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

Complaint/Incident Intake #:
59026-C

April 19, 2016

Mr. Kent Walton, Administrator
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233

RE: Final Complaint/Incident Investigation Report, Promise House, Hiawatha, Iowa

Dear Mr. Walton:

Enclosed is the **Final Complaint/Incident Investigation 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 an investigation by DIA on **March 29, 30 & 31, 2016.** An investigation of Complaint #59026-C was completed. The following allegation was investigated in regards to Complaint #59026-C:

1. Allegation: Medication Management
   Findings: Unsubstantiated
   Comments: Review of tenant files, staff interviews and review of Program documents did not reveal a regulatory insufficiency related to medication management.

2. Allegation: Tenant Rights
   Findings: Unsubstantiated
   Comments: Review of tenant files, staff interviews and review of Program documents did not reveal a regulatory insufficiency related to tenant rights.

There were regulatory insufficiencies cited during the course of the investigation of Complaint #59026-C. The regulatory insufficiencies are indicated on the enclosed report. The Report notes Regulatory Insufficiencies in the area(s) of: Notification of Dependent Adult Abuse, Program Policies and Procedures, Staffing and Criteria for Admission/Retention of Tenants..

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.

If you have any questions in regard to the enclosed 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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 18 Total Population of Program at time of on-site: 19 TOTAL census of Assisted Living Program: 19 An investigation of Complaint #59026-C was investigated. There were regulatory insufficiencies cited related to Complaint #59026-C. Iowa Code 235E.2 (3)a. If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours. The Requirement is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents, staff failed to immediately notify the person in charge of an allegation of dependent adult abuse. It was alleged Staff A restrained Tenant #2 and it was witnessed by Staff B. The allegation regarding the restraint was not immediately reported to the	A 000		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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	Continued From page 1 person in charge. 1. Tenant #2, a 72 year old, was admitted on 1-18-15 and diagnoses included: moderate Alzheimer's disease, cardiomyopathy, hypertension and carotid bruit. Tenant #2 was staged at a seven on the Global Deterioration Scale, which indicated very severe cognitive decline. The service plan dated 3-15-16, indicated Tenant #2 was increasingly confused. Tenant #2 was aware of Tenant #2's disease progression and increase in Tenant #2's confusion. Tenant #2 was easily frustrated, agitated and was angered easily. Those periods had become less frequent. Staff cued/redirected as needed with increased confusion. Staff offered reassurance as needed and one to one time to help decrease depression, diffuse anger/agitation. The more people that surrounded Tenant #2 at once the more Tenant #2 escalated. The service plan indicated not to stand in front of Tenant #2 while Tenant #2 kicked and to walk away and diffuse the situation. It indicated to not encourage group interaction as the increased stimulation increased Tenant #2's anxiety. Tenant #2 also had a Haldol cream as needed for agitation. 2. According to an occurrence report dated 3-1-16 at 6:30 p.m., Tenant #2 made a comment to a new staff. Staff A came and got Tenant #2 and Tenant #2 refused. Staff A then grabbed Tenant #2 and took Tenant #2 into the library. Tenant #2 was placed in a chair and Staff A sat right in front of Tenant #2. Staff A was holding Tenant #2's hands. Staff A's feet were on top of Tenant #2's feet. It went on for about 15 to 20 minutes and the location was the library.	A 000		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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	Continued From page 2 The occurrence report indicated the Director was notified on 3-21-16. The occurrence report was completed by Staff B and given to the Director on 3-23-16. The entry on the occurrence report regarding notification of the family with date and time was not completed. The entry on the occurrence report regarding notification of the physician with date and time was not completed. The entry on the occurrence report regarding documentation in the tenant's file was not completed. Narrative documentation on the occurrence report indicated the Director was first told verbally of the alleged occurrence when she arrived at work on 3-21-16. The Director addressed it with the Administrator that same morning. The Director was told to discuss it with Staff A and explain that was not proper procedure but it was also information given through third party statements. The Director asked Staff B, who witnessed the alleged event, to fill out the occurrence report. Staff B turned in the occurrence report on 3-23-16. The Director spoke with Staff A and asked for Staff A's side of the story. Staff A said she could not remember exactly but Tenant #2 was doing something so Staff A took Tenant #2 into the library one to one. When the Director asked about the positioning that was reported, Staff A said she probably did have her feet on top of Tenant #2's feet because Tenant #2 was kicking. The Director explained that not unacceptable and it was form of restraint. Staff A said she did not know that and would not do it again. 3. According to an interview with Staff A, Tenant #2 was going after another tenant and had tried	A 000		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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	Continued From page 3 to hit staff. The staff on that side of the building did not want to do anything because of Tenant #2's combativeness. Staff A and Tenant #2 went into he library. Staff A was initially sitting on the side of Tenant #2 and Tenant #2 tried to hit Staff A. Tenant #2 grabbed Staff A's wrist. Staff A then moved to sit in front of Tenant #2. Staff A tried to calm Tenant #2 down. Tenant #2's feet were on the inside of Staff A's shoes. Staff A's feet were not on top of Tenant #2's feet and Staff A's feet were on the outside of Tenant #2's feet. Staff A did not hold down Tenant #2's hands. No other staff came into the library and the door was closed with the light on. Staff A said no force was used to bring Tenant #2 into the library. They were in the library for 10 minutes. According to an interview with Staff B, Tenant #2 made a comment to a new staff and Staff A took Tenant #2 into the library. Tenant #2 wanted to keep standing there and Staff A forced Tenant #2 into the library. Staff B was then with another tenant and not paying attention. Staff B came back and saw Staff A sitting directly in front of Tenant #2 and Tenant #2 was seated in a recliner. Staff A's feet were on top of Tenant #2's feet. Tenant #2's hands were in Tenant #2's lap and Staff A's hands were over Tenant #2's hands. Staff B did not know Tenant #2's reaction when Tenant #2 came out of the room. No other staff witnessed the alleged incident. The Assistant Director was there, but might have been on a break. Staff A said to staff that Tenant #2 was going crazy and Staff A held Tenant #2 down. At that time, Staff B did not know it was a form of restraint. Regarding why it was not reported earlier, Staff B said Staff B did not know it was wrong, until Staff B talked to another staff.	A 000		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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	Continued From page 4 According to an interview with the Assistant Director, she was the medication passer the morning of the alleged incident and did not believe she was in the building at that time; however, was on-call at the time of the alleged incident. The Assistant Director had no knowledge of the alleged incident prior to 3-30-16. According to an interview with the Director, it was brought to the Director's attention on Monday morning (3-21-16) by another staff that Staff B witnessed an alleged incident between Tenant #2 and Staff A. It was reported to the Director that Tenant #2 was agitated and Staff A took Tenant #2 into the library. Tenant #2 was in the recliner and Staff A sat across from Tenant #2. Staff A's feet were on top of Tenant #2's feet and Staff A was holding Tenant #2's hands. The Director talked to the Administrator about the allegation. Staff B wrote the incident report and it was consistent with what staff had reported to the Director. Staff B gave the incident report to the Director on Wednesday (3-23-16) and the Director talked to Staff A on Friday (3-25-16). Staff A said there was an incident and Staff A took Tenant #2 into the library to calm down. Staff A sat in front of Tenant #2 and Staff A was hanging on to Tenant #2's hands. Staff A said Staff A might have had Staff A's feet on top of Tenant #2's feet. The Director told Staff A it was a restraint and Staff A could not do it. Tenant #2 did not sustain any injuries. Staff A thought Tenant #2 was a threat to staff/tenants and Staff A did not realize it was a restraint. The date of the alleged incident was 3-1-16 and the Director did not find out until 3-21-16. The Assistant Director was there and on-call at the time of the allegation.	