IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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RODNEY A. ROBERTS, DIRECTOR

March 16, 2015

Ms. Chelsea Tebo, Manager
Floyd Place
403 C Street
Sergeant Bluff, IA 51054

RE: Final Initial Certification Monitoring Evaluation Report – Floyd Place, Sergeant Bluff, IA

Dear Ms. Tebo:

Enclosed is the **Final Initial Certification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following a survey by DIA on **March 9 & 10, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures, Record Checks and Service Plans.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The on-site evaluation demonstrates regulatory compliance by the Program, and the Program's certification will continue for a period of two years, without interruption, from the original date of certification.

Enclosed you will find the Assisted Living Program Certificate **S0343** with effective dates of **September 29, 2014** through **September 28, 2016**. This certificate is to be posted in the building for public viewing.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0343	A. BUILDING _____ B. WING _____	03/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOYD PLACE	403 C STREET SERGEANT BLUFF, IA 51054

(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: 11 Number of tenants with cognitive disorder: 3 Total Population of Program at time of on-site: 14 TOTAL census of Assisted Living Program: The following regulatory insufficiencies were cited during the initial certification conducted to determine compliance with certification for an Assisted Living Program:	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of eye drop administration procedures, the Program failed to follow it's procedures. On 3-9-15 at 11:46 a.m. Staff C was observed	A 003		

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A 003	Continued From page 1 during a medication pass. Staff C prepared to administer eye drops to Tenant #1. Staff C washed hands, applied gloves, used the gloved hands to pour water into the drinking cup, grab the medication cup, walked to Tenant #1's apartment, gave the medication cup and drinking cup to Tenant #1, then administered the eye drops. The process of applying the gloves was not done immediately prior to the administration of the eye drops. After removing gloves and washing hands, Staff C proceeded to Tenant #5. Staff C donned gloves, then touched the medication records. Staff C then administered the eye drops to Tenant #5. Natural Tears, two drops to both eyes, were administered. Staff C did not wait between eye drops to each eye. In a specialized task instruction sheet specific to Tenant #5, hands were to be washed and gloves applied immediately before the tenant was approached for the eye drop instillation. The specialized task instructions also stated if the dose was more than one drop of the same medication, staff was to wait three minutes between drops. The task instruction sheet was signed by the RN and Staff C. The RN was interviewed on 3-9-15 at 12:35 p.m. and stated staff members should put on gloves immediately before instilling eye drops, and should not be using gloved hands to touch objects prior to the administration of the eye drops.	A 003		
A 125	481-67.19(5) Record Checks 481-67.19(135C,231B,231C,231D) Criminal,	A 125		

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A 125	Continued From page 2 dependent adult abuse, and child abuse record checks. 67.19(5) Employment prohibition. A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services. This REQUIREMENT is not met as evidenced by: Based on interview and a review of background checks, the Program employed persons prior to evaluations being performed by the Department of Human Services (DHS). The Program provided an employee list which identified Staff A, who was hired on 1-5-15. The Single Contact Repository (SING) system was utilized and returned results on 1-5-15 that no child abuse or dependent adult abuse records were found. Dated 1-6-15, the SING system identified a criminal record was found. The Program did not provide documentation as to the nature of the the criminal history. The Program failed to provide documentation of evaluations performed by the DHS following identification of a positive criminal history. The employee list identified Staff B who was hired on 11-10-14 The SING system was utilized and returned results on 11-3-14 that revealed no dependent adult abuse records or criminal history was found. The SING system identified a possible child abuse record was found and further evaluation was required. The Program failed to provide documentation of an evaluation performed by the DHS following identification of a possible child abuse record.	A 125		

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A 125	Continued From page 3 On 3-9-15 at 2:55 p.m. an interview was conducted with the Regional Director of Operations. He stated further evaluations had not been completed on the background checks for Staff A and Staff B.	A 125		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the service plans did not meet the specific service needs of tenants. Service plans were not updated when changes were needed. 1. Tenant #1, an 89 year-old, was admitted on 8-28-14 and had diagnoses of: diabetes, depression, and dementia. On 2-24-15, Tenant #1 was staged at three on the Global Deterioration Scale (GDS), which indicated mild cognitive impairment. In an interview with the RN on 3-9-15 at 12:35 p.m., she stated Tenant #1 was admitted to hospice for failure to thrive. According to the physician's plan of care for hospice, Tenant #1 was admitted into hospice on	A 083		

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A 083	Continued From page 4 11-17-14. According to the physician's plan of care (POC) for hospice dated 2-25-15, Tenant #1 had a history of urinary tract infection and cellulitis. The POC noted Tenant #1 had frequent loose stools with antibiotics. Tenant #1's weight had dropped 18 pounds in 90 days with a current body mass index (BMI) of 16% (underweight is generally considered to be a BMI of less than 18%). Documentation revealed Tenant #1 had a poor appetite. The POC went on to document Tenant #1 slept in a recliner and used a cushion for pressure reduction, and that Tenant #1 was at risk for skin breakdown. Tenant #1 had been seeing a podiatrist for debridement of several wounds to the right foot. Heel protectors were used and the feet were elevated to decrease pressure. Tenant #1 also used a cervical collar to keep the neck in an upright position. When sitting in the recliner, the POC documented Tenant #1's ear touched the shoulder. In an interview with the RN on 3-9-15 at 12:35 p.m. she stated Tenant #1 was originally admitted to hospice in November 2014 for failure to thrive. At the time, Tenant #1 was refusing cares, and would not walk or eat. Tenant #1 had given up. Communication was opened with the family and Tenant #1 began to improve. Hospice was going to discharge Tenant #1, but did not due to Tenant #1's weight loss Hospice recertified Tenant #1 for care in February 2015. The RN reported Tenant #1 had shoes that rubbed on the foot. The foot became red, then blistered. Tenant #1 was seen by the physician on more than one occasion. Three open areas developed on the foot. The RN reported currently there was only one area of concern on the foot	A 083		

