

*M/11/18*

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  775543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 05/15/2018
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  GLEN OAKS ALZHEIMER'S SPECIAL CARE CE	STREET ADDRESS, CITY, STATE, ZIP CODE 8525 URBANDALE AVENUE URBANDALE, IA 50322
---	---

(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
R 000	Initial Comments  The following deficiencies were cited during the investigation of Complaint #75730-C and Incident #75611-I.	R 000	Glen Oaks Alzheimer's Special Care Center respectfully submits the Plan of Correction for your approval. Glen Oaks' response is specific to the Incident and complaint visit 5/7-5/10/2018. Execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of insufficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Iowa law.	
R 640	481-57.17(3)d Records  481-57.17(135C) Records.  57.17(3) Incident record.  d. An incident report shall be completed for every accident or incident where there is apparent injury or where an injury of unknown origin may have occurred. (II)  This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an incident report had been completed following an event resulting in injury for 1 of 1 residents reviewed with a history of choking (Resident #1). Findings include:  On 5/08/18 at 3:15 p.m. review of Resident #1's progress notes revealed on the evening 4/17/18 the resident choked on a peanut butter sandwich. The Heimlich maneuver was attempted. Resident #1 was noted as unconscious. CPR was started and 911 was called. Resident #1 was transported to the hospital and returned to the facility later that same evening.  No incident report regarding this choking event could be located.	R 640	R640  The facility does and will complete an incident report on any resident where an accident or incident with apparent injury or injury of unknown origin occurred.  Staff nurses completed an inservice conducted by [REDACTED], RN HSD on 4/26/2018 regarding completion of incident reports. HFD and the Administrator will verify and sign all	

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

*Rekia Saleh Administrator*

TITLE

*June 28, 2018*

(X8) DATE

*ADD - 7/6/18*

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  775543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/15/2018
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  GLEN OAKS ALZHEIMER'S SPECIAL CARE CE	STREET ADDRESS, CITY, STATE, ZIP CODE 8525 URBANDALE AVENUE URBANDALE, IA 50322
---	---

(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
R 640	Continued From page 1 On 5/09/18 at 4:02 p.m. the Health Services Director confirmed this finding.	R 640	incident reports upon completion. Incomplete IR will be returned to the nurse for completion.	
R 834	481-57.22(3)c Orientation and Service Plan  481-57.22(135C) Orientation and service plan.  57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III)  c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III)  This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure service plans were modified as dietary needs changed for 2 of 5 residents	R 834	This will be monitored monthly through the QA process.  R834  The facility does and will develop and update service plans for all residents.  Upon completion of an incident report by a nurse the HSD will be responsible for reviewing the service plans to ensure any changes are documented.  This will be monitored monthly through the QA process.	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>775543</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLEN OAKS ALZHEIMER'S SPECIAL CARE CE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8525 URBANDALE AVENUE URBANDALE, IA 50322</b>		
(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
R 834	Continued From page 2 reviewed (Resident #1, #3). Findings include:  1. On 5/08/18 at 3:15 p.m. record review revealed Resident #1 was admitted to the facility on 2/16/18 with orders for a regular diet. On 4/05/18 Resident #1's diet order changed to a Mechanical Soft Meat (ground meat) diet per the consultant dietitian due to difficulty chewing regular meat and potential for pocketing.  The service plan dated 4/04/18 documented the resident was on a Regular diet. The service plan was not been modified to include the new orders for a Mechanical Soft Meat diet. The plan also noted Resident #1 needed assistance with meals. The plan did not include specifics concerning the type of assistance required. Resident #1 choked and went unresponsive on 4/17/18 and again on 5/01/18 and was transported to the hospital on both occasions.  2. On 5/09/18 at 12:15 p.m. record review revealed Resident #3's diet order dated 5/2/18 was for a Mechanical Soft diet. Review of the diet list used by the kitchen revealed Resident #3 was on a Pureed diet. Resident #3's service plan dated 1/30/18 listed the diet as Regular. Neither the service plan or the diet list located in the kitchen were consistent with the diet order dated 5/2/18. Physician orders for a Pureed diet could not be located.  The Health Services Director confirmed these findings on 5/9/18 at 1:00 p.m.	R 834		
R1024	481-57.34(3)c Safety  481-57.34(135C) Safety. The licensee of a residential care facility shall be responsible for	R1024		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>775543</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLEN OAKS ALZHEIMER'S SPECIAL CARE CE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8525 URBANDALE AVENUE URBANDALE, IA 50322</b>		
(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
R1024	<p>Continued From page 3</p> <p>the provision and maintenance of a safe environment for residents and personnel. (I, II, III)</p> <p>57.34(3) Resident safety.</p> <p>c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III)</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure adequate supervision and safety measures were in place for 1 of 1 residents reviewed with a history of choking (Resident #1). Findings include:</p> <p>A review of incident reports revealed on 5/1/18 at 9:00 am the Health Services Director was called to the back dining room area and found Resident #1 choking. Staff present were encouraging the resident to cough. The resident was visibly shaken with noted extreme dyspnea (difficulty in breathing). The resident's mouth was full of bread and an oral cavity sweep was done. The resident continued to have a partially blocked airway and respiratory wheezing was noted. The Heimlich maneuver was attempted several times unsuccessfully and 911 was called. The resident became hypoxic, turned blue and passed out. CPR was initiated as the resident was without a pulse and not breathing. Emergency Medical Technicians suctioned the resident's mouth and throat and transported to the hospital.</p> <p>According to the hospital records the resident was seen in the emergency room on 5/1/18 after a choking spell with CPR performed. A chest</p>	R1024	<p>R1024</p> <p>The facility does and will provide a safe environment for residents and personnel.</p> <p>An inservice for Certified Nurses Aides was conducted on June 22<sup>nd</sup>, 2018 by [REDACTED], Admin. in regards to: following prescribed diets and performing the Heimlich Maneuver.</p> <p>An all staff inservice was conducted by [REDACTED], Admin., [REDACTED], HSD and [REDACTED], Speech Therapist with Kindred on June 27<sup>th</sup>, 2018 in regards to: Incident reporting, following prescribed diets and the use of the stop and watch tool.</p>	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  775543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/15/2018
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  GLEN OAKS ALZHEIMER'S SPECIAL CARE CE	STREET ADDRESS, CITY, STATE, ZIP CODE 8525 URBANDALE AVENUE URBANDALE, IA 50322
---	---

