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
	775543	A. BUILDING: _____ B. WING _____	C 07/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS ALZHEIMER'S SPECIAL CARE CE	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 #76881-C and Incident #76882-I.	R 000	On behalf of Glen Oaks Alzheimer Special Care, I respectfully submit our Plan of Correction for your approval. Our response is specific to the RCF certification. 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 conclusion set forth in the statement of insufficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Iowa law.	
R 266	481-57.7(5)b General Requirements 481-57.7(135C) General requirements. 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comply with requirements related to notification to the Department found in Iowa Administrative Code 481-chapter 50. Findings include: A review of facility records revealed the facility failed to notify the Department of a suicide attempt as required by Iowa Administrative Code rule 50.7(4). The administrator confirmed this finding. See deficiency under 50.7(5) for details.	R 266	R266 The facility does and will comply with all applicable laws and with the rules of the department. The facility administrator and/or Health Service Director will be notified by facility staff of all resident incidents. The facility administrator or HSD will make the report to the department if the incident meets the self reporting criteria.	
R 826	481-57.22(2) Orientation and Service Plan 481-57.22(135C) Orientation and service plan. 57.22(2) Initial service plan. Within 48 hours of admission, the administrator or the administrator's designee shall develop an initial	R 826		

8/9/18 DD 7/27/18

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R 826	Continued From page 1 service plan to address any immediate health and safety needs. The plan shall be based on information gathered from the resident, family, referring party, primary care provider, and other significant persons. The plan shall be followed until the service plan required in subrule 57.22(3) is complete. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to address all safety needs in the inital 48 hour service plan for 1 of 1 residents reviewed with a history of suicide attempts (Resident #1). Findings include: On 7/01/18 the facility self-reported an incident that involved Resident #1 putting a plastic trash bag over her head resulting in 1:1 staff supervision 24 hours a day. The self-report indicated Resident #1 may have had a previous incident of this type but was unsure of the date. Record review revealed Resident #1 was admitted to the facility on 6/28/18 with a diagnosis of dementia. The resident had previously lived at the facility from 9/27/17 to 2/26/18. Review of Tenant Care Notes from this previous time period revealed on 2/2/18 Resident #1 was found in the shower with the shower hose wrapped around her neck. She was sent to the local hospital and admitted on Level 1 suicide precautions. The resident returned to the facility on 2/13/18. On 2/26/18 Resident #1 was found attempting to cut her wrists with a coffee cup she had broken. Following this last episode Resident #1 was sent to the hospital and discharged from	R 826	This will be monitored through the monthly QA process. R826 The facility does and will initiate a service plan within 48 hours of admission that addresses health and safety needs of each resident. The Health Service Director will develop a service plan within 48 hours of admission. Service plans will be comprehensive for	

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R 826	Continued From page 2 the facility. On 6/28/18 Resident #1 was readmitted to the facility from the hospital. Prior to hospitalization she had been living at home with her husband. The hospital recommended a locked memory care unit for Resident #1. On 7/01/18 at 2:00 p.m. Resident #1 was observed by staff in her room with plastic garbage bags she intended to put over her head in an attempt to commit suicide. On 7/03/18 at 4:22 p.m. review of Resident #1's service plan dated 6/28/18 revealed no mention of previous suicide attempts during the resident's prior residency. On 7/03/18 at 4:25 p.m. the Health Services Director confirmed this finding	R 826	each resident based on information gathered from multiple sources. Any additional information obtained after admission will be added to the working service plan. This will be monitored through the monthly QA process.	
C 148	50.7(5) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(5) When a resident attempts suicide, regardless of injury. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to notify the Department within 24 hours of a suicide attempt for 1of 1 residents	C 148	C148 The facility does and will provide notification to the department within 24 hours of any reportable incident that meets the requirements to include: suicide attempt.	

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C 148	Continued From page 3 reviewed (Resident #1). Findings include: Record review revealed Resident #1 was admitted to the facility on 6/28/18 with a diagnosis of dementia. The resident had previously lived at the facility from 9/27/17 to 2/26/18. Review of Tenant Care Notes from this previous time period revealed on 2/2/18 Resident #1 was found in the shower with the shower hose wrapped around her neck. She was sent to the local hospital and admitted on Level 1 suicide precautions. The resident returned to the facility on 2/13/18. On 2/26/18 Resident #1 was found attempting to cut her wrists with a coffee cup she had broken. Following this last episode Resident #1 was sent to the hospital and discharged from the facility. On 7/10/18 at 10:04 a.m. the Administrator confirmed the Department had not been notified concerning the two attempted suicides on 2/02/18 and 2/26/18.	C 148	Facility staff is to notify the facility administrator or Health Services Director in regards to any incident involving a resident. Administrator or Health Services Director will notify the department within 24 hours of an incident when applicable. This will be monitored through the monthly QA process.	