A 000		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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	Continued From page 5 4. Staff A had dependent adult abuse training completed on 11-4-14 . Staff B had dependent adult abuse training completed on 1-26-16. 5. According to the Program's policy regarding abuse prevention and reporting, all employees of the Program were mandatory reports and were required by law to report incidents of suspected abuse. Any employee that witnessed an incident that might be considered abuse should verbally report the incident immediately to the charge nurse, nurse on-call or director of nursing (DON) and would be expected to provide a written account of the facts of the incident before leaving work that day. The nurse to whom the incident had been reported would immediately take the following steps: removed the alleged suspect from tenant contact within the building by suspending him/her immediately without pay pending results of the investigation, perform a physical assessment of the tenant and determine the need for emergency medical services or trauma evaluation, determine possible etiologies for injuries of unknown etiology, wounds related to suspected or alleged abuse should be photographed and labeled and gathered any evidence or immediate information surrounding the incident that might be destroyed or distorted over time. The Administrator would be notified as soon as the steps mentioned above were completed. The Administrator or DON would notify the tenant's responsible party and state officials as appropriate within 24 hours of receiving the report.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies	A 003		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 6 and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents, the Program did not follow the Program's policies regarding the completion of a medication error report and occurrence report for two of four tenant files reviewed (Tenants #1 and #2). Tenant #1 had two tablets of unaccounted medication and a medication error report was not completed as required per the Program's policy. There was an allegation that Staff A restrained Tenant #2 and an occurrence report was not completed per the Program's policy regarding notification of responsible party of an event that required the completion of an occurrence report. 1. Tenant #1, a 75 year old, was admitted on 8-14-14 and had a diagnosis of dementia with behavioral disturbances. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. According to a Controlled Medication Utilization Record, Tenant #1 had an order for Lorazepam 0.5 milligram tablet, one tablet by mouth daily. On 3-2-16 at 11:45 a.m. two tablets remained. On 3-3-16 Staff A indicated the tablets were	A 003		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 7 returned to pharmacy. A fax was sent to the pharmacy to confirm the receipt of two Lorazepam tablets for Tenant #1 on 3-2-16 or 3-3-16. It was discussed with staff that narcotics were not sent back. A fax from the pharmacy to the Program dated 3-9-16 indicated they looked through all of their records and had no record of the two Lorazepam tablets being returned. They scanned in all returns and kept a record of the controls they destroyed. The two tablets were not returned to the pharmacy. A hand written note (by the Program) indicated it was discussed with the Administrator and they looked through medication rooms, narcotic boxes and all scheduled medications and it was not found. The Administrator was going to call pharmacy. A pharmacy staff requested all narcotic sheets for an audit and they were faxed. It was discussed again with Staff A and she said she put them in small box and locked them to return. Staff A was confused because of the medication change over. 2. According to an interview with the Director, she became aware two of Tenant #1's Lorazepam were sent back to pharmacy and it was not the policy to send them back. The Director spoke with Staff A and Staff A said she put them in the pharmacy tote and it was locked in the medication room. Pharmacy reported they did not get the bubblepack returned. The Administrator and Director went through the medication room and searched everywhere and it was not found. The Administrator talked to Staff A and pharmacy completed an internal audit. The tablets were not found. There were no other discrepancies noted. Narcotics were not	A 003		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 8 to be sent back with the medication change over. 3. According to the Program's Medication Error Policy, it was the policy of the Program that whenever a medication error was found to have occurred that it be brought to the attention of the Director/Assistant Director, or the nurse on duty in their absence. At that time the medication error form would be initiated and filled out in its entirety. A medication error form was not completed regarding Tenant #1's missing Lorazepam tablets. 4. Tenant #2, a 72 year old, was admitted on 1-18-15 and diagnoses included: moderate Alzheimer's disease, cardiomyopathy, hypertension and carotid bruit. Tenant #2 was staged at a seven on the GDS, which indicated very severe cognitive decline. The service plan dated 3-15-16, indicated Tenant #2 was increasingly confused. Tenant #2 was aware of Tenant #2's disease progression and increase in Tenant #2's confusion. Tenant #2 was easily frustrated, agitated and was angered easily. Those periods had become less frequent. Staff cued/redirected as needed with increased confusion. Staff offered reassurance as needed and one to one time to help decrease depression, diffuse anger/agitation. The more people that surrounded Tenant #2 at once the more Tenant #2 escalated. The service plan indicated not to stand in front of Tenant #2 while Tenant #2 kicked and to walk away and diffuse the situation. It indicated to not encourage group interaction as the increased stimulation increased Tenant #2's anxiety. Tenant #2 also	A 003		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 9 had a Haldol cream as needed for agitation. 5. According to an occurrence report dated 3-1-16 at 6:30 p.m., Tenant #2 made a comment to a new staff. Staff A came and got Tenant #2 and Tenant #2 refused. Staff A then grabbed Tenant #2 and took Tenant #2 into the library. Tenant #2 was placed in a chair and Staff A sat right in front of Tenant #2. Staff A was holding Tenant #2's hands. Staff A's feet were on top of Tenant #2's feet. It went on for about 15 to 20 minutes and the location was the alleged occurrence was the library. The occurrence report indicated the Director was notified on 3-21-16. The occurrence report was completed by Staff B and given to the Director on 3-23-16. The entry on the occurrence report regarding notification of the family with date and time was not completed. The entry on the occurrence report regarding notification of the physician with date and time was not completed. The entry on the occurrence report regarding documentation in the tenant's file was not completed. Narrative documentation on the occurrence report indicated the Director was first told verbally of the alleged occurrence when she arrived at work on 3-21-16. The Director addressed it with the Administrator that same morning. The Director was told to discuss it with Staff A and explain that was not proper procedure but it was also information given through third party statements. The Director asked Staff B, who witnessed the alleged event, to fill out the occurrence report as Staff B witnessed it. Staff B turned in the occurrence report on 3-23-16. The Director spoke with Staff	A 003		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 10 A and asked for Staff A's side of the story. Staff A said she could not remember exactly but Tenant #2 was doing something so Staff A took Tenant #2 into the library one to one. When the Director asked about the positioning that was reported, Staff A said she probably did have her feet on top of Tenant #2's feet because Tenant #2 was kicking. The Director explained that not unacceptable and it was a form of restraint. Staff A said she did not know that and would not do it again. 