on 4/5/19 at 12:40 AM without apparent injury. The Health Care Coordinator noted "staff to check on him every 30 minutes during the remainder of the shift." Tenant #4 fell on 4/6/18 at 4:00 AM and had pain in his hip. He was transported to the emergency room. According to a note from the Emergency Department Tenant #4 was diagnosed with an accidental fall, hematoma and confusion. He returned to the Program later in the day. On 4/7/19 at 4:45 AM, staff heard a loud sound and found Tenant #4 sitting on the floor with fresh blood on his shirt. An open area was noted on the top of his head. Tenant #4 was transferred to the emergency room. The Health Care Coordinator spoke with the ER nurse who informed her Tenant #4 had a brain bleed. Tenant #4 was admitted to the hospital. A nurse at the hospital informed the Health Care Coordinator Tenant #4 was essentially unresponsive with a poor prognosis. Tenant #4 returned to the program on 4/8/19 on hospice and was noted to be unresponsive to touch or verbal stimuli. Tenant #4 passed on 4/15/19. A review of Documentation Survey reports for April 2019 identified Tenant #4 was to have visual checks every 30 minutes. Tenant #4 received no documented safety checks until 4/8/19 at 4:30 PM. The Health Care Coordinator confirmed checks were not documented until 4/8/19. She reported	A 013		

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A 013	Continued From page 3 staff were frequently in Tenant #4's apartment but there was no documentation to reflect this.	A 013		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to provide adequate staffing on the locked memory care unit, potentially affecting all 16 tenants. Findings follow: Record review on 7/3/19 of a Documentation Survey Report for Tenant #1 revealed she was to be checked on by staff sixteen times per shift (once every thirty minutes). There was no documentation of checks being conducted for Tenant #1 at the following times: 5/13/19 from 3:00 AM - 7:00 AM, 5/15/19 from 1:00 AM - 4:00 AM and on 5/24/19 from 12:00 AM - 6:00 AM. There were 1-2 hour gaps in checks on 5/1/19, 5/3/19, 5/6/19, 5/11/19, 5/12/19, 5/16/19, 5/18/19, 5/22/19, 5/26/19, 5/31/19. On 5/26/19, the Documentation Survey Report reflected Tenant #1 was checked on at 5:00 AM but not again until 6:55 AM at which time a Progress Note reflected she was heard yelling and found on the floor by her sink with an abrasion to her right elbow.	A 055		

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A 055	Continued From page 4	A 055		

Continued From page 4

On 7/2/19 at 4:25 PM Staff C reported more often than not there were two staff members working second shift in the memory care unit during the week, however there was usually one staff person working second shift on the weekend. Staff C identified seven tenants who required 1:1 assistance with ambulation. She stated she could not keep up with checking on tenants every 30 minutes when she was working by herself.

On 7/2/19 at 1:40 PM, Staff D reported there often was only one staff working on the unit. She felt she was unable to quickly respond to tenant pages when she was there by herself. Staff D reported it was difficult to care for the tenants when she was also responsible for doing things such as serving meals, responding to pages, caring for tenants' needs and providing supervision.

When interviewed on 7/2/19 at 1:58 PM. Staff E reported first shift staff members on the memory care unit were responsible for doing laundry, meals, administering medication and getting tenants up in the morning. She felt it was not safe for the tenants to only have one staff working first shift.

An interview with Staff B on 7/2/19 at 2:25 PM revealed she did not think tenant needs could be met with only one person working. Staff B said there was no way to respond to a tenant when showering another tenant. Staff B had come to the memory care unit and found tenants with soiled briefs. She said one person could not do it all.

On 7/2/19 at 4:00 PM Staff F reported most of the

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A 055	Continued From page 5 time there were two people working on the memory care unit, except on weekends. She felt there were a lot of falls on the memory care unit due to a lack of staff. She said one person could not do it all. On 7/3/19 at 12:35 PM the Manager stated she had never worked in an assisted living program in which there had been so many people falling. The Manager had worked on the memory care unit for one week from 3:00 PM - 6:00 PM during the month of April. She said she realized at that time having one staff member working on that unit was not enough. They attempted to schedule two staff in the memory care unit but it was not always possible due to staffing issues.	A 055		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure service plans addressed identified needs for 5 of 6 tenants reviewed (Tenant #1, #2, #3, #4 and #6). Findings follow: 1. Record review on 7/2/19 revealed Tenant #1 had a service plan dated 4/15/19. According to the service plan, Tenant #1 had a history of falls.	A 089		

