IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

September 29, 2015

Incident Intake #: 55079-I

Ms. Amanda Brewer, Administrator
Swan Place
1024 E. 12th Street
Carroll, IA 51401

RE: Final Incident Investigation & Initial Certification Monitoring Evaluation Report – Swan Place, Carroll, IA

Dear Ms. Brewer:

Enclosed is the **Final Incident Investigation & 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 **September 14 - 17, 2015.**

The following areas were investigated during the investigation of the self-reported Incident #55079-I.

Allegation: Tenant Rights
Findings: Not substantiated
Comments: Based on observations, record review and tenant interviews, it could not be determined Tenants' rights concerning kind and considerate care were violated. Tenants were encouraged to exercise their rights that included sitting out in the courtyard of the Program. Observations revealed several tenants doing so. Tenant interviews revealed tenants were happy with the way they were treated by staff. Tenants reported in interview that they also felt staff is well trained and aware of their responsibilities that included treating tenants with dignity and respect.

Allegation: Service plans
Findings: Not substantiated
Comments: Based on observation, record review and staff interview, the Tenant involved with Incident #55079-I was able to make her needs known as noted in the Tenant's service plan. The tenant had a GDS score of 2. Interview with the Tenant revealed the Tenant was able to recall the incident and referenced the use of the pendent when outside in the courtyard of the Program. The Tenant recalled thinking she had pushed the button on the pendent to alert the staff on the inside of the Program she was ready to come back inside. Review of the call system revealed the button

on the pendent had not been pushed as the Tenant thought. The actual pendent worn by the Tenant worked when tested during this investigation. Record review revealed the Tenant had recently demonstrated the ability to activate the pendent when it was necessary. The Tenant had sat out on the courtyard days before the last reported incident without incident. This was also consistent with staff interviews that revealed when the Tenant was ready to come in, she pushed the button on the pendent to alert staff that she was ready to come in. The Tenant had done this several times without incident. On the date in question, none of the involved staff indicated that the Tenant's going outside to sit in the courtyard would have been viewed as contraindicated or ill-advised. All staff interviews viewed the Tenant as capable of letting staff know when she wanted to return inside. Staff interviews also revealed the Tenant would have been able to maneuver the wheelchair independently back under the canopy to get out of the sun. The Tenant's family reported in interview they encouraged the Tenant to sit out in the courtyard and viewed it as a healthy alternative to sitting indoors. It appeared the Tenant had fallen asleep and staff had become preoccupied when another Tenant had complaints of difficulty breathing that required calling 911. Staff lost track of time and had not gotten back to the Tenant. Tenant interviews revealed staff were good, well trained, caring and there were enough staff to assist the tenants. On the date of this incident there were two staff working.

During the investigation of Incident #55079-I there were no regulatory insufficiencies cited regarding Tenants' Rights and or Service Plans. However, the following concern was identified during the investigation of the incident that occurred on 9/05/15;

Based on policy and procedures review, incident report review and staff interview, the Program failed to follow their policy and procedures related to the reporting on incidents. The Report notes a Regulatory Insufficiency in the area(s) of: Program policies and procedures.

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 or a contested case hearing 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.

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
	S0349	A. BUILDING: _____ B. WING _____	C 09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWAN PLACE	1024 E 12TH STREET CARROLL, IA 51401

(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: 29 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 31 TOTAL census of Assisted Living Program: 31 The following regulatory insufficiency was cited during the investigation of self reported Incident #55079-I. In addition, there were no regulatory insufficiencies cited during the initial survey conducted to determine compliance with certification for an Assisted Living Program.	A 000		
A 004	481-67.2(1)a 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. 67.2(1) The program ' s policies and procedures on incident reports, at a minimum, shall include the following: a. The program shall have available incident report forms for use by program staff.	A 004		

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A 004	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on policy and procedures review, incident report review and staff interview, the Program failed to follow it's policy and procedures related to the reporting on incidents. Findings include; On 9/09/15 the Program reported an incident to the Department that involved first and second degree burns to Tenant #1's legs. On 9/16/15 at 9:40 a. m. Incident report review failed to locate an incident report for the 9/05/15 incident that involved Tenant #1. On 9/16/15 at 9:45 a.m. record review revealed Tenant #1 was a 92 year old, admitted to the Program on 12/05/14, with a diagnoses of hypertension and osteoporosis. The Tenant had a GDS score of 2, indicating very mild cognitive impairment. On 9/05/15 Tenant #1 requested to sit in the Program's courtyard. Staff assisted Tenant #1 outside. Following Tenant #1's return back inside the Program, staff realized Tenant #1 had areas to the legs that appeared sunburned. Tenant #1's family requested the Tenant be transported to the emergency room for evaluation. Review of the Emergency Room records revealed a complaint of sun exposure. Tenant #1 also had a urinary tract infection (UTI), was dehydrated and suffered redness and blisters on his/her inner thighs. On 9/15/15 at 8:00 interview with Staff B revealed an incident report concerning the incident on	A 004		

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A 004	Continued From page 2 9/05/15 that involved Tenant #1 had not been completed. On 9/15/15 at 2:07p.m. review of the Program's Incident reporting policy revealed incident reporting guidelines for the communication of adverse events. The policy indicated the universal incident report form should be completed as soon as possible after an incident occurs. The employee who observes or first becomes aware of an incident should begin the incident report form. Community incident reporting guidelines defined an incident as any unusual occurrence that results in actual or potential injury to a Tenant.	A 004		

October 2, 2015

Ms. Rose Boccella, Program Coordinator

Adult Services Bureau

Iowa Department of Inspections and Appeals

Lucas State Building

321 East 12th Street

Des Moines, IA 50319-0083

RE: Swan Place Plan of Correction

Dear Ms. Boccella

Enclosed is the required "Plan of Correction" regarding the Final Incident Investigation & Initial Certification Monitoring Evaluation report at Swan Place which was conducted on September 14th - 17th,2015. Submission of this response of the Plan of Correction is not a legal admission that a deficiency exists, or that the Statement of Deficiencies was correctly cited, and is also not to be constructed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response on the Plan of Correction. In addition, preparation and submission of the Plan of Correction does NOT constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

IAC r 481-67.2(1)a Program policies and procedures

- The Regional Director of Care Services will reeducate the Care Services Manager on proper incident reporting guidelines. This will be completed by October 17th,2015.
- The Care Services Manager will reeducate staff on the proper incident reporting guidelines. This will be completed on October 23rd , 2015 during a scheduled all staff meeting.
- The Regional Director of Care Services or designee will conduct a monthly audit of incident reports to ensure accurate completion. This will be conducted for the next three months and quarterly thereafter for one year.
- The Regional Director of Care Services or designee will conduct a monthly audit of the Resident Service Notes for any unusual occurrences to ensure incident reports are completed. This will be conducted for the next three months and quarterly thereafter for one year.

Date of completion for the Plan of Correction is October 30th, 2015.

Sincerely,

Traci Mefferd, RN

Care Services Manager/Swan Place