(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
R1024	<p>Continued From page 4</p> <p>x-ray revealed a sternal fracture. The resident was admitted to the hospital for further evaluation and management. On 5/9/18 the resident was discharged back to the facility.</p> <p>Review of Resident #1's record on 5/8/18 revealed an admission date of 2/16/18 with a diagnosis of early onset frontotemporal dementia. According to a report written by the resident's Primary Care Provider (PCP) following a routine visit on 2/27/18, staff were worried about choking as the resident tended to eat very quickly. The service plan dated 4/04/18 indicated Resident #1 was on a Regular diet. An order dated 4/05/18 from the consultant dietitian documented the resident was to receive a Mechanical Soft Meat (ground meat) diet due to difficulty chewing regular meat and potential for pocketing. The service plan was not amended to change the resident's diet order. In addition, the service plan noted the resident was to have assistance at meals but did not specify the type of assistance required.</p> <p>A progress note dated 4/17/18 AT 8:55 P.M. documented the resident was asking for cake. Staff gave him/her a soda and a peanut butter sandwich cut into fourths. The resident ate a fourth of the sandwich and began choking. Staff attempted to get the food out but the resident clenched their teeth shut. Staff got the resident to breath and then dislodged food from his/her mouth. The resident was taken to the hospital via ambulance due to low oxygen levels. A subsequent progress note documented the resident received potassium at the hospital and returned to the facility later that same night.</p> <p>Review of the diet list used by dietary staff</p>	R1024	<p>The HSD and dietary staff conducted a complete chart audit of all diets on June 26<sup>th</sup>, 2018. All diets have been updated and are accurate on the dietary's list and the service plans.</p> <p>A dry erase board is available in the kitchen to list residents with alternate diets. This board will be updated by the Food service director or designee as residents have changes to their diet orders.</p> <p>Resident service plans will/are individualized and include diet type, adaptive equipment, and any other special dietary accommodations.</p> <p>Resident #1's service plan indicates this resident is to be served one food item at a time at all meals.</p>	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>775543</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLEN OAKS ALZHEIMER'S SPECIAL CARE CE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8525 URBANDALE AVENUE URBANDALE, IA 50322</b>		
(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	
R1024	<p>Continued From page 5</p> <p>revealed Resident #1 was on a Mechanical Soft diet for meats. The facility utilized a document from St Croix Hospice that outlined the parameters of a Mechanical Soft diet. According to the document all foods were to be moist, soft textured and easily chewed. Meats were to be ground and served with gravy or sauce. Under the food group of meats and meat substitutes, foods to be avoided included dry meat (such as sausage or hot dogs), peanut butter and sandwiches.</p> <p>According to the menu, breakfast served the morning of 5/1/18 included hot or cold cereal, scrambled eggs, sausage and a pastry.</p> <p>On 5/7/18 at 1:31 p.m. interview with Staff F revealed Resident #1 was known to shovel food/eat exceedingly fast. Sometimes staff took the plate away when this occurred. She did not know if Resident #1 had a program for this or not. Staff F confirmed on the morning of 5/1/18 she had initially given Resident #1 the wrong plate of food as it was for someone on a Regular diet and not a Mechanical Soft diet. She thought the resident had the wrong plate for three minutes. Staff F confirmed she did not sit with Resident #1 as she was busy serving other residents. She stated she had never seen Resident #1 eat too quickly. Staff F reported that of all the residents who ate in the back dining room there were at least five who needed significant assistance to eat, and two who required verbal cueing. Staff F said staff bounced between tables the best they could in order to assist residents at meals.</p> <p>Interview with Staff E on 5/8/18 at 10:37 a.m. revealed she did not see anyone sitting with Resident #1 when she passed by him/her. She</p>	R1024	<p>Staff is to assist this resident at all meals.</p> <p>The dietician will come on a monthly basis and monitor dietary systems and resident diets.</p> <p>This will be monitored monthly through the QA process.</p>		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  775543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/15/2018
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  GLEN OAKS ALZHEIMER'S SPECIAL CARE CE	STREET ADDRESS, CITY, STATE, ZIP CODE 8525 URBANDALE AVENUE URBANDALE, IA 50322
---	---