6. According to an interview with Staff A, Tenant #2 was going after another tenant and had tried to hit staff. The staff on that side of the building did not want to do anything because of Tenant #2's combativeness. Staff A and Tenant #2 went into he library. Staff A was initially sitting on the side of Tenant #2 and Tenant #2 tried to hit Staff A. Tenant #2 grabbed Staff A's wrist. Staff A then moved to sit in front of Tenant #2. Staff A tried to calm Tenant #2 down. Tenant #2's feet were on the inside of Staff A's shoes. Staff A's feet were not on top of Tenant #2's feet and Staff A's feet were on the outside of Tenant #2's feet. Staff A did not hold down Tenant #2's hands. No other staff came into the library and the door was closed with the light on. Staff A said no force was used to bring Tenant #2 into the library. They were in the library for 10 minutes. According to an interview with Staff B, Tenant #2 made a comment to a new staff and Staff A took Tenant #2 into the library. Tenant #2 wanted to keep standing there and Staff A forced Tenant #2 into the library. Staff B was then with another tenant and not paying attention. Staff B came back and saw Staff A sitting directly in front of Tenant #2 and Tenant #2 was seated in a	A 003		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 11 recliner. Staff A's feet were on top of Tenant #2's feet. Tenant #2's hands were in Tenant #2's lap and Staff A's hands were over Tenant #2's hands. Staff B did not know Tenant #2's reaction when Tenant #2 came out of the room. No other staff witnessed the alleged incident. The Assistant Director was there but might have been on a break. Staff A said to staff that Tenant #2 was going crazy and Staff A held Tenant #2 down. At that time Staff B did not know it was a form of restraint. Regarding why it was not reported earlier, Staff B said Staff B did not know it was wrong until Staff B talked to another staff. According to an interview with the Assistant Director, she was the medication passer the morning of the alleged incident and did not believe she was in the building at that time; however, was on-call at the time of the alleged incident. The Assistant Director had no knowledge of the alleged incident prior to 3-30-16. According to an interview with the Director, it was brought to the Director's attention on Monday morning (3-21-16) by another staff that Staff B witnessed an alleged incident between Tenant #2 and Staff A. It was reported to the Director that Tenant #2 was agitated and Staff A took Tenant #2 into the library. Tenant #2 was in the recliner and Staff A sat across from Tenant #2. Staff A's feet were on top of Tenant #2's feet and Staff A was holding Tenant #2's hands. The Director talked to the Administrator about the allegation. Staff B wrote the incident report and it was consistent with what staff had reported to the Director. Staff B gave the incident report to the Director on Wednesday (3-23-16) and the Director talked to Staff A on Friday (3-25-16).	A 003		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 12 Staff A said there was an incident and Staff A took Tenant #2 into the library to calm down. Staff A sat in front of Tenant #2 and Staff A was hanging on to Tenant #2's hands. Staff A said Staff A might have had Staff A's feet on top of Tenant #2's feet. The Director told Staff A it was a restraint and Staff A could not do it. Tenant #2 did not sustain any injuries. Staff A thought Tenant #2 was a threat to staff/tenants and Staff A did not realize it was a restraint. The date of the alleged incident was 3-1-16 and the Director did not find out until 3-21-16. The Assistant Director was there and on-call at the time of the allegation. 7. According to the Program's Occurrence Report policy, whenever an occurrence or event led to unintentional consequences and an unfortunate happening to a tenant, visitor or staff on the grounds of the Program an occurrence report must be completed. The occurrence report would be completed by the Unit Director and if the Unit Director was not available the report would be completed by the staff (s) involved. Completed occurrence reports would be routed to the Unit Director or designee, who would review and maintain the report. When in doubt, the form was to be completed. The responsible party was to be informed of any event that involved the tenant that required the completion of an occurrence report. Notification would be made by the Unit Director. If the occurrence required emergency services and the staff involved was unavailable, notification would be made by the direct caregiver.	A 003		
A 058	481-67.9(4)a Staffing 481-67.9(231B,231C,231D) Staffing.	A 058		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 058	Continued From page 13 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program ' s newly hired registered nurse shall within 60 days of beginning employment as the program ' s registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on review of a staff file and review of Program documents the Program failed to have the Program's newly hired registered nurse (RN) within 60 days of employment document a review to ensure that staff were sufficiently trained and competent in all tasks that were assigned or delegated for Staff A. One staff did not have a documented review to ensure staff was sufficiently trained and competent in all tasks within 60 days of the RN's employment. 1. Staff A, a certified nursing assistant (CNA), was hired on 11-12-09. Staff A did not have a review documented by the Director, who was also a RN, within 60 days of the Director's employment to ensure Staff A was sufficiently trained and competent in all tasks assigned or delegated. The Assistant Director, a licensed practical nurse (LPN), completed a Medication Distribution Certification Form dated 7-1-15. The tasks listed included: hand washing, dispensing procedure, medication pass procedure, eye drop procedure, blood sugar training, wound care,	A 058		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 058	Continued From page 14 inhalers and diskus training and nebulizer training. The form indicated the undersigned had performed return demonstration of how medications were appropriately distributed. The form was not completed by an RN and was not completed within 60 days of the Director's employment. 2. According to the ALP Monitoring Entrance form, the Director was the delegating RN. According to a staff list, the Director was hired on 7-28-14.	A 058		
A 039	481-69.23(1)b Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on review of tenant files, observations, staff interviews and review of Program documents, the Program failed to follow admission and retention criteria for one of four tenant files reviewed (Tenant #2). One tenant exceeded the criteria for retention by requiring a routine two-person transfer with standing, transfers or evacuation. 1. Tenant #2, a 72 year old, was admitted on 1-18-15 and diagnoses included: moderate Alzheimer's disease, cardiomyopathy, hypertension and carotid bruit. Tenant #2 was	A 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 039	Continued From page 15 staged at a seven on the Global Deterioration Scale (GDS), which indicated very severe cognitive decline. According to a Nurse Review dated 3-15-16, the review was completed due to a significant change in Tenant #2. Tenant #2 had rapidly declined in all aspects of cognitive, physical and functional abilities. Tenant #2 was a GDS of seven and required total assistance with all aspects of activities of daily living (ADLs) due to the decline in cognition. Tenant #2's was oriented to self only and had garbled words. Tenant #2 had days when Tenant #2 was very lethargic and other days when Tenant #2 was very much alert. Tenant #2 had periods of agitation, which occurred normally in the late afternoon or evening. The periods of agitation had become less frequent, were decreased in intensity and had a shorter duration. Tenant #2 had a Haldol rub which seemed to be effective most of the time. Tenant #2 was minimally weight bearing and at times not at all. Tenant #2 was an assist of two with a gait belt for all transfers and staff propelled Tenant #2 in a wheelchair. Tenant #2 was unable to make Tenant #2's needs known and was incontinent of bladder and bowel. Regarding meals, Tenant #2 needed cueing, was at times fed and had a decreased appetite overall. Tenant #2 had shown a rapid decline due to Tenant #2's disease process and had been changed to comfort care. According to a Health Status Review dated 3-15-16, Tenant #2 was transferred with assistance of two and was propelled in a wheelchair by staff. Staff was to perform all ADLs and allow Tenant #2 to do what Tenant #2 could do. According to a Geriatric Activities of	A 039		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 039	Continued From page 16 Daily Living Functional Assessment dated 3-15-16, there were scores for ADLs including: a score of two, which indicated able to perform task without assistance, a score of one, which indicated able to assist with the task and no more than one assistant needed and a score of zero, which indicated unable to give any assistance or required more than one assistant. Tenant #2 received zeros in all categories including: bathing, eating, dressing/grooming, transfer, ambulation, bowel/bladder continence and mental status. According to the service plan dated 3-15-16, Tenant #2 was alert and oriented to self only. Tenant #2 was incontinent of bladder and bowel and staff managed. Regarding mobility, Tenant #2 was a two assist with transfers. Tenant #2 had days where Tenant #2 might be able to take a few steps or transfer but it was very rare anymore. Staff was to transfer and propel Tenant #2 in the wheelchair. Staff was to assist/feed Tenant #2 as needed at meals. Tenant #2 was bathed twice a week, staff was to encourage Tenant #2's participation with baths and allow Tenant #2 to do whatever Tenant #2 could do. For grooming and personal hygiene Tenant #2 received total assistance. Tenant #2 started on comfort care on 3-14-16 and Tenant #2 would remain comfortable and stay at the Program utilizing comfort care status. 2. According to observation on 3-30-16 at 11:35 a.m., Tenant #2 was transferred from a wheelchair to a dining room chair with two staff and a gait belt. According to observation on 3-31-16 at 4:38 p.m., Tenant #2 was transferred from a wheelchair to a dining room chair with two staff and a gait belt.	A 039		

