IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #:
51894-C
52897-I

May 29, 2015

Ms. Jean Greeley, Executive Director
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360-7055

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL RECERTIFICATION & COMPLAINT/INCIDENT INVESTIGATION REPORT - KEELSON HARBOUR ASSISTED LIVING
II. Reduction of Civil Penalty
III. Informal Conference
IV. Standard Certification
V. Conclusion

Dear Ms. Greeley:

I. Final Recertification & Complaint/Incident Investigation Report – Keelson Harbour Assisted Living, Spirit Lake, IA

Enclosed is the **Final Recertification & Complaint/Incident Investigation Report ("Report")** issued 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 an investigation by DIA on **May 12 - 14, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures, Staffing and Service Plans.

A recertification visit and investigation of Complaint #51894-C and Incident #52897-I was completed. There were no regulatory insufficiencies related to the investigation of Complaint #51894-C. There were regulatory insufficiencies cited related to the recertification and the investigation of Incident #52897-I. The regulatory insufficiencies are indicated on the enclosed report.

The following allegation was investigated in regards to Complaint #51894-C:

Allegation: Tenant Rights
Findings: Unsubstantiated
Comments: A community meeting with seven tenants, tenant interviews, staff interviews, review of Program documents and review of six tenant files did not reveal concerns with tenant rights regarding the Program prohibiting visitors or locking tenants in their apartments. The Program obliged tenant requests for ensuring visitors that were not desired in the building were not allowed to be on the property. Observation and staff interviews indicated if a tenant apartment was locked from the outside the tenant would be able to egress from inside the apartment. Staff interviews and review of six tenant files did not reveal concerns with a tenant walking long distances outside the building or with significant tenant weight loss.

Keelson Harbour Assisted Living ("Program") is being assessed a **$5,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

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.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;

(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$5,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, a tenant was injured while riding in the Program's vehicle after the tenant's wheelchair tipped over. The wheelchair had not been appropriately secured and staff had no documented training regarding transporting tenants safely. The tenant required sutures for a skin tear, had multiple abrasions and a fractured rib.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.17(5). If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **three thousand two hundred and fifty dollars ($3,250)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

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.

IV. Standard Certification

The recertification process has not been completed as the policies and procedures for operation have not been submitted. In addition, the State Fire Marshal's (SFM) inspection report has not been received for your program. The certificate will be sent when the process has been completed.

Conclusion

The Program is being assessed a **$5,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

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
	S0258	A. BUILDING: _____ B. WING _____	C 05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEELSON HARBOUR ASSISTED LIVING	2810 AURORA AVENUE SPIRIT LAKE, IA 51360

(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: 41 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 41 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 22 Total Population of Program at time of on-site: 22 TOTAL census of Assisted Living Program: 63 A recertification visit and investigation of Complaint #51894-C and Incident #52897-I was completed. No regulatory insufficiencies were identified related to the investigation of Complaint #51894-C. There were regulatory insufficiencies identified related to the recertification and Incident #52897-I.	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.	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews, observation and review of Program documents, the Program failed to follow the Program's policy and procedure related to transportation regarding an incident with Tenant #1. The Program's policy and procedure regarding transportation indicated tenants would be secured while being transported with adequate seatbelts and securing devices for ambulatory and wheelchair using passengers. The policy and procedure was not followed as Tenant #1 was not secured while being transported and a seatbelt was not used for Tenant #1. Seatbelts had not previously been used when other wheelchair using passengers were transported. The policy and procedure also indicated staff would be trained and documentation of the training would be maintained. The policy and procedure was not followed related to staff training. (Incident #52897-I) 1. Tenant #1, a 91 year old, was admitted on 1-8-14 and had a diagnosis of: memory loss. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #1 resided in the dementia unit. The service plan dated 4-24-15 indicated Tenant #1 needed help to sit up regarding bed mobility and had an assistive device to aid positioning. Tenant #1 required assistance of one staff (two staff at times) with transfers dependent on the time of day and if Tenant #1 was unsteady. Tenant #1 needed assistance to walk and staff	A 003		

