Handwritten: [illegible] 1/18/17

PRINTED: 10/27/2016
FORM APPROVED

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
	S0123	A. BUILDING: ______ B. WING ______	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY PLACE	**11 DEBORAH DRIVE BLOOMFIELD, IA 52537**

(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: 13 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 13 TOTAL census of Assisted Living Program: 13 The following regulatory insufficiency was identified during the investigation of Complaint #62291-C.	A 000		
A 115	481-69.29(1) Staffing 481-69.29(231C) Staffing. In addition to the general staffing requirements in rule 481-67.9(231B,231C,231D), the following requirements apply to staffing in programs. 69.29(1) Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the Program failed to provide a timely staff response to the personal emergency response system (pendant) activated by a tenant. This pertained to one of three tenants reviewed (Tenant #2). Findings include:	A 115	Handwritten: See attached Plan of Correction [signature]	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 115	Continued From page 1 Interview with Tenant #2 on 10-12-16 revealed there was an incident when staff did not respond after he/she activated the emergency pendant to ask for assistance regarding issues with their blood sugar. After no one responded to the activation of the pendant the tenant attempted to call staff on the telephone but no one answered. Tenant #2 then attempted to draw attention by knocking on the wall as well as going in the hall to see if anyone was present. Eventually Tenant #2 called 911 and went to the hospital. Record review of Tenant #2's file revealed Progress Notes indicating the following: - On 8-4-16 it was noted last p.m. (on 8-3-16) Tenant #2's blood sugar was 61 after supper - On 8-5-16 Tenant #2 was shaky and perspiring and his/her blood sugar was 42 at 3:20 p.m. The doctor was notified and a new order for insulin was received. - On 8-6-16 it was noted that around 7:00 p.m. (on 8-5-16) Tenant #2 felt he/she was shaking and having trouble and decided to go to the ER. Tenant #2 returned from the hospital at 10:20 p.m. with a diagnosis of a UTI and an order for antibiotic therapy. Review of a written statement from the Assisted Living (AL) Manager revealed on 8-5-16 at approximately 7:20 p.m. she received a call from Staff A (designated nurse for the Program after direct care staff left for the day). Staff A noted she heard the exit door, responded and saw the ambulance outside along with Tenant #2. Tenant #2 had reported when no one responded after he/she activated the pendant, he/she eventually called 911. When emergency services was unable to reach anyone at the adjacent nursing	A 115		

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A 115	Continued From page 2	A 115		

home, an ambulance was dispatched to the Program and transported the tenant to the emergency room (ER). Tenant #2 had been having low blood sugar issues and had an elevated blood pressure when emergency responders arrived at the apartment. At the ER Tenant #2 was diagnosed with urinary tract infection (UTI) and was ordered an antibiotic. Tenant #2 returned to the apartment with family at 10:10 p.m. According to an internal investigation one of the staff working thought someone else had responded to Tenant #2's request for assistance. Another staff forgot to turn her pager back on after her meal break.

Interview with the Assisted Living (AL) Manager on 10-12-16 at 2:58 pm revealed the charge nurse called her and reported what happened with Tenant #2. The pendant had been activated at 6:54 p.m. and Tenant #2 was sent out by ambulance at 7:20 p.m. (26 minutes). Staff A did not have a pager at the time of the call and another staff thought someone had answered it.

According to a Action Request and Follow Up Form dated 8-5-16, there was no response to a call cord at 6:54 p.m. and Tenant #2 called the ER his/her self after no response. The action plan indicated the Administration would address at an in-service on 8-10-16. The results of the actions taken indicated staff were all aware of timeliness of responding to call lights. The date resolved indicated 8-30-16.

Staff statement from Staff A dated 8-10-16 revealed on 8-5-16 she heard a door alarm sound at the Program, responded and was met by a police officer. The officer said Tenant #2 had called 911. Staff A noted no AL pager was

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A 115	Continued From page 3 available for her at the beginning of the shift. Staff statement from Staff B dated 8-5-16 revealed she was in the middle of bedtime cares for another individual when she saw Tenant #2's pendant light go off. Staff B assumed someone else was answering the call light as she had been told she could not go over to the Program until she was trained to work with tenants in the AL program. Staff statement from Staff C dated 8-5-16 revealed she turned her pager off when she was on supper break and she forgot to turn it back on. Staff statement from Staff D dated 8-5-16 revealed she had not seen the call light up on her pager. It was later discovered the pager was not working correctly and was given to maintenance staff. Staff statement from Staff E revealed Staff E got off break at 7:10 p.m. and there was another call light on. When in the other room responding to that call light, Staff E noticed Tenant #2's (call light/pendant) was also on. Review of call data for the pendant system revealed on 8-5-16 at 6:54 p.m. Tenant #2's pendant was activated and the response time indicated 99:59 (the system timed out). The AL Manager indicated in interview on 10-12-16 that Tenant #2 left for the hospital and staff was not able to reset the pendant before he/she left. Review of the ALP Monitoring Entrance Form and schedules revealed after 5:30 or 7:00 p.m. (dependent on the day) staff from the attached nursing facility provided oversight of the tenants	A 115		