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
	S0090	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 039	Continued From page 17 3. According to an interview with Staff A, Tenant #2 was a two person transfer all of the time, for the past one to two weeks. Tenant #2 did not help with cares. According to an interview with the Assistant Director, Tenant #2 was always a two person transfer. Tenant #2 had been a two person transfer for the past week or so. It was dependent on the day if Tenant #2 could bear weight. Tenant #2 used a wheelchair. According to an interview with the Director, Tenant #2 took two people to transfer 80% of the time and basically used two people to transfer most of the time. Tenant #2's weight bearing status was day to day. 4. According to the Program's protocol regarding level of care, the Program would not knowingly admit or retain a tenant who required a routine, two-person assistance with standing, transfer and evacuation.	A 039		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	()(2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	S0090	A. BUILDING._____ B WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA52233

()(4) 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. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 18 Total Population of Program at time of on-site: 19 TOTAL census of Assisted Living Program: 19 An investigation of Complaint #59026-C was investigated. There were regulatory insufficiencies cited related to Complaint #59026-C. Iowa Code 235E.2 (3)a. If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours. The Requirement is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents, staff failed to immediately notify the person in charge of an allegation of dependent adult abuse. It was alleged Staff A restrained Tenant #2 and it was witnessed by Staff B. The allegation regarding the restraint was not immediately reported to the	A 000	Promise House Hiawatha will continue to follow the facility policy regarding dependent adult abuse. All staff members have been trained to immediately notify Administration of any suspected abuse. Promise House Hiawatha Quality Assessment & Assurance Committee comprised of Administrator, Unit Director, Assistant Unit Director and Universal Worker will annually or more often review with all staff and monitor the compliance of our dependent adult abuse policy.	5/31/16

