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10/21/17

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2017
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NAME OF PROVIDER OR SUPPLIER WELCOV AT SPIRIT LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 1819 23RD ST SPIRIT LAKE, IA 51360
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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 000	481-67 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: 35 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 36 TOTAL census of Assisted Living Program: 36 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program.	A 000		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a criminal history	A 118	A 118: Program will conduct appropriate background checks and receive final approval through SING and DHS prior to new employees or re-hires beginning their first day of employment. This was implemented immediately. An orientation checklist will be maintained to ensure proper procedures are being followed. Audits on the check list will be conducted semi-annually to assure compliance.	

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

TITLE

(X6) DATE

[Handwritten signature] 10/21/17

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A 118	Continued From page 1 check prior to employment for 1 out of 4 staff reviewed (Staff A). Findings follow: Record review revealed Staff A was hired on 5-23-17. A Single Contact License and Background Check (SING) was completed 5-22-17. Further research was required for the criminal history background check. The criminal history, completed on 5-28-17, revealed no criminal history for Staff A. During an interview with the Executive Director on 9-19-17 at 9:15 am she confirmed that Staff A had begun her training prior to receiving the final criminal history check. She stated Staff A was only doing training and was not doing direct care for the tenants.	A 118		
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 develop a service plan based on all identified needs and preferences for 1 out of 1 tenants reviewed with a Global Deterioration Score (GDS) of 4 and above (Tenant #1). Findings follow: Review of Tenant #1's file revealed the following:	A 089	A 089: The direct care staff was in-serviced on 9/27/17 on the importance of reporting the refusal of assigned cares and were instructed to document any refusal of cares on the ICAL Staff Communication Report as well as electronically . In addition, the Director of Healthcare Services will run a weekly report on the Point, Click, Care program to	

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A 089	<p>Continued From page 2</p> <ul style="list-style-type: none"> - Progress Notes dated 1-17-17 through 9-19-17 revealed he/she consistently refused to take a shower for the following: March-3 times, May-5 times, June-3 times, July-4 times, August-2 times, and September-1. - A Global Deterioration Scale dated 6-9-17 revealed he/she had a score of 5 which indicated a moderately severe cognitive decline. - Senior Level of Care evaluations dated 6-9-17 and 9-7-17 indicated he/she required assistance with bathing two times per week (eight times per month) and he/she did not have any refusals to accept care. - The tenant's Service Plan dated 9-12-17 did not reflect his/her refusals to shower or interventions to encourage him/her to complete them. <p>During an interview with the Health Services Director on 9-19-17 at 12:37 p.m. she stated she was not aware Tenant #1 was frequently refusing showers and would have addressed this in the service plan. She stated she must have missed seeing this when reviewing Progress Notes and confirmed Tenant #1 had a GDS of 5.</p>	A 089	<p>A 089 (cont): facilitate timely amendments to services plans that reflect interventions for refusal of cares. The DHS will set up a Quality Assurance tool to monitor the communications and subsequent service plan interventions on a monthly basis for 6 months. If this plan is successful, the audit will be modified to a quarterly review. The resident's service plan that was cited in the report was modified on the day of the visit to include interventions to provide appropriate responses to the refusal of care.</p>	
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