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A 089	Continued From page 6 Tenant #1 was to receive escorts to/from activities or the dining room, use a wheeled walker and call for assistance. A review of Progress Notes and Incident Reports revealed Tenant #1 experienced a fall on 5/16/19 which resulted in a transfer to the ED (Emergency Department). She fell twice on 5/22/19. On 5/24/19, Tenant #1 fell in her apartment and had a laceration to her head resulting in three staples in her head at the ED. Tenant #1 had a fall on 5/26/19, resulting in an abrasion to her right elbow. Tenant #1 fell on 5/28/19, cut the back of her head and was transferred to the ED where she received staples to her head. Tenant #1 fell again on 6/4/19 resulting in a transfer to the ED for blood found on her head. Tenant #1's service plan was not updated until 6/4/19 to put in new interventions to address her falls. 2. Record review on 7/3/19 revealed Tenant #2 had a service plan dated 6/14/19. The service plan identified Tenant #2 required assistance with ordering her medication and wished it to be administered safely according to doctor's orders. A comprehensive assessment dated 6/14/19 noted Tenant #2 preferred to have her medication crushed and given to her in applesauce. A progress note dated 6/26/19 documented Tenant #2 was consistently refusing meds, while the program was using different approaches and different staff. The Health Care Coordinator notified Tenant #2's POA (power of attorney) who reported Tenant #2 had refused medication frequently when she was temporarily in a skilled	A 089		

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A 089	Continued From page 7 nursing facility from 5/8/19 to 6/13/19. A progress note dated 7/1/19 noted Tenant #2 continued to refuse medication at times. The tenant's service plan did not list interventions to address Tenant #2's medication refusals. 3. Review of a 90 Day Nurse Review for Tenant #3 dated 2/10/19 revealed a 90-minute family meeting was held on 12/12/18. On 7/8/19 at 11:45 AM the Health Care Coordinator confirmed she attended this meeting. She stated during the December meeting, the family reported they did not think Tenant #3 was being bathed regularly. They questioned some clothing choices the tenant was making. They also didn't want Tenant #3 just sitting in the dining room following a meal. The Health Care Coordinator did not believe any of these requests required a change to Tenant #3's service plan. An email was received from a family member of Tenant #3 on 7/14/19. This family member reported taking notes at the meetings. She reported at the December 2018 meeting, the family expressed concern with Tenant #3 losing weight. They requested that caregivers ask Tenant #3 if she needed food cut up and to also divide up her food onto different plates so she was not overwhelmed with the amount. They asked Tenant #3 to receive escorts to and from the dining room. The family was worried they had found Tenant #3 sitting in soiled undergarments when they arrived at her apartment due to increased incontinence of bowel and bladder and wondered if she could be checked on more frequently. The tenant's service plan dated 11/12/18 was not	A 089		

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A 089	Continued From page 8	A 089		

updated to reflect these requested services.

In addition, a comprehensive assessment dated 11/12/18 indicated Tenant #3 preferred staff to stand by during transfers. The tenant was to communicate this request to staff as needed. The comprehensive assessment also noted Tenant #3 needed an escort to/from activities and the dining room. According to the 11/12/18 service plan, Tenant #3 was independent with ambulation and not identified as a fall risk. According to a 90 day review dated 2/10/19, Tenant #3 had falls on 11/10/18 and 11/11/18. She also received Physical Therapy and Occupational Therapy from 11/11/18 to 12/12/18. A 90 day review dated 5/10/19 noted Tenant #3 fell on 2/24/19 and 4/22/19.

The tenant's service plan was not updated to reflect the falls, assistance with transfers and escorts, or the therapies she received.

4. Record review on 7/3/19 revealed Tenant #4 was admitted to the program on 2/21/19. He was diagnosed with Lewy Body Dementia. A note from Tenant #4's physician dated 2/27/19 noted Tenant #3 had worsened over the past month. There were several days when Tenant #4 was barely able to function. The doctor noted Tenant #4 was having more difficulty walking and was shaky. The Health Care Coordinator sent a fax to Tenant #4's doctor on 3/1/19 notifying him Tenant #4 had three falls since admission and seemed somewhat weaker.