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(2) MULTIPLE CONSTRUCTION	(3) DATE SURVEY COMPLETED
	S0000	A. BUILDING: _____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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	Continued From page 1 person in charge. 1. Tenant #2, a 72 year old, was admitted on 1-18-15 and diagnoses included: moderate Alzheimer's disease, cardiomyopathy, hypertension and carotid bruit. Tenant #2 was staged at a seven on the Global Deterioration Scale, which indicated very severe cognitive decline. The service plan dated 3-15-16, indicated Tenant #2 was increasingly confused. Tenant #2 was aware of Tenant #2's disease progression and increase in Tenant #2's confusion. Tenant #2 was easily frustrated, agitated and was angered easily. Those periods had become less frequent. Staff cued/redirected as needed with increased confusion. Staff offered reassurance as needed and one to one time to help decrease depression, diffuse anger/agitation. The more people that surrounded Tenant #2 at once the more Tenant #2 escalated. The service plan indicated not to stand in front of Tenant #2 while Tenant #2 kicked and to walk away and diffuse the situation. It indicated to not encourage group interaction as the increased stimulation increased Tenant #2's anxiety. Tenant #2 also had a Haldol cream as needed for agitation.. 2 According to an occurrence report dated 3-1-16 at 6:30 p.m., Tenant #2 made a comment to a new staff. Staff A came and got Tenant #2 and Tenant #2 refused Staff A then grabbed Tenant #2 and took Tenant #2 into the library. Tenant #2 was placed in a chair and Staff A sat right in front of Tenant #2. Staff A was holding Tenant #2's hands. Staff A's feet were on top of Tenant #2's feet. It went on for about 15 to 20 minutes and the location was the library.	A 000		