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A 003	Continued From page 2 was to ambulate Tenant #1 with the use of a gait belt. Tenant #1 had a wheeled walker and a manual wheelchair. The service plan reflected Tenant #1 needed occasional help with the wheelchair for mobility and Tenant #1 could maneuver on Tenant #1's own. Tenant #1 was on Coumadin and staff was instructed to look for side effects such as a bloody nose, bruising, rectal bleeds and bleeding. 2. According to the Program's Facility Vehicles/Transportation of Residents policy, the Program would identify, verify and document that all staff who drove organization vehicles met applicable legal requirements. The procedure included: every tenant transported would be seated in the vehicle, except for a tenant who remained in a wheelchair during transport. Every tenant would be secured with adequate seatbelts and securing devices for ambulatory and wheelchair using passengers. Wheelchairs would be secured by the driver prior to the vehicle being in motion. Driver requirements included: the Program would keep an updated list of approved drivers and the drivers would have a valid and appropriate Iowa driver's license as required by law for the vehicle being utilized for transport. All approved drivers would complete the appropriate training of the vehicle operations prior to driving the vehicle and would review all vehicle operation at a minimum of annually. The Program would keep a record of all training in the personnel file. 3. The Program's vehicle was observed on 5-14-15. The bus had a capacity for 14 passengers plus the driver. There were two floor restraints in the back of the bus for wheelchairs. Each wheelchair restraint had four locks/hooks.	A 003		

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A 003	Continued From page 3 There were also seatbelts for ambulatory and wheelchair passengers. 4. According to a Program document, Staff A, B and C were listed as drivers of the Program vehicle and were covered by the auto insurance policy. According to Program documents, Staff A, B and C had appropriate driver's licenses for the vehicle (chauffeur's license with a passenger endorsement). 5. According to an incident report dated 4-24-15 at 11:40 a.m., Tenant #1 was returning from the hospital on the Program's bus and the wheelchair tipped over while on the bus. Tenant #1 complained of pain to the right rib area. Tenant #1 had four abrasions to the right side of the skull, two abrasions to the right shoulder, two skin tears to the right ear and approximately a two inch skin tear to the right elbow. According to the incident report, 911 was called and Tenant #1 was transported to the emergency room (ER). 6. According to a Physician's Orders document, Tenant #1's ER orders included: apply Bacitracin twice daily to wounds until healed and Tramadol one to two tablets by mouth every six hours scheduled for three days. The diagnosis was rib fractures and multiple abrasions. According to a Major Injury Determination Form, it was determined to be a major injury by the doctor. 7. According to the wheelchair and occupant securement system driver/operator instruction guide, for the front-rear belts ensure a straight line from the anchorage to the wheelchair attachment, attach to a solid frame member (use webbing loop on areas that were hard to reach with the hook), ensure belts were properly tensioned and tie down anchorage should be	A 003		

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A 003	Continued From page 4 installed with center to center distance. It indicated for lap-shoulder belts to attached the lap and shoulder belt and it should bear upon the bony structure of the body and should be worn low across the front of the pelvis with the junction between the lap and shoulder belts located near the passengers hip. It indicated for the postural belt to place the postural belt around the person, below the arms. It indicated to buckle up around the wheelchair and to make sure the padding was located at chest height. 8. According to an interview on 5-13-15 at 2:13 p.m. and 5-14-15 at 9:14 a.m. with Staff A, she was driving the bus at the time of the incident with Tenant #1. In addition to Staff A, another tenant and the Director of Health Services were on the bus and had gone to a funeral before picking up Tenant #1. Tenant #1 was picked up at the hospital after the funeral. Staff A placed Tenant #1 in the wheelchair location next the window, facing forward and three anchors were secured. The front left anchor was not secured. Staff A said due to the size of Tenant #1 and Tenant #1's wheelchair it was very hard to maneuver between the seat and the back of the bus. Staff A said Tenant #1 was not wearing a seatbelt. They arrived at the Program and she dropped off the Director of Health Services at the front door. As she was turning the corner Tenant #1 fell over to the right. The wheelchair and Tenant #1 had fallen. Staff A stopped the bus, radioed for the Director of Health Services and put a blanket under Tenant #1's head. Staff A said she had not been trained on seatbelts (for wheelchair using passengers) and had not used a seatbelt for Tenant #1 the day of the incident. Staff A said seatbelts had not been used for other tenants in wheelchairs on the bus. Seatbelts for the ambulatory tenants in seats were used. Staff A	A 003		