A progress note dated 4/3/19 reflected Tenant #4 fell at 2:50 AM without injury. Tenant #4 suffered another fall on 4/3/19 at 5:50 PM during which time he was transported to the hospital by EMTs.

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A 089	Continued From page 9	A 089		

He returned to program on 4/4/19 with no new orders. Tenant #4 fell on 4/5/19 at 12:40 AM without apparent injury. The Health Care Coordinator noted "staff to check on him every 30 minutes during the remainder of the shift". Tenant #4 fell on 4/6/18 at 4:00 AM and had pain in his hip. He was transported to the emergency room.

According to a note from the ED Tenant #4 was diagnosed with an accidental fall, hematoma and confusion. He returned to the program later in the day. On 4/7/19 at 4:45 AM, staff heard a loud sound and found Tenant #4 sitting on the floor with fresh blood on his shirt. An open area was noted on the top of his head. Tenant #4 was transferred to the emergency room. The Health Care Coordinator spoke with the ER nurse who informed her Tenant #4 had a brain bleed. Tenant #4 was admitted to the hospital. A nurse at the hospital informed the Health Care Coordinator Tenant #4 was essentially unresponsive with a poor prognosis. Tenant #4 returned to the program on 4/8/19 on hospice and was noted to be unresponsive to touch or verbal stimuli. Tenant #4 passed away on 4/15/19.

A service plan dated 3/21/19 noted Tenant #4 was at risk for falls due to his history. He was identified as independent with ambulation but needed to use an assistive device. The tenant's service plan was not updated to provide interventions related to his falls until 4/9/19.

5. Record review revealed Tenant #6 had a service plan dated 4/30/19. Tenant #6's service plan identified she was independent with ambulation but may need reminders to slow

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A 089	Continued From page 10 down her pace while walking. Tenant #6 was to be reminded to call for assistance and to wait after standing to ensure she was not light headed before she started walking. A review of Incident Reports revealed Tenant #6 fell on 3/19/19 and 3/20/19. On 6/10/19, she was found sleeping on the floor at the foot of her bed. She expressed no pain and was helped to bed. On 6/11/19, a progress note indicated Tenant #6 reported pain in her left shoulder while dressing and had limited range of motion. Tenant #6's husband took her to the Emergency Room where she was treated for a closed fracture of the distal clavicle and dehydration. Tenant #6 received home care instructions which included wearing a splint. A progress note dated 6/13/19 identified Tenant #6 did not want the sling on and was taking it off independently. A progress note dated 6/18/19 documented Tenant #6 was found on her bathroom floor on her back. She complained of hip pain and right shoulder pain. Tenant #6 was transferred to the emergency room via ambulance. She returned on 6/19/19 without a fracture but did have a closed head injury. Tenant #6's service plan was not updated to reflect her falls or interventions put in place to assist her to wear her splint. 6. On 7/8/19 at 11:45 AM the Health Care Coordinator confirmed service plans were not updated as needed.	A 089		
A 138	481-69.32(2) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements.	A 138		

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A 138	Continued From page 11	A 138		

69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the Program failed to ensure there was an operating alarm system connected to each exit door, potentially affecting 56 of 56 tenants of the program.
Findings follow:

The Monitor arrived at the program on 7/1/19 at 4:00 PM. There was no audible alarm upon walking through the main front door. It took approximately one minute for the Executive Director to arrive at the door. On 7/2/19 at 8:15 AM, the Monitor arrived through the main front door. No one was seen at the front of the building. The Monitor found a worker in the kitchen who provided assistance. On 7/3/19 at 7:55 AM, the Monitor arrived and did not see any visible staff. Staff did not respond to the Monitor coming through the door on 7/2/19 or 7/3/19.

An interview was conducted with Staff A on 7/3/19 at 8:45 AM. Staff A and the Monitor tried the front door at that time to see if it was alarmed. Staff A had an IPad on which a notification was to be sent if someone went through the door. A notification was not sent to the IPad. Staff A reported the alarm on the door was turned off during the daytime hours.