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
	S0090	A. BUILDING:_____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA52233

(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)	()(5) COMPLETE DATE
A 000	Continued From page 2 The occurrence report indicated the Director was notified on 3-21-16. The occurrence report was completed by Staff B and given to the Director on 3-23-16. The entry on the occurrence report regarding notification of the family with date and time was not completed. The entry on the occurrence report regarding notification of the physician with date and time was not completed. The entry on the occurrence report regarding documentation in the tenant's file was not completed. Narrative documentation on the occurrence report indicated the Director was first told verbally of the alleged occurrence when she arrived at work on 3-21-16. The Director addressed it with the Administrator that same morning. The Director was told to discuss it with Staff A and explain that was not proper procedure but it was also information given through third party statements. The Director asked Staff B, who witnessed the alleged event, to fill out the occurrence report. Staff B turned in the occurrence report on 3-23-16. The Director spoke with Staff A and asked for Staff A's side of the story. Staff A said she could not remember exactly but Tenant #2 was doing something so Staff A took Tenant #2 into the library one to one. When the Director asked about the positioning that was reported, Staff A said she probably did have her feet on top of Tenant #2's feet because Tenant #2 was kicking. The Director explained that not unacceptable and it was form of restraint. Staff A said she did not know that and would not do it again. 3 According to an interview with Staff A, Tenant #2 was going after another tenant and had tried	A 000		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0090	A. BUILDING:_____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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)	()(5) COMPLETE DATE
A ooo	Continued From page 3	A 000		

to hit staff. The staff on that side of the building did not want to do anything because of Tenant #2's combativeness. Staff A and Tenant #2 went into he library. Staff A was initially sitting on the side of Tenant #2 and Tenant #2 tried to hit Staff A. Tenant #2 grabbed Staff A's wrist. Staff A then moved to sit in front of Tenant #2. Staff A tried to calm Tenant #2 down. Tenant #2's feet were on the inside of Staff A's shoes. Staff A's feet were not on top of Tenant #2's feet and Staff A's feet were on the outside of Tenant #2's feet. Staff A did not hold down Tenant #2's hands. No other staff came into the library and the door was closed with the light on. Staff A said no force was used to bring Tenant #2 into the library. They were in the library for 10 minutes.

According to an interview with Staff B, Tenant #2 made a comment to a new staff and Staff A took Tenant #2 into the library. Tenant #2 wanted to keep standing there and Staff A forced Tenant #2 into the library. Staff Bwas then with ar,mther tenant and not paying attention. Staff B came back and saw Staff A sitting directly in front of Tenant #2 and Tenant #2 was seated in a recliner Staff A's feet were on top of Tenant #2's feet. Tenant #2's hands were in Tenant #2's lap and StaffA's hands were over Tenant #2's hands. Staff B did not know Tenant #2's reaction when Tenant #2 came out of the room No other staff witnessed the alleged incident. The Assistant Director was there, but might have been on a break. Staff A said to staff that Tenant #2 was going crazy and Staff A held Tenant #2 down. At that time, Staff B did not know it was a form of restraint. Regarding why it was not reported earlier, Staff B said Staff B did not know it was wrong, until Staff B talked to another staff.

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
	S0090	A. BUILDING _____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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	Continued From page 4 According to an interview with the Assistant Director, she was the medication passer the morning of the alleged incident and did not believe she was in the building at that time; however, was on-call at the time of the alleged incident. The Assistant Director had no knowledge of the alleged incident prior to 3-30-16. According to an interview with the Director, it was brought to the Director's attention on Monday morning (3-21-16) by another staff that Staff B witnessed an alleged incident between Tenant #2 and Staff A. It was reported to the Director that Tenant #2 was agitated and Staff A took Tenant #2 into the library. Tenant #2 was in the recliner and Staff A sat across from Tenant #2. Staff A's feet were on top of Tenant #2's feet and Staff A was holding Tenant #2's hands. The Director talked to the Administrator about the allegation. Staff B wrote the incident report and it was consistent with what staff had reported to the Director. Staff B gave the incident report to the Director on Wednesday (3-23-16) and the Director talked to Staff A on Friday (3-25-16). Staff A said there was an incident and Staff A took Tenant #2 into the library to calm down. Staff A sat in front of Tenant #2 and Staff A was hanging on to Tenant #2's hands. Staff A said Staff A might have had Staff A's feet on top of Tenant #2's feet. The Director told Staff A it was a restraint and Staff A could not do it. Tenant #2 did not sustain any injuries. Staff A thought Tenant #2 was a threat to staff/tenants and Staff A did not realize it was a restraint. The date of the alleged incident was 3-1-16 and the Director did not find out until 3-21-16. The Assistant Director was there and on-call at the time of the allegation.	A 000		

D'"PARTMENT .."F INSP'"CTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER	()(2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	S0090	A. BUILDING:_____ B.WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