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A 003	Continued From page 5 indicated Tenant #1 was not secured into the four wheelchair anchors and was not wearing a seatbelt at the time of the incident. 9. According to an interview on 5-14-15 at 9:08 a.m. with Staff B, she had not received training on the seatbelts and seatbelts were not used in transporting tenants in wheelchairs prior to the incident with Tenant #1. Staff B said the restraints were attached to the wheelchair frame and four were attached for each wheelchair. 10. According to an interview on 5-13-15 at 12:00 p.m. with Staff C, prior to the incident with Tenant #1, no one used seatbelts for tenants in wheelchairs. Staff C said a wheelchair passenger should be secured and anchored at four points on the frame of the wheelchair. 11. There was no training documented for Staff A, B or C for transporting tenants using the Program's vehicle as indicated in the Program's policy.	A 003		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants ' identified needs. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews, observation and review of Program documents the Program failed to provide sufficient training for staff regarding transporting tenants in a Program	A 055		

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A 055	Continued From page 6 vehicle for three staff (Staff A, B and C). Tenant #1 was riding in the Program's vehicle, the wheelchair tipped over and Tenant #1 sustained injuries. Tenant #1's wheelchair was not secured appropriately on the bus and Tenant #1 was not wearing a seatbelt. Three staff who drove the vehicle, including the driver at the time of Tenant #1's incident, did not have sufficient training on the vehicle and transporting tenants. (Incident #52897-I) 1. Tenant #1, a 91 year old, was admitted on 1-8-14 and had a diagnosis of: memory loss. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #1 resided in the dementia unit. The service plan dated 4-24-15 indicated Tenant #1 needed help to sit up regarding bed mobility and had an assistive device to aid positioning. Tenant #1 required assistance of one staff (two staff at times) with transfers dependent on the time of day and if Tenant #1 was unsteady. Tenant #1 needed assistance to walk and staff was to ambulate Tenant #1 with the use of a gait belt. Tenant #1 had a wheeled walker and a manual wheelchair. The service plan reflected Tenant #1 needed occasional help with the wheelchair for mobility and Tenant #1 could maneuver on Tenant #1's own. Tenant #1 was on Coumadin and staff was instructed to look for side effects such as a bloody nose, bruising, rectal bleeds and bleeding. According to Resident Notes dated 4-23-15, Tenant #1 had a syncopal episode and was sent to the emergency room (ER). Resident Notes dated 4-24-15 indicated Tenant #1 stayed overnight for a syncopal episode and nothing was found. According to Resident Notes dated	A 055		

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A 055	Continued From page 7 4-24-15, Tenant #1 was returning from the hospital in the bus when Tenant #1's wheelchair tipped over. Tenant #1 was assessed and complained of right side pain. Tenant #1 had a skin tear on the right arm that measured two inches by three inches that looked to require sutures. Tenant #1 also had several abrasions to the head and right ear. Tenant #1 was able to move Tenant #1's legs and arms, was assisted up and back in the wheelchair. Tenant #1 was taken by ambulance to the ER and had sutures to the right arm and an x-ray showed a fractured rib. Tenant #1 returned with an order for Tramadol and Bacitracin. According to Resident Notes dated 4-25-15, Tenant #1 had neurological checks completed every four hours and Tenant #1 complained of pain with movement from the fractured rib. Resident Notes dated 4-30-15 indicated Tenant #1's elbow dressing was changed, the area was healing well and there was a small scab starting to form over the wound. Tenant #1 did not mention rib discomfort at that time and the head wounds were almost healed completely. Resident Notes dated 5-4-15 indicated Tenant #1's elbow was healing well but was tender. Tenant #1's shirt was removed and Tenant #1 did not complain of any pain from the rib area. Tenant #1's wounds on the head and face had healed. 2. According to the Program's Facility Vehicles/Transportation of Residents policy, the Program would identify, verify and document all staff who drove organization vehicles met applicable legal requirements. The procedure included: every tenant transported would be seated in the vehicle, except for a tenant who remained in a wheelchair during transport. Every tenant would be secured with adequate seatbelts and securing devices for ambulatory and	A 055		