The Housekeeper was interviewed on 7/3/19 at 9:30 AM. The Housekeeper stated he had set up the computer such that the alarm to the main front door was turned off at 7:00 AM and not

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A 138	Continued From page 12 turned back on until 4-4:30 PM. The Housekeeper was under the assumption as long as there were staff at the front of the building to monitor the door, it did not need to be alarmed. He reported other doors were alarmed all of the time. Staff B was interviewed on 7/2/19 at 2:25 PM. She reported the front door was not alarmed and did not notify staff of tenants entering or exiting the building from 7:00 AM - 4:00 PM. The Manager confirmed these findings on 7/3/19 at 12:35 PM.	A 138		

√9/19/19

August 26, 2019

Incident and Complaint Visit:
Prairie Hills of Clinton visit 7/1/19-7/8/19

Iowa Department of Inspection & Appeals
Deb Dixon
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

To Whom It May Concern,

Please consider this our plan of correction for the regulatory insufficiency cited during 7/3/19 visit, with the **Final Results, Prairie Hills of Clinton, Clinton, IA** completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapter 481-69, pertaining to regulatory insufficiencies in the areas of service plans.

<u>Tenant Rights</u>
<u>A013</u>
67.3(2) Tenant rights. All tenants have the following rights:
To receive care, treatment and services which are adequate and appropriate.

1. **Elements detailing how the program will correct the regulatory insufficiency.**
    a. Residents missing documentation for visual checks 16 times per shift. Tasks are monitored daily for missing documentation.
2. **What measures will be taken to ensure the problem does not recur?**
    a. HCC, Manager or designee will ensure the residents tasks have been completed daily.
3. **How the program plans to monitor performance to ensure compliance.**
    a. HCC, Manager or designee will review task documentation daily for 4 weeks, weekly for 4 weeks and then as scheduled by the Program Manager or designee.
4. **Date by which the regulatory insufficiency will be corrected?**
    a. Regulatory Insufficiency will be corrected by 9/15/2019.

<u>Staffing</u>

A055

67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

1. **Elements detailing how the program will correct the regulatory insufficiency.**
   a. Appropriate number of staff are scheduled each day to meet residents' needs.

2. **What measures will be taken to ensure the problem does not recur?**
   a. HCC, Manager or designee will ensure appropriate number of staff are scheduled each day to meet residents' needs.

3. **How the program plans to monitor performance to ensure compliance.**
   a. HCC, Manager or designee will review schedule weekly to ensure appropriate number of staff are available to residents for four weeks and then as scheduled by the Program Manager or designee.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 9/15/2019.

Service Plans

A089

69.26(4) The service plan shall be individualized and shall indicate, at a minimum:
a. The tenant's identified needs and preferences for assistance

1. **Elements detailing how the program will correct the regulatory insufficiency.**
   a. Residents' ISPs are being reviewed and updated as appropriate.

2. **What measures will be taken to ensure the problem does not recur?**
   a. HCC, Manager or designee will ensure the residents service plan is current and specific to the individual upon admission, with any change of condition assessment, 90-day assessments, and/or annually by completing an ISP review with each assessment.

3. **How the program plans to monitor performance to ensure compliance.**
   a. HCC, Manager or designee will review a random sample of ISPs for accuracy and specified for individualized needs monthly for four months and then as scheduled by the Program Manager or designee.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 9/15/2019.

<u>Life Safety</u>
<u>A 138</u>
481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements.
69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.

1. **Elements detailing how the program will correct the regulatory insufficiency.**
   a. Alarm connected to front door of community was not active during the day hours. Front door is alarmed at all times currently.

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

   a. HCC, Manager or designee will ensure all exit doors are alarmed at all times.

3. **How the program plans to monitor performance to ensure compliance.**

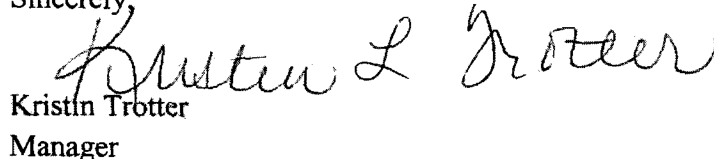
   a. HCC, Manager or designee will ensure exit door alarms are functioning daily for 3 weeks, weekly for three months and then as scheduled by the Program Manager or designee.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency by 9/15/2019.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Thank you for your time and consideration in correcting these important matters.

Sincerely,



Kristin Trotter
Manager