()(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A ooo	Continued From page 5 4. Staff A had dependent adult abuse training completed on 11-4-14 . Staff B had dependent adult abuse training completed on 1-26-16. 5 According to the Program's policy regarding abuse prevention and reporting, all employees of the Program were mandatory reports and were required by law to report incidents of suspected abuse. Any employee that witnessed an incident that might be considered abuse should verbally report the incident immediately to the charge nurse, nurse on-call or director of nursing (DON) and would be expected to provide a written account of the facts of the incident before leaving work that day. The nurse to whom the incident had been reported would immediately take the following steps: removed the alleged suspect from tenant contact within the building by suspending him/her immediately without pay pending results of the investigation, perform a physical assessment of the tenant and determine the need for emergency medical services or trauma evaluation, determine possible etiologies for injuries of unknown etiology, wounds related to suspected or alleged abuse should be photographed and labeled and gathered any evidence or immediate information surrounding the incident that might be destroyed or distorted *over* time. The Administrator would be notified as soon as the steps mentioned above were completed. The Administrator or DON would notify the tenant's responsible party and state officials as appropriate within 24 hours of receiving the report.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies	A 003	Promise House will continue to follow all policies and procedures related to allegations of dependent adult abuse and also policies and procedures related to medication	5/31/2016

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
	S0090	A. BUILDING _____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 6 and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents, the Program did not follow the Program's policies regarding the completion of a medication error report and occurrence report for two of four tenant files reviewed (Tenants #1 and #2). Tenant #1 had two tablets of unaccounted medication and a medication error report was not completed as required per the Program's policy. There was an allegation that Staff A restrained Tenant #2 and an occurrence report was not completed per the Program's policy regarding notification of responsible party of an event that required the completion of an occurrence report. 1. Tenant #1, a 75 year old, was admitted on 8-14-14 and had a diagnosis of dementia with behavioral disturbances. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. According to a Controlled Medication Utilization Record, Tenant #1 had an order for Lorazepam 0.5 milligram tablet, one tablet by mouth daily. On 3-2-16 at 11:45 a.m. two tablets remained. On 3-3-16 Staff A indicated the tablets were	A 003	administration. Compliance shall be maintained by the Quality Assurance Committee comprised of Administrator, Unit Director, Assistant Unit Director and Universal Worker monitoring and reviewing the dependent adult abuse and medication administration policy and procedures on an annual or more frequent basis to assure staff are aware of and complying with the above policies.	

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
	S0090	A. BUILDING _____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 7 returned to pharmacy. A fax was sent to the pharmacy to confirm the receipt of two Lorazepam tablets for Tenant #1 on 3-2-16 or 3-3-16. Itwas discussed with staff that narcotics were not sent back. A fax from the pharmacy to the Program dated 3-9-16 indicated they looked through all of their records and had no record of the two Lorazepam tablets being returned. They scanned in all returns and kept a record of the controls they destroyed. The two tablets were not returned to the pharmacy. A hand written note (by the Program) indicated it was discussed with the Administrator and they looked through medication rooms, narcotic boxes and all scheduled medications and it was not found. The Administrator was going to call pharmacy. A pharmacy staff requested all narcotic sheets for an audit and they were faxed. Itwas discussed again with Staff A and she said she put them in small box and locked them to return. Staff A was confused because of the medication change over 2. According to an interview with the Director, she became aware two of Tenant #1's Lorazepam were sent back to pharmacy and it was not the policy to send them back. The Director spoke with Staff A and Staff A said she put them in the pharmacy tote and it was locked in the medication room. Pharmacy reported they did not get the bubblepack returned. The Administrator and Director went through the medication room and searched everywhere and it was not found. The Administrator talked to Staff A and pharmacy completed an internal audit The tablets were not found. There were no other discrepancies noted. Narcotics were not	A 003		

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
	S0090	A. BUILDING: _____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 8 to be sent back with the medication change over. 3. According to the Program's Medication Error Policy, it was the policy of the Program that whenever a medication error was found to have occurred that it be brought to the attention of the Director/Assistant Director, or the nurse on duty in their absence. At that time the medication error form would be initiated and filled out in its entirety. A medication error form was not completed regarding Tenant #1's missing Lorazepam tablets. 4. Tenant #2, a 72 year old, was admitted on 1-18-15 and diagnoses included: moderate Alzheimer's disease, cardiomyopathy, hypertension and carotid bruit. Tenant #2 was staged at a seven on the GOS, which indicated very severe cognitive decline. The service plan dated 3-15-16, indicated Tenant #2 was increasingly confused. Tenant #2 was aware of Tenant #2's disease progression and increase in Tenant #2's confusion. Tenant #2 was easily frustrated, agitated and was angered easily. Those periods had become less frequent. Staff cued/redirected as needed with increased confusion. Staff offered reassurance as needed and one to one time to help decrease depression, diffuse anger/agitation. The more people that surrounded Tenant #2 at once the more Tenant #2 escalated. The service plan indicated not to stand in front of Tenant #2 while Tenant #2 kicked and to walk away and diffuse the situation. It indicated to not encourage group interaction as the increased stimulation increased Tenant #2's anxiety. Tenant #2 also	A 003		

