IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #:
54624-I
55302-I

October 12, 2015

Ms. Lauri Fulkerth, Manager
Arlington Place of Pocahontas
101 NE 5th Street
Pocahontas, IA 50574

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - ARLINGTON PLACE OF POCAHONTAS
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Fulkerth:

I. Final Complaint/Incident Investigation Report – Arlington Place of Pocahontas, Pocahontas, IA

Enclosed is the **Final 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 **September 22, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Staffing, Service Plans and Food Service.

Arlington Place of Pocahontas ("Program") is being assessed a **$2,000 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 **$2,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, staff failed to follow directions from RN resulting in a tenant choking and being transported to the hospital. Upon the tenant's return, Program failed to follow the therapeutic diet.

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 **one thousand three hundred dollars ($1,300)** 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. Conclusion

The Program is being assessed a **$2,000 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, 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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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: 19 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 23 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 8 TOTAL census of Assisted Living Program: 31 The following regulatory insufficiencies were cited during the investigation of Incident #54624-I and #55302-I:	A 000		
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 record review and interview a sufficient number of trained staff were not available to meet tenant needs. (#54624-I) 1. Tenant #1, a 79-year old, was admitted on	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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 055	Continued From page 1 7-6-15 and had diagnoses of: vascular dementia, generalized anxiety disorder, hypertension, and history of choking. Tenant #1 was staged at six on the global deterioration scale which indicated severe cognitive decline. Tenant #1 resided in the dementia unit. 2. According to nurse's notes dated 7-24-15 and timed 6:00 p.m. Tenant #1 was found on the floor with food spewed around and a mouth full of food. Tenant #1 was unable to cough or speak. The Heimlich maneuver was performed unsuccessfully. Ambulance personnel arrived and a large bolus of potato was extracted. At that point, Tenant #1 had no pulse and was not breathing. Cardiopulmonary resuscitation was initiated. Tenant #1 was transported to the hospital. 3. Staff B, Universal Worker during interview on 9-22-15 at 10:13 a.m. stated she was working on 7-24-15 at the time of the choking incident with Tenant #1. Staff B stated another staff member had cut the food for Tenant #1. Tenant #1 wanted to eat in the apartment rather than the dining room. Staff B gave Tenant #1 the food, then left the room "for a couple minutes" to assist another tenant. Staff B returned to Tenant #1's apartment to find Tenant #1 on the floor. Staff B stated she received no instructions as to how to assist Tenant #1 at meal time. 4. A review of Tenant #1's service plan dated 7-6-15 documented staff was to cut food into bite-sized portions. Tenant #1 was to have only small portions of the meal served at one time until it was gone. The service plan documented this helped Tenant #1 chew and swallow before putting more food in the mouth.	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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 055	Continued From page 2 5. The Registered Nurse (RN) was interviewed on 9-22-15 at 10:38 a.m. and stated Tenant #1 would "eat and eat" and would pocket food. The RN stated instructions were in place for someone to be with Tenant #1 when eating, to watch Tenant #1, and to give small amounts of food at one time. The RN stated she expected staff to be with Tenant #1 when eating and at the time of the choking incident on 7-24-15; the directions were not followed.	A 055		
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 record review and interview, service plans did not meet specific service needs of individual tenants. (#54624-I, #55302-I) 1. Tenant #1, a 79 year-old, was admitted on 7-6-15 and had diagnoses of: vascular dementia, generalized anxiety disorder, hypertension, and history of choking. Tenant #1 was staged at six on the global deterioration scale (GDS) which indicated severe cognitive decline. Tenant #1 resided in the dementia unit.	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 083	Continued From page 3 According to nurse's notes dated 7-24-15 and timed 6:00 p.m. Tenant #1 was found on the floor with food spewed around and a mouth full of food. Tenant #1 was unable to cough or speak. The Heimlich maneuver was performed unsuccessfully. Ambulance personnel arrived and a large bolus of potato was extracted. At that point, Tenant #1 had no pulse and was not breathing. Cardiopulmonary resuscitation was initiated. Tenant #1 was transported to the hospital. The Registered Nurse (RN) was interviewed on 9-22-15 at 10:38 a.m. and stated Tenant #1 would "eat and eat" and would pocket food. The RN stated instructions were in place for someone to be with Tenant #1 when eating, to watch Tenant #1, and to give small amounts of food at one time. The RN stated she expected staff to be with Tenant #1 when eating and at the time of the choking incident on 7-24-15; the directions were not followed. The service plan dated 7-6-15 and current at the time of the incident of 7-24-15 did not clearly identify Tenant #1 was not to be left unattended during meals. 2. Tenant #1 returned to the Program on 8-6-15 according to nurse's notes. Tenant #1 was receiving home health services. The home health plan of care dated 8-7-15 and signed by a healthcare provider documented Tenant #1 was to have a mechanical soft, pureed meat diet. The evaluations of 8-5-15 documented Tenant #1 has swallowing difficulty and required a mechanical soft diet with ground meat. The service plan dated 8-5-15 indicated meat could be cut into very small pieces. The service plan did not follow	A 083		