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A 055	Continued From page 8 wheelchair using passengers. Wheelchairs would be secured by the driver prior to the vehicle being in motion. Driver requirements included: the Program would keep an updated list of approved drivers and the drivers would have a valid and appropriate Iowa driver's license as required by law for the vehicle being utilized for transport. All approved drivers would completed the appropriate training of the vehicle operations prior to driving the vehicle and would review all vehicle operation at a minimum of annually. The Program would keep a record of all training in the personnel file. 3. The Program's vehicle was observed on 5-14-15. The bus had a capacity for 14 passengers plus the driver. There were two floor restraints in the back of the bus for wheelchairs. Each wheelchair restraint had four locks/hooks. There were also seatbelts for ambulatory and wheelchair passengers. There was a two passenger seat in front of one of the wheelchair restraint locations on the left side of the bus (if facing front when seated on the bus). The seat folded up when observed. According to a driving directions website, the approximate distance between the Program and the hospital was 0.9 miles and the estimated travel time was 2 minutes. 4. According to a Program document, six tenants used wheelchairs on a routine basis and four tenants used wheelchairs as needed. According to a Program document, Staff A, B and C were listed as drivers of the Program vehicle and were covered by the auto insurance policy. According to Program documents, Staff A, B and C had appropriate driver's licenses for the vehicle	A 055		

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A 055	Continued From page 9 (chauffeur's license with a passenger endorsement). 5. According to an incident report dated 4-24-15 at 11:40 a.m., Tenant #1 was returning from the hospital on the Program's bus and the wheelchair tipped over while on the bus. Tenant #1 complained of pain to the right rib area. Tenant #1 had four abrasions to the right side of the skull, two abrasions to the right shoulder, two skin tears to the right ear and approximately a two inch skin tear to the right elbow. According to the incident report, 911 was called and Tenant #1 was transported to the ER. 6. According to a Physician's Orders document, Tenant #1's ER orders included: apply Bacitracin twice daily to wounds until healed and Tramadol one to two tablets by mouth every six hours scheduled for three days. The diagnosis was rib fractures and multiple abrasions. According to a Major Injury Determination Form, it was determined to be a major injury by the doctor. 7. According to the wheelchair and occupant securement system driver/operator instruction guide, for the front-rear belts ensure a straight line from the anchorage to the wheelchair attachment, attach to a solid frame member (use webbing loop on areas that were hard to reach with the hook), ensure belts were properly tensioned and tie down anchorage should be installed with center to center distance. It indicated for lap-shoulder belts to attached the lap and shoulder belt and it should bear upon the bony structure of the body and should be worn low across the front of the pelvis with the junction between the lap and shoulder belts located near the passengers hip. It indicated for the postural belt to place the postural belt around the person,	A 055		

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
	S0258	A. BUILDING _____ B. WING _____	C 05/14/2015

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A 055	Continued From page 10 below the arms. It indicated to buckle up around the wheelchair and to make sure the padding was located at chest height. 8. According to an interview on 5-13-15 at 2:13 p.m. and 5-14-15 at 9:14 a.m. with Staff A, she drove the bus twice a week prior to the incident with Tenant #1. After the incident with Tenant #1 Staff A had not driven the bus. Regarding vehicle training, Staff A observed Staff C and he showed her how to run the lift and how to secure a wheelchair one time. There was no additional training provided and there was no documented training. Staff A had not been trained on seatbelts and had not used a seatbelt for Tenant #1 at the time of the incident. Staff A said seatbelts had not been used for other tenants in wheelchairs on the bus. Staff A did not know the seat in front of the wheelchair anchors flipped up and she had no training on the seat prior to the incident. She said seatbelts for the ambulatory tenants in seats were used. Regarding the incident with Tenant #1, she was the bus driver and another tenant and the Director of Health Services were on the bus and had gone to a funeral. Tenant #1 was picked up at the hospital after the funeral. Staff A placed Tenant #1 in the wheelchair location next the window, facing forward and three anchors were secured. The front left anchor was not secured. Staff A said due to the size of Tenant #1 and Tenant #1's wheelchair it was very hard to maneuver between the seat and the back of the bus. Staff A said Tenant #1 was was not wearing a seatbelt. They arrived at the Program and she dropped off the Director of Health Services at the front door. As she was turning the corner Tenant #1 fell over to the right. The wheelchair and Tenant #1 had fallen. Staff A stopped the bus,	A 055		