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A 083	Continued From page 5	A 083		

and Tenant #1 continued visits to the physician. The RN stated Tenant #1 had special shoes and an elastic wrap to the right foot. The RN reported the foot was not to get wet. The RN also reported Tenant #1 had a heel protector when sitting in the recliner.

The RN reported Tenant #1 had hallucinations at night during which Tenant #1 believed a person was talking to him/her through the television. The RN reported Tenant #1 had no further problems once the apartment door was locked.

The RN reported Tenant #1 did have weight loss, and the staff was to report a weight loss of five pounds in one month. Staff was offering fluids, shakes from the kitchen, and ice cream sundaes. Tenant #1 was diabetic, so the intake of sweet foods was watched.

The RN reported Tenant #1 had three urinary infections since admission. The RN also reported Tenant #1 had a history of skin breakdown; the foot, an ear, and redness of the buttocks at times. Tenant #1 had bouts of diarrhea especially noted when Tenant #1 was on antibiotics. The staff were to report areas of redness if noted on Tenant #1's skin.

Resident services notes were reviewed 11-25-14 through 3-9-15. The notes documented urinary infections, the use of antibiotics, diarrhea, an open area on the right ear, the use of special shoes and protectors to the foot, and Tenant #1 not going to the dining room for meals.

Physician orders dated 1-21-15 documented the right foot was not to get wet.

On 3-10-15 at 8:35 a.m. Tenant #1 was observed

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A 083	Continued From page 6 with a cervical collar at the neck and an elastic wrap on the right foot. A review of the current service plan dated 2-24-15 did not identify the use of a special shoe, the heel protector when in the recliner, or the use of the cervical collar. The service plan did not identify Tenant #1 had a history of urinary infection with signs or symptoms for staff to report to the nurse, or a history of skin breakdown with symptoms to report to the nurse especially with episodes of diarrhea. The service plan did not identify staff was to report a weight loss of more than five pounds in one month. The earlier service plan of 11-26-14 revealed no new interventions for weight loss were instituted on 2-24-15 with the continued weight loss. The service plan did not identify Tenant #1 preferred the apartment door locked due to hallucinations. The service plan was not updated with changes and did not meet the specific service needs of Tenant #1. 2. Tenant #3, a 77 year-old, was admitted on 3-29-13 and had diagnoses of: diabetes, anxiety, dementia, gastroesophageal reflux disease, and Parkinson's disease. On 12-19-14, Tenant #3 was staged at five on the GDS which indicated moderately severe cognitive decline. Resident service notes dated 12-12 and 12-17-14 documented Tenant #3 was found on the floor. Service notes dated 12-19-14 documented staff was to do hourly checks on	A 083		

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A 083	Continued From page 7 Tenant #3 for fall prevention. Notes dated 12-23-14 documented Tenant #3 was found sitting on the floor. Notes dated 12-24-14 documented the physician's office reported Tenant #3 would have falls because of the Parkinson's and Tenant #3 was to have fall precautions. Notes of 1-9-15 documented Tenant #3 was found on the floor. Service notes dated 12-22-14 and timed 9:15 p.m. documented Tenant #3 was leaning over the sink, sweating profusely. Tenant #3 complained of chest pain, stomach pain, difficulty breathing, and nausea. Staff called a nurse. Notes timed 11:05 p.m. documented Tenant #3 felt "fine." Service notes dated 3-7-15 documented Tenant #3 was shaking severely and sweating profusely. Tenant #3 complained of chest and stomach pain. The RN was notified and an "as needed" medication for anxiety was given. In an interview on 3-10-15 at 1:30 p.m. the RN stated Tenant #3 exhibited anxiety with symptoms of chest pain and difficulty breathing. Staff would call the nurse when Tenant #3 exhibited the chest pain. Resident services notes dated 2-7-15 and timed 6:15 p.m. documented the Tenant's representative revealed estranged family members were not to visit. A review of the most current service plan dated 12-19-14 documented Tenant #3 would take medication for anxiety per physician's order. The service plan did not identify Tenant #3 exhibited chest pain and difficulty breathing as signs of anxiety, or that staff was to call the nurse. The service plan did not provide direction to staff as to when to use the "as needed" medication.	A 083		

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A 083	Continued From page 8 The service plan dated 12-19-14 documented Tenant #3 would have a staff escort if Tenant #3 was unsteady on the feet. Tenant #3 was found on the floor twice after the completion of the service plan and the interventions were put in place. The hourly checks as documented in the resident service notes were not on the service plan. The service plan for Tenant #3, a cognitively impaired person with Parkinson's disease, documented Tenant #3 was to be re-educated to use the walker at all time. The service plan did not identify visitors were to be restricted. The service plan did not meet the specific service needs of Tenant #3.	A 083		