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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 083	Continued From page 4 the directives of the healthcare provider and did not meet the needs of Tenant #1. 3. Diet orders were confirmed in a fax to the healthcare provider dated 8-12-15. A healthcare provider's order dated 8-12-15 identified Tenant #1 was to have a mechanical soft diet with ground meat. The service plan for Tenant #1 was updated on 8-28-15 and indicated meat could be cut into very small pieces. The service plan did not follow the directives of the healthcare provider and did not meet the needs of Tenant #1. 4. Tenant #2, a 93 year-old was admitted on 3-17-14 and had diagnoses of: coronary artery disease, hypertension, osteoarthritis and anxiety. On 7-24-15 Tenant #2 was staged at four on the GDS which indicated moderate cognitive decline. Tenant #2 resided in the general population. An incident report dated 8-30-15 documented Tenant #2 fell and thought the wrist was broken. Tenant #2 was sent to the hospital. Tenant #2 returned to the Program on 8-31-15 and according to the nurse's notes, Tenant #2 was moved to the dementia unit. Evaluations of 8-31-15 documented Tenant #2 had a fractured right wrist and was casted up to the elbow. The right fingers were swollen. 5. Nurse's notes dated 9-4-15 documented Tenant #2 had increased pain to the right hand, fingers were more swollen and cold to the touch. There was decreased movement to the fingers. The service plan dated 8-31-15 did not give staff directions as to signs or symptoms to report to the nurse related to Tenant #2 with a new cast. 6. The service plan dated 8-31-15 was reviewed.	A 083		

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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 083	Continued From page 5 The service plan identified Tenant #2 required assistance with bathing but did not identify care of the cast during bathing. 7. The service plan identified Tenant #2 ambulated independently with a cane. In an interview with the RN on 9-22-15 at 2:45 p.m. she stated Tenant #2 was right-handed and the cast was on the right forearm. The service indicated the use of an alarm system for the prevention of falls. The service plan did not clearly indicate the required assistance for ambulation. The service plan did not meet the identified needs of Tenant #2.	A 083		
A 103	481-69.28(4) Food Service 481-69.28(231C) Food service. 69.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced registered nurse practitioner. A current copy of the Iowa Simplified Diet Manual published by the Iowa Dietetic Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets. This REQUIREMENT is not met as evidenced by: Based on record review, observation, menu review, interview, and observation the Program did not appropriately provide a therapeutic diet. The Program did not have a current copy of the	A 103		

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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 103	Continued From page 6 Iowa Simplified Diet Manual available, and did not have a therapeutic menu written by a dietitian. (#54624-I) 1. Tenant #1, a 79-year old, was admitted on 7-6-15 and had diagnoses of: vascular dementia, generalized anxiety disorder, hypertension, and history of choking. Tenant #1 was staged at six on the global deterioration scale which indicated severe cognitive decline. Tenant #1 resided in the dementia unit. 2. According to nurse's notes dated 7-24-15 and timed 6:00 p.m. Tenant #1 was found on the floor with food spewed around and a mouth full of food. Tenant #1 was unable to cough or speak. The Heimlich maneuver was performed unsuccessfully. Ambulance personnel arrived and a large bolus of potato was extracted. At that point, Tenant #1 had no pulse and was not breathing. Cardiopulmonary resuscitation was initiated. Tenant #1 was transported to the hospital. 3. Tenant #1 returned to the Program on 8-6-15 according to nurse's notes. Tenant #1 was receiving home health services. The home health plan of care dated 8-7-15 and signed by a healthcare provider documented Tenant #1 was to have a mechanical soft, pureed meat diet. Diet orders were confirmed in a fax to the healthcare provider dated 8-12-15. A healthcare provider's order dated 8-12-15 identified Tenant #1 was to have a mechanical soft diet with ground meat. 4. The Culinary Coordinator was asked to provide a copy of the Iowa Simplified Diet Manual. During interview on 9-22-15 at 12:30 p.m. the Culinary Coordinator stated she did not have the manual.	A 103		