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A 055	Continued From page 11 radioed for the Director of Health Services and put a blanket under Tenant #1's head. 9. According to an interview on 5-12-15 at 3:39 p.m. and 5-14-15 at 9:08 a.m. with Staff B, she drove for outings and would fill in for transportation to doctor appointments. Regarding vehicle training, Staff B observed Staff C and then Staff C observed Staff B. She observed Staff C secure a wheelchair twice. Staff B said the restraints were attached to the wheelchair frame and four were attached for each wheelchair. Staff B said she used three restraints one time when she could not get around to get the front anchor. At no other times did she use less than four restraints. She had not received training on the seatbelts (wheelchair passengers) and seatbelts were not used in transporting tenants in wheelchairs prior to the incident with Tenant #1. Staff B did not know the seat in front of the wheelchair anchors could be folded up prior to the incident with Tenant #1. Staff B had not received training on the seat prior to the incident with Tenant #1. Staff B said she was not sure the training completed prior to the incident with Tenant #1 was adequate. The training after the incident with Tenant #1 was adequate and she felt comfortable. Staff B was working in the kitchen on the day of the incident with Tenant #1. There was a funeral for a tenant in the dementia unit and on the way back from the funeral they stopped to pick up Tenant #1 from the hospital. Staff A called on the walkie talkie and asked for a nurse on the bus. Tenant #1 had fallen out of the wheelchair. After the fact Staff B heard Tenant #1 tipped over on the bus in Tenant #1's wheelchair. Staff B did not know why Tenant #1 tipped over but when Staff A went around the corner in the parking lot Tenant	A 055		

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A 055	Continued From page 12 #1 had tipped. 10. According to an interview on 5-13-15 at 12:00 p.m. with Staff C, when he first started working at the Program there was no training on the bus or transporting tenants provided. Staff C was told by previous administrative staff he was a "smart guy figure it out." Staff C looked at the owner's manual but did not have any formal training related to transporting tenants using the Program vehicle. Staff C said training was in process after the incident with Tenant #1. Staff A, B and C were allowed to drive the bus. Since the incident with Tenant #1, Staff B and Staff C would be the driving the bus. Staff C said he trained Staff B, had her drive the bus and back the bus up using the mirrors. Staff C took a wheelchair in the bus and showed Staff B how to hook it up. Staff C did the same training with Staff A. Staff C said a wheelchair passenger should be secured and anchored at four points on the frame of the wheelchair. Staff C said Staff A and Staff B were showed how to anchor the wheelchairs. Prior to the incident with Tenant #1, no one was using seatbelts for tenants in wheelchairs. There was no documented training regarding transportation, the bus or wheelchairs. Staff C said the education going forward would be sufficient. Staff C said on the day of the incident with Tenant #1 he was getting ready to leave and the Director of Health Services called for assistance. Tenant #1 was lying on Tenant #1's right side on the bus. Tenant #1 had tipped towards the wheelchair lift and was still in the wheelchair. The Director of Health Services assessed the situation and Tenant #1 could move Tenant #1's legs. The wheelchair was slid out and they sat Tenant #1 up. The Director of Health Services asked Tenant #1 a lot of questions and Staff C and the	A 055		

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A 055	Continued From page 13 Director of Health Services stood Tenant #1 up. Tenant #1 had a cut on Tenant #1's elbow, Tenant #1's ear was bleeding and Tenant #1 complained of pain on Tenant #1's side. Staff C was not on the bus when the incident happened. Staff C said after the weekend Staff A demonstrated to staff how Tenant #1 was strapped in at the time of the incident. The wheelchair was anchored at two points, there were no anchors on the left side and no seatbelt was used. Staff C said regarding the incident with Tenant #1 four anchors were not used to secure the wheelchair and he did not know why all four anchors were not used. A shoulder belt was also not applied. 11. According to an interview on 5-14-15 at 11:01 a.m. with the Director of Health Services, they went to a funeral and stopped to pick up Tenant #1. Another tenant, Staff A and the Director of Health Services were on the bus. Staff A put Tenant #1 on the bus facing forward. She could not attest to how many anchors were used but knew two were used for sure. She heard Staff A tighten the anchors and observed the outside tethers. They proceeded to travel to the Program and pulled up to the front of the building and she got out. She heard staff report Staff A needed help. She went to the bus and Tenant #1 was on Tenant #1's side and the wheelchair was underneath Tenant #1. Straps were on the wheelchair and there were two on at that time. Tenant #1 said Tenant #1's side hurt and Tenant #1 could move Tenant #1's extremities. The wheelchair was removed and Tenant #1 was assisted up by the Director of Health Services and Staff C. She completed an assessment of Tenant #1. Tenant #1's spouse was agreeable to send Tenant #1 to the ER. When Tenant #1 returned neurological checks were completed every 4 hours for 24 hours and then once every	A 055		