(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
R1024	<p>Continued From page 6</p> <p>noted Resident #1 had been served the wrong diet at that time as there was a whole sausage on the plate. She requested a Mechanical Soft breakfast from the kitchen. Staff E said she assumed Resident #1 had already eaten most of the croissant because there was approximately three inches of it left on the plate. There was nothing on the floor and both of Resident #1's cheeks were full of food. She believed neither Staff F or Staff G sat with Resident #1 because they were ensuring everyone had been served. Staff E did not think there were enough staff to sit with Resident #1 for the entire meal because they were required to move from table to table to assist other residents. Staff E thought there were between 25 and 27 residents in the back dining room at the time with three direct care staff present.</p> <p>Interview with Staff G on 5/8/18 at 12:36 p.m. revealed during breakfast Resident #1's cheeks were observed to be full of food. She took the resident to the restroom for privacy to assist him/her with removing the food at approximately 8:50 a.m. Staff E and Staff F remained in the back dining room. As Staff G attempted to remove some of the food, which appeared to be a croissant, Resident #1 attempted to speak. She believed the resident's voice sounded muffled so she called for a nurse on the walkie-talkie. Two nurses showed up within seconds. One of the nurses told her to call 911 as the resident was turning blue, the Heimlich maneuver wasn't working and CPR was initiated due to loss of consciousness. The paramedics arrived and were able to remove a piece of a croissant from Resident #1's airway and regain a pulse. Staff G stated prior to this incident she had helped another resident (Resident #6) use the restroom.</p>	R1024		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>775543</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLEN OAKS ALZHEIMER'S SPECIAL CARE CE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8525 URBANDALE AVENUE URBANDALE, IA 50322</b>		
(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	
R1024	<p>Continued From page 7</p> <p>Staff E and Staff F were in the dining room helping with breakfast. When she brought Resident #6 to the dining room, the last plate was being served. They hadn't sent cereal for Resident #6 so she went to the kitchen to get it. When she returned she observed Resident #1 staring out the window with cheeks full of food. No staff were near Resident #1. According to Staff G, staff were to sit with Resident #1 as soon as the plate arrived as he/she often shoveled food in their mouth. The resident was also known to shove items such as plastic gloves, paper towels and toilet paper in their mouth.</p> <p>Review of the South Dining Room meal attendance logs revealed on 5/1/18 there were a total of 19 residents scheduled to eat in the back dining room. From the list, 18 were noted as attending breakfast.</p> <p>On 5/7/18 at 2:42 p.m. interview with the cook who worked during breakfast on the morning of 5/1/18 revealed she first dished up food for residents on Pureed diets, then those on Mechanical Soft diets and finally individuals on a Regular diet. After she served up the plates, she left the dining room.</p> <p>Interview with the Dietary Supervisor on 5/8/18 at 11:39 a.m. revealed that even though Resident #1 was on a Mechanical Soft diet for meats only on 5/1/18, the whole croissants served at breakfast that day were considered appropriate for anyone on a Mechanical Soft diet. However since that time, Resident #1's bread was being cut up.</p>	R1024			