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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 103	Continued From page 7 4. The Culinary Coordinator was asked to provide a copy of menus. Menus were provided from a food vendor for a general diet and did not outline menus for a mechanical soft ground meat diet. 5. The Culinary Coordinator was interviewed on 9-22-15 at 9:56 a.m. and stated she had received information on a mechanical soft diet from the nurse, and nothing from a dietitian on a mechanical soft diet. 6. The Cook was interviewed on 9-22-15 at 9:52 a.m. and stated she did not know what a mechanical soft diet was. The Cook stated the noon meal on the day of the onsite visit was either a hamburger or chicken fried steak. The Cook stated there were no alterations needed for either of those as Tenant #1 could eat those. 7. On 9-22-15 at 11:23 a.m. the plate of food for Tenant #1 included a slice of tomato including the skin of the tomato. 8. The Program was asked to provide contact information for the contact person at the food vendor. The Program provided a phone number for the Dietitian. The Dietitian was interviewed by phone and stated the Program had been provided with menus for a general diet. The Program had not been given menus for a mechanical soft ground meat diet. The Dietitian stated she had not been consulted regarding Tenant #1's diet. The Dietitian stated a slice of tomato would not be included in a mechanical soft diet.	A 103		
A 113	481-69.28(6)f Food Service 481-69.28(231C) Food service. 69.28(6) Programs engaged in the	A 113		

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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 113	Continued From page 8 preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. The department will not require the program to be licensed as a food establishment if the program limits food activities to the following: f. Warewashing may be done in the program ' s kitchen as long as the program utilizes a commercial dishwasher and documents daily testing of sanitizer chemical ppm and proper water temperatures. Verification by the department of these practices may be conducted during on-site visits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the non-commercial dishwasher in the dementia unit was used to clean glassware for tenant use. This was identified during the course of the investigation. 1. Staff A, Universal Worker, was interviewed on 9-22-15 at 10:22 a.m. She stated cups and glasses were washed in the dishwasher in the dementia unit. Staff A reported other dish ware was taken to the main kitchen for washing. 2. On 9-22-15 at 10:22 a.m. the dishwasher in the dementia unit was observed to be a non-commercial dishwasher and contained dirty cups. 3. On 9-22-15 at 12:30 p.m. the Culinary Coordinator was interviewed and stated staff was not to use the dishwasher in the dementia unit and was unaware staff was doing so. Dirty cups	A 113		

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
	S0226	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF POCAHONTAS	101 NE 5TH STREET POCAHONTAS, IA 50574

(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 113	Continued From page 9 and glasses were observed in the non-commercial dishwasher in the dementia unit.	A 113		

Arlington Place - Pocahontas
101 NE 5th St.
Pocahontas, Iowa 50574
Ph: 712-335-3020
Fx: 712-335-4456

Date: 10-20-15

Complaint/Investigation Intake #'s: 54624-I and 55302-I

Plan of Correction (POC) Submitted For:

- Investigation Date: 9-22-15
- Monitors: Lori Miner

POC:

A. Deficiency:

a. **Regulatory Insufficiency:** 481-67.9(1) Staffing. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

Program POC:

1. **Elements detailing how the program will correct the insufficiency as it relates to the tenant:**

   A. Tenant #1 received a Doctors order upgrading tenant #1 diet of Mechanical soft to a regular diet with meat cut into small pieces on 9-30-15. Tenant #1 will require higher level of care in a nursing home setting if Mechanical Soft diet is re-established.