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A 055	Continued From page 14 24 hours until completed. The Director of Health Services stayed Friday night through Saturday afternoon and completed the neurological checks until a licensed practical nurse arrived at 2:00 p.m. The neurological checks did not reveal any concerns. Tenant #1 had discomfort when Tenant #1 got up and down. Tenant #1 was sleepy from the Tramadol as Tenant #1 was not used to pain medications. 12. According to an interview on 5-14-15 at 12:00 p.m. with the Executive Director, she was out of town and received a telephone call from the Director of Health Services regarding the incident with Tenant #1. The Executive Director said Tenant #1 was in the hospital and was ready to come back (the hospital did transport people back). Staff A, another tenant and the Director of Health Services were on the bus. Staff A secured Tenant #1 in with three straps and dropped off the Director of Health Services at the door. Staff A heard a loud noise and called for help. The Director of Health Services came out immediately, 911 was called and Tenant #1 was made comfortable. Tenant #1 sustained a rib fracture, scrapes, a skin tear (arm) and cuts/abrasions. On the following Monday the Executive Director returned and met with Tenant #1. Tenant #1 had started to heal and the injuries were well treated. The Executive Director talked with Tenant #1, Tenant #1's spouse and family. Regarding current status she said Tenant #1 was not showing any signs of pain and there was not any evidence of redness outside of a scratch. The Executive Director said there was no documented training regarding transportation for Staff A, B or C prior to the incident with Tenant #1. Staff A, B, C and the Executive Director went to the bus and had Staff A demonstrate what	A 055		

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A 055	Continued From page 15 happened. The Executive Director said it was impossible to get the fourth anchor latched with the wheelchair and she was not able to latch it with four anchors. The Executive Director said none of the drivers knew the seat in front of the wheelchair restraints could fold up. She said none of the staff had used shoulder seatbelts prior to the incident with Tenant #1. She said Staff A would not be driving the bus and Staff C would be the designated trainer going forward with the new training program. 13. There was no training documented for Staff A, B or C for transporting tenants using the Program's vehicle including: seatbelts for ambulatory and wheelchair passengers, securing wheelchairs on the bus and operating the lift. 14. According to a Program document, after the incident with Tenant #1 there were changes that were made immediately and those included: the bus was taken to a car dealership for inspection and to assure all seatbelts and straps were functioning appropriately. The bus was removed for use for tenant transportation and the Program paid for tickets with a local transit company for the tenants to go to appointments within city limits. There would be new training for the Executive Director, the designated trainer and drivers and a new policy would be developed. According to a Program document, the planned bus driver training included: the transportation policy would be finalized using the Fleet Safety Program and Q'Straint from the Program's bus. Training would include a video on lift safety and a video on securement, both regular lap and shoulder belts and securing the wheelchair. Drivers would take a quiz and return demonstration which would show they understood	A 055		

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A 055	Continued From page 16 how to use the lift safely, secure tenants in seatbelts and secure tenants in wheelchairs. A Fleet Safety Program would also be used to train the Executive Director and designated trainer on corporate expectations of knowledge and awareness of bus safety. The training would include the role and responsibility of the drivers, Executive Director, fleet coordinator and senior management in the quest for "Zero" accidents. It would also include expectations for reporting an accident, vehicle inspection and maintenance. An Acknowledgement and Consent Agreement would be signed and kept in the personnel file. Additional documents were provided including a Q'Straint Wheelchair and Occupant Securement System Training Record and certificate for the completion of the training program. The Acknowledgement and Consent Agreement was also provided.	A 055		
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 review of tenant files and Program documents the Program failed to develop service plans that were individualized and indicated at a minimum tenants' identified needs and preferences for assistance for four of six tenant files reviewed (Tenants #2, #3, #4 and #5). Four tenant files reviewed did not have service plans that reflected the tenants' identified needs and	A 089		

