IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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321 East 12th Street
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

April 20, 2015

Mr. Ryan Larmore, Director
Reflections AL
512 13th Street
Wellman, IA 52356

**RE: Final Recertification Monitoring Evaluation Report – Reflections AL, Wellman, IA**

Dear Mr. Larmore:

Enclosed is the **Final Recertification 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 **April 8, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Staffing 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 recertification process has not been completed. 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.

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 |
|---|---|---|---|
| | S0168 | A. BUILDING. _____ B. WING _____ | 04/08/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REFLECTIONS ASSISTED LIVING | 512 13TH STREET WELLMAN, IA 52356 |

| (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<br><br>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.<br><br>Dementia-Specific Program by Dedication<br><br>Number of tenants without cognitive disorder: 6<br>Number of tenants with cognitive disorder: 8<br>Total Population of Program at time of on-site: 14<br><br>TOTAL census of Assisted Living Program: 14<br><br>The following regulatory insufficiencies were cited during the Recertification conducted to determine compliance with certification for an Assisted Living Program. | A 000 | | |
| A 055 | 481-67.9(1) Staffing<br><br>481-67.9(231B,231C,231D) Staffing.<br>67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants ' identified needs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation of a medication pass and review of medication delegation, staff did not wash hands at the beginning and end of each medication pass.<br><br>Per review of Staff A's medication pass, Staff A did not wash hands per the delegation of Administration of Oral Medications.<br><br>On 4-8-15 at 11:55 a.m., Staff A initiated a | A 055 | | |

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| A 055 | Continued From page 1<br>medication pass. Staff A washed hands in the kitchen sink, proceeded to the medication room, unlocked the door and removed the medication cart. Staff A checked the Medication Administration Record (MARs) for Tenant #1. She punched the medication from the bubble pack, gave the medication to Tenant #1 and documented on the MAR. Staff A prepared Tenant #2's medications and gave them to Tenant #2. She observed Tenant #2 swallow the medications and documented on the MAR. Staff A used hand sanitizer and prepared Tenant #3's medication, gave to Tenant #3, observed swallowing and documented on the MAR. Staff A prepared Tenant #4's medication, gave to Tenant #4, observed swallowing and documented on the MAR.<br><br>According to Staff A's Checklist for Administration of Oral Medications, dated 7-30-14, the first step in medication administration was to wash hands. The last step after administration was to wash hands. Staff A washed her hands prior to the medication pass and used hand sanitizer between Tenant #2 and Tenant #3. Staff A did not follow the expectations for hand washing as outlined in the Checklist for Administration of Oral Medications. | A 055 | | |
| A 089 | 481-69.26(4)a Service Plans<br><br>481-69.26(231C) Service plans.<br>69.26(4) The service plan shall be individualized and shall indicate, at a minimum:<br>a. The tenant ' s identified needs and preferences for assistance<br><br>This REQUIREMENT is not met as evidenced | A 089 | | |

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| A 089 | Continued From page 2<br>by:<br>Based on review of tenant files, service plans were not individualized to reflect the tenant's identified needs and preferences for assistance.<br><br>Per review of Tenants' #3 and #5 files, service plans were not individualized to reflect identified needs and preferences for assistance.<br><br>1. Tenant #3, an 87 year old, was admitted on 2-10-14 and diagnoses included: pneumonia, mitral valve regurgitation, renal failure, osteoarthritis, bladder carcinoma, hernia, hypertension and congestive heart failure. According to Tenant #3's service plan, Tenant #3 had a urostomy bag and emptied bag independently. Nurse would change urostomy bag as needed. Tenant #3 was independent with connecting night bag for sleeping. Companions would cleanse night bag as needed. A review of Tenant #3's Treatment Administration Records (TARs) for January through April 2015, indicated to cleanse bed bag every morning with vinegar/water 50/50 solution. The vinegar/water 50/50 solution was to be changed weekly on Sundays. The service plan did not reflect the same information as the TAR in regards to cleansing instructions. The service plan did not reflect the need to cleanse the night bag daily and to clean with a 50/50 vinegar and water solution. (A physician order for the treatment and cleansing instructions was not available.) Tenant #3's service plan was not individualized to reflect Tenant #3's identified needs and preferences for assistance.<br><br>2. Tenant #5, a 93 year old, was admitted on 11-3-14 and diagnoses included: anxiety, Alzheimer's polymyalgia and rheumatic osteoarthritis. Tenant #5 was staged at a four on | A 089 | | |

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| A 089 | Continued From page 3<br>the Global Deterioration Scale which indicated moderate cognitive decline. According to Physician's Telephone Orders dated 12-10-14, the physician ordered Tenant #5 receive wound care every day, clean with saline and cover with petroleum jelly, dressing covered in nonstick bandage until healed. According to Tenant #5's December MARs, the dressing change began on 12-10-14 and was performed daily through 12-13-14 at which time the treatment was discontinued as the wound was healed. According to a review of Tenant #5's Tenant Unobserved Incident Reports, on 2-27-14 (2015) Tenant #5 was found sitting on the floor by the bed, Tenant #5 stated had slid off bed when trying to get up; on 3-11-15, staff heard a thump and then a call for help, found Tenant #5 on the floor; on 4-8-15, the nurse heard someone saying "help me" and found Tenant #5 sitting on floor with feet out in front, small skin tear on right elbow. Tenant #5's service plan was not updated to reflect the initiation of wound care, the discontinuation of wound care, a history of falls and interventions to prevent falls. Tenant #5's service plan was not individualized to reflect Tenant #5's identified needs and preferences for assistance. | A 089 | | |

Plan of Correction for Regulatory Insufficiencies received 4/20/15:

RI: Staffing A055

1. Staff A will be re-trained to wash hands per the delegation of Administration of Oral Meds by 5/8/15.
2. All universal workers will be re-trained to wash hands per the delegation of Administration of Oral Meds.
3. The DON or designee will randomly audit 1 medication pass per week for 4 weeks to assure hand washing per delegation of Administration of Oral Meds.
4. Date of Correction by: 5/8/15

RI: Service Plans A089

1. Tenant #5 has been moved to the NF so no longer resides in the Assisted Living Facility. Tenant #3's service plan will be reviewed and updated to assure identified needs and preferences for assistance are included by 5/8/15.
2. All service plans will be reviewed and revised as needed to reflect identified needs and preferences for assistance.
3. DON or designee will randomly audit 2 service plans/week for 4 weeks to assure they reflect identified needs and preferences for assistance.
4. Date of Correction by 5/8/15