   B. Staffing will be reviewed by the Program Nurse and Manager as tenant needs and services change. The program will provide adequate staffing to meet the tenant needs and services.

2. **Actions program taking to protect tenants in similar situations:**

   A. Tenants with orders for a therapeutic diet will not be admitted or retained by the program per programs regulatory requirements and policy and procedures.

   B. All tenants in memory care will be encouraged to eat in the dining room of the memory care area. If a resident chooses to eat in their apartment. Staff will provide assistance as needed.

C. The Program Nurse will schedule staff to meet the needs of the program tenants residing at Arlington Place and as the tenant needs and services change.

3. Measures taken to ensure problem does not recur:

A. Program Nurse will evaluate staffing needs to accommodate tenant service needs.

B. Program Health Care Coordinator will monitor staffing to assure sufficient coverage in the memory care area during mealtimes and personal care times.

4. Date by which the regulatory insufficiency will be corrected:

A. 10/12/15

B. Discrepancy:

a. Regulatory Insufficiency: 481.-69.26(1) 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.

Program POC:

1. Elements detailing how the program will correct the insufficiency as it relates to the tenant:

A. Tenant #1 Therapeutic Diet removed by Medical Doctor verbally 9-30-15 with written order received on 10/12/15. Tenant #2 Cast removed on 9-24-15.

B. Program Nurse will assure Individual Service Plans for both Tenant #1 and Tenant #2 have detailed instructions regarding cares of tenants. Tenant #2 - Program Nurse will delegate cast cares with staff. Tenant #2- Program Nurse will provide a list of adverse reactions, with signs, and symptoms to look for and when to call the Program Nurse.

C. Program Nurse will ensure staff comprehension and competency through return demonstration of reviewed delegated tasks as it pertains to the observations of the monitor to include detailed instructions on Individualized Service Plans.

D. Program Nurse will retain delegations in employee files as it pertains to the service plan and cares for each tenant to ensure training and understanding of resident needs and services being provided in accordance to Individual Service Plans.

2. **Actions program is taking to protect tenants in similar situations:**

A. Program will not provide therapeutic diets. Tenants in memory care area will receive supervision during all meals. Service Plans will have detailed instructions for staff on supervision during meal times.

B. Program Nurse will ensure staff comprehension and competency through return demonstration of reviewed delegated tasks as it pertains to the observations of the monitor for needs and services listed on Individualized Service Plans.

C. Random observation by RN and Manager to ensure proper procedures are being followed to meet compliance at a minimum, monthly.

3. **Measures taken to ensure problem does not recur:**

A. Therapeutic diet was illuminated on 9-29-15. Program will not be providing therapeutic diets.

B. Program RN will give detailed instruction to all staff through the service plan as well as through delegations and training.

C. Random observation by Program RN and Manager to ensure proper procedures are being followed to meet compliance at a minimum, monthly.

4. **Date by which the regulatory insufficiency will be corrected:**

A. 10/12/15

C.-Discrepancy:

a. **Regulatory Insufficiency:** 481.69.28(231C) 481.69.28(6) Food Service Programs engaged in the preparation and service of meals and snacks shall meet the standards of State and local health laws and ordinance pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F.

Program POC:

1. **Elements detailing how the program will correct the insufficiency as it relates to the tenant:**

A. Program staff will return all dishware to the main kitchen to be washed in the commercial dishwasher. Staff who use the non-commercial dishwasher for activities of daily living with residents will assure any dishware a resident places in the dishwasher for activities of daily living are removed and sent to the dietary department for proper washing and sanitizing before use.

2. **Actions program is taking to protect tenants in similar situations:**
Proper food handling, storage and sanitation training is conducted with all staff upon hire and on a yearly basis. A sign has been attached to the front of the dishwasher stating, This is not a Commercial dishwasher. Using dishware washed in this dishwasher is prohibited.

3. **Measures taken to ensure problem does not recur:**
Ongoing training of staff, a sign has been attached to the front of the dishwasher stating, This is not a Commercial dishwasher. Using dishware washed in this dishwasher is prohibited.

4. **Date by which the regulatory insufficiency will be corrected:**

A. 9/23/2015

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 regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.