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A 089	Continued From page 17 preferences for assistance. (Recertification) 1. Tenant #2, an 88 year old, was admitted on 10-1-13 and had a diagnosis of: memory loss. Tenant #2 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #2 resided in the dementia unit. The service plan dated 1-20-15 reflected Tenant #2 transferred without assistance and ambulated independently with a walker. The service plan reflected Tenant #2 received well being checks. Tenant #2 had physical therapy; however, it was discontinued dated 3-17-15. Review of incident reports for the past three months revealed Tenant #2 had 12 incident reports for falls from 2-21-15 to 4-27-15. Two incident reports were noted as falls with injuries. The service plan did not reflect Tenant #2 had falls and interventions related to the falls. Tenant #2 refused all of Tenant #2's 8:00 p.m. medications on 4-2-15, according to a Program document dated 4-8-15. Tenant #2 refused Tenant #2's medications at least once a day from the 15th through the 21st, according to a Program document dated 4-22-15. It was noted Tenant #2 had been resistive in the evening taking Tenant #2's medications. The time of the 8:00 p.m. medications was changed to 6:30 p.m., according to a Program document dated 4-23-15. Tenant #2 refused all 8:00 a.m. medications, according to a Program document dated 5-1-15. According to a Program document dated 5-5-15, Tenant #2 refused Tenant #2's evening medications on 5-1-15 and 5-4-15. Tenant #2 refused all of	A 089		

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A 089	Continued From page 18 Tenant #2's 8:00 p.m. medications, according to a Program document dated 5-5-15. The service plan dated 1-20-15 was updated on 3-20-15 and reflected Tenant #2 was more resistant, staff was to redirect and if that did not work to leave Tenant #2 alone and keep other tenants away from Tenant #2. The service plan reflected Tenant #2 was more resistant; however, did not reflect Tenant #2 refused medications and interventions related to the refusals. The service plan did not reflect the identified needs of Tenant #2. 2. Tenant #3, an 86 year old, was admitted on 8-30-08 and diagnoses included: dementia and diabetes. Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #3 resided in the dementia unit. The service plan dated 4-16-15 reflected Tenant #3 transferred without assistance and ambulated independently with a walker. Incident reports for the past three months revealed Tenant #3 had five incident reports for falls from 2-14-15 to 5-1-15. Three incident reports were noted as falls with injuries. The service plan did not reflect Tenant #3 had falls and interventions related to the falls. The service plan did not reflect the identified needs of Tenant #3. 3. Tenant #4, a 90 year old, was admitted on 7-28-07 and diagnoses included: hyperthyroidism, atrial fibrillation, cerebral vascular accident and depressive disorder. The service plan dated 1-31-15 reflected medications were administered by staff. Resident Notes dated 4-8-15 indicated Tenant #4 went to the doctor on 4-7-15 and came back with new orders to start Artificial Tears eye drops. The service	A 089		

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A 089	Continued From page 19 plan did not reflect staff administered Tenant #4's eye drops. The service plan did not reflect the identified needs of Tenant #4. 4. Tenant #5, an 89 year old, was admitted on 11-8-14 and diagnoses included: hypertension, chronic abdominal pain, depressive disorder, fatigue and hypokalemia. Tenant #5 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #5 resided in the dementia unit. Tenant #5 received hospice services. The service plan dated 4-28-15 indicated Tenant #5 had bladder incontinence, needed reminders/help to use the bathroom through the day and night. The service plan also reflected Tenant #5 had an area on the right buttocks that was open and measured 0.4 by 0.4 centimeters. According to Resident Notes dated 3-23-15, Tenant #5 was started on Bactrim DS twice a day for five days. It was a discretionary change due to chronic urinary tract infection (UTI). Resident Notes dated 3-30-15 indicated the course of antibiotics was finished. According to Resident Notes dated 5-12-15, Tenant #5 completed a round of antibiotics and exhibited no signs of infection. The service plan did not reflect Tenant #5 had chronic UTIs and interventions related to the UTIs. According to Resident Notes dated 4-6-15, hospice brought in a skin moisturizer cream and a skin protectant cream to use twice daily on Tenant #5's buttocks to help prevent sores and rash. The service plan reflected Tenant #5 had an open area on the right buttocks; however, did not reflect interventions and treatment of the open area. The service plan did not reflect the identified needs of Tenant #5.	A 089		