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A 115	Continued From page 4	A 115		

until the next morning when staff arrived at 7:00 a.m.

According to the Program's policy and procedure regarding emergency response, the Program would provide a mechanism for assuring emergency services were available to all tenants in the event of a sudden illness or accident. Tenants could call 911 for immediate notification and transportation to the local hospital (at their discretion and expense at any time). Tenants could utilize the telephone or the call-light system within their apartment to call the nursing facility to request assistance from the staff on duty at the nursing facility. Each tenant of the Program had access to an emergency call system. The emergency call system could be activated by the tenant whenever assistance was needed and staff was not present in the immediate vicinity. Staff would hear and see the activated call light from the Program at the nurses' station in the nursing facility. A staff would be sent to the Program and would look at the emergency panel and proceed to the apartment, reset the alarm and assist the tenant (if able).

According to the Program's policy and procedure regarding staffing, the Program would have sufficient trained staff available at all times to meet the tenant's identified needs. Staff for the Program would be available onsite in the proximate area (able to be there within five minutes) 24 hours a day to respond to a call light, emergency requests and to meet the needs of the tenants.

According to the following definition, and the Program's policy, the Program needed to ensure there was enough staff to provide a five minute or

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A 115	Continued From page 5 less response time to calls for assistance. 481-69.1(231C) Definitions. In addition to the definitions in 481-Chapter 67 and Iowa Code chapter 231C, the following definitions apply. " In the proximate area " means located within a five minutes or less response time. Review of the documentation of calls for assistance from 8/1/16 to 10/12/16 revealed the following - a response time of 14:37 minutes on 8/1/16 at 2:34 am for Apt. 4 - a response time of 21:38 minutes on 8/8/16 at 6:25 pm for Apt. 12 - a response time of 9:32 minutes on 8/13/16 at 11:49 pm for Apt. 4 - a response time of 7:29 minutes on 8/24/16 at 11:07 am for Apt. 9 - a response time of 7:24 minutes on 8/25/16 at 1:57 am for Apt. 9 - a response time of 17:33 minutes on 8/30/16 at 6:06 pm for Apt. 11 - a response time of 11:07 minutes on 9/13/16 at 8:33 am for Apt. 12 - a response time of 12:52 minutes on 10/5/16 at 9:25 pm for Apt. 10 - a response time of 11:38 minutes on 10/5/16 at 9:24 pm for Apt. 7 - a response time of 17:58 minutes on 10/12/16 at 8:05 am for Apt. 12	A 115		

11 Deborah Drive
Bloomfield, Iowa 52537

Mulberry Place

INDEPENDENT & ASSISTED LIVING

Ph: (641) 664-2523
Fax: (641) 664-7378

Plan of Correction related to complaint survey completed on October 12, 2016.

Preparation and Implementation of this Plan of Correction should not be construed as an admission of the deficiency cited. This plan of correction is prepared solely because it is required under federal or state law.

A000- Correction Date: November 26, 2016

A115- 481-69.29(1)- STAFFING
Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch.

- The facility will continue to follow the Program's policy and procedure for staffing which incorporates that the Staff for the assisted living program will be available on site in the proximate area 24 hours a day to respond to a call light or other emergent requests and to meet the tenant's needs and individual preferences as identified in the Service Plan Agreements. The regulatory definition of *"In the proximate area"* means located within a five minutes or less response time.
- Call light alerts will be answered promptly. The facility will use the standard benchmark of a maximum of 15 minutes call light response time as a measure to ensure tenant needs are met.
- Staff will respond to each tenant call-light activation. Offgoing Assisted Living staff will report any illness or issues to NF staff before leaving building before the day.
- Staff were educated via inservice on August 10, 2016 on proper procedure of pager usage and AL call light responses.
- Administrator of designee will audit call light response compliance 5x/weekly for 2 weeks and weekly thereafter. The data and trends identified will be reviewed as part of our on-going quality assurance process.

Patricia Quail RN, LNHA

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