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A 089	Continued From page 20 5. According to the Program's service plan policy, a service plan would be developed that provided the tenant's need of services.	A 089		

June 1, 2015

Department of Inspections and Appeals
Attn: Jim Friberg
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Mr. Friberg:

On behalf of Keelson Harbour Assisted Living, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Recertification and Complaint/Incident Report dated May 29, 2015. 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 conclusions 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.

Programs Policies and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Bus was taken out of service until staff received appropriate training.
    - Tenant #1's wheelchair, and any tenant using a wheelchair, will be appropriately secured when being transported on the bus.
    - Staff A no longer drives the bus.
    - Staff B and C were trained on the Transportation Policy by the Executive Director on May 19, 2015. Training is documented.
    - Staff B and C, and all new hires who will drive the bus will be trained on how to secure a wheelchair in the van by watching The QRT DVD by Q'Straint, the maker of the securement system, reading the Workbook for Trainees, and completing Review Questions. The Review Questions are signed and dated. A return demonstration was conducted and documented.

2. What measures will be taken to ensure the problem does not recur.
    - All staff responsible for transportation will receive training prior to operating vehicle on transportation policy, proper use of securement equipment, including a return demonstration . Training will be done by Maintenance Director and/or designee. Documentation will be kept showing completion of training and return demonstration.

3. How the Program plans to monitor performance to ensure compliance.
    - The Executive Director or designee will monitor for compliance at least annually by reviewing documentation of training and return demonstrations of all staff who drive the bus.

4. The date by which the regulatory insufficiency will be corrected.
    - Keelson Harbour will be in compliance by June 30, 2015.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Bus was taken out of service until staff received appropriate training.
    - Tenant #1's wheelchair, and any tenant using a wheelchair, will be appropriately secured when being transported on the bus.
    - Staff A no longer drives the bus.
    - Staff B and C were trained on the Transportation Policy by the Executive Director on May 19, 2015. Training is documented.
    - Staff B and C, and all new hires who will drive the bus will be trained on how to secure a wheelchair in the van by watching The QRT DVD by Q'Straint, the maker of the securement system, reading the Workbook for Trainees, and completing Review Questions. The Review Questions are signed and dated. A return demonstration was conducted and documented.

2. What measures will be taken to ensure the problem does not recur.
    - All staff responsible for transportation will receive training prior to operating vehicle on transportation policy, proper use of securement equipment, including a return demonstration . Training will be done by Maintenance Director and/or designee. Documentation will be kept showing completion of training and return demonstration.

3. How the Program plans to monitor performance to ensure compliance.
    - The Executive Director or designee will monitor for compliance at least annually by reviewing documentation of training and return demonstrations of all staff who drive the bus.

4. The date by which the regulatory insufficiency will be corrected.
    - Keelson Harbour will be in compliance by June 30, 2015.

Service Plan

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #2, 3, 4, and 5 service plans, will be updated to reflect their identified needs. Updates to the service plan will be made by an RN.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and designee will be re-educated on Iowa regulatory requirements for service plan.

- Staff will be re-educated to communicate concerns that differ from the norm or from the current service plan using the Staff Communication Report form.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN will review tenant incident reports and staff communication reports at least weekly. The RN will follow-up with a nurse review, assessment, or service plan update if concerns are identified.
    - The RN or designee will review at least every 90 days when completing the 90-day nurse review. This process will include review fall history. In addition, this process will include ensuring the service plan includes identified tenant needs and services to be provided.

4. The date by which the regulatory insufficiency will be corrected.
    - Keelson Harbour will be in compliance by June 30, 2015.

Please contact me at 712-336-4501 with any questions you have. Thank you.

Sincerely,

Jean Greeley
Executive Director