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
	50090	A BUILDING: _____ B WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 9 had a Haldol cream as needed for agitation. 5. According to an occurrence report dated 3-1-16 at 6:30 p.m., Tenant #2 made a comment to a new staff. Staff A came and got Tenant #2 and Tenant #2 refused. Staff A then grabbed Tenant #2 and took Tenant #2 into the library. Tenant #2 was placed in a chair and Staff A sat right in front of Tenant #2. Staff A was holding Tenant #2's hands. Staff A's feet were on top of Tenant #2's feet. It went on for about 15 to 20 minutes and the location was the alleged occurrence was the library. The occurrence report indicated the Director was notified on 3-21-16. The occurrence report was completed by Staff B and given to the Director on 3-23-16. The entry on the occurrence report regarding notification of the family with date and time was not completed The entry on the occurrence report regarding notification of the physician with date and time was not completed. The entry on the occurrence report regarding documentation in the tenant's file was not completed Narrative documentation on the occurrence report indicated the Director was first told verbally of the alleged occurrence when she arrived at work on 3-21-16. The Director addressed it with the Administrator that same morning. The Director was told to discuss it with Staff A and explain that was not proper procedure but it was also information given through third party statements. The Director asked Staff B, who witnessed the alleged event, to fill out the occurrence report as Staff B witnessed it. Staff B turned in the occurrence report on 3-23-16. The Director spoke with Staff	A 003		

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
	S0090	A. BUILDING=———— ——— B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 10 A and asked for Staff A's side of the story. Staff A said she could not remember exactly but Tenant #2 was doing something so Staff A took Tenant #2 into the library one to one. When the Director asked about the positioning that was reported, Staff A said she probably did have her feet on top of Tenant #2's feet because Tenant #2 was kicking. The Director explained that not unacceptable and it was a form of restraint. Staff A said she did not know that and would not do it again. 6. According to an interview with Staff A, Tenant #2 was going after another tenant and had tried to hit staff. The staff on that side of the building did not want to do anything because of Tenant #2's combativeness. Staff A and Tenant #2 went into he library. Staff A was initially sitting on the side of Tenant #2 and Tenant #2 tried to hit Staff A. Tenant #2 grabbed Staff A's wrist. Staff A then moved to sit in front of Tenant #2. Staff A tried to calm Tenant #2 down. Tenant #2's feet were on the inside of Staff A's shoes. Staff A's feet were not on top of Tenant #2's feet and Staff A's feet were on the outside of Tenant #2's feet. Staff A did not hold down Tenant #2's hands. No other staff came into the library and the door was closed with the light on. Staff A said no force was used to bring Tenant #2 into the library They were in the library for 10 minutes. According to an interview with Staff B, Tenant #2 made a comment to a new staff and Staff A took Tenant #2 into the library. Tenant #2 wanted to keep standing there and Staff A forced Tenant #2 into the library. Staff B was then with another tenant and not paying attention. Staff B came back and saw Staff A sitting directly in front of Tenant #2 and Tenant #2 was seated in a	A 003		

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
	S0090	A. BUILDING:_____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 003	Continued From page 11	A 003		

recliner. Staff A's feet were on top of Tenant #2's feet. Tenant #2's hands were in Tenant #2's lap and Staff A's hands were over Tenant #2's hands. Staff B did not know Tenant #2's reaction when Tenant #2 came out of the room. No other staff witnessed the alleged incident. The Assistant Director was there but might have been on a break. Staff A said to staff that Tenant #2 was going crazy and Staff A held Tenant #2 down. At that time Staff B did not know it was a form of restraint. Regarding why it was not reported earlier, Staff B said Staff B did not know it was wrong until Staff B talked to another staff.

According to an interview with the Assistant Director, she was the medication passer the morning of the alleged incident and did not believe she was in the building at that time; however, was on-call at the time of the alleged incident. The Assistant Director had no knowledge of the alleged incident prior to 3-30-16.

According to an interview with the Director, it was brought to the Director's attention on Monday morning (3-21-16) by another staff that Staff B witnessed an alleged incident between Tenant #2 and Staff A. It was reported to the Director that Tenant #2 was agitated and Staff A took Tenant #2 into the library. Tenant #2 was in the recliner and Staff A sat across from Tenant #2. Staff A's feet were on top of Tenant #2's feet and Staff A was holding Tenant #2's hands. The Director talked to the Administrator about the allegation. Staff B wrote the incident report and it was consistent with what staff had reported to the Director. Staff B gave the incident report to the Director on Wednesday (3-23-16) and the Director talked to Staff A on Friday (3-25-16).

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVJDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()(2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	S0090	A. BUILDING:_____ B WING	C 03/31/2016

NAME OF PROVJDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, A 52233

()(4)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 CORRECTNE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 003	Continued From page 12 Staff A said there was an incident and Staff A took Tenant #2 into the library to calm down. Staff A sat in front of Tenant #2 and Staff A was hanging on to Tenant #2's hands. Staff A said Staff A might have had Staff A's feet on top of Tenant #2's feet. The Director told Staff A it was a restraint and Staff A could not do it. Tenant #2 did not sustain any injuries. Staff A thought Tenant #2 was a threat to staff/tenants and Staff A did not realize it was a restraint. The date of the alleged incident was 3-1-16 and the Director did not find out until 3-21-16 The Assistant Director was there and on-call at the time of the allegation. 7. According to the Program's Occurrence Report policy, whenever an occurrence or event led to unintentional consequences and an unfortunate happening to a tenant, visitor or staff on the grounds of the Program an occurrence report must be completed. The occurrence report would be completed by the Unit Director and if the Unit Director was not available the report would be completed by the staff (s) involved. Completed occurrence reports would be routed to the Unit Director or designee, who would review and maintain the report. When in doubt, the form was to be completed. The responsible party was to be informed of any event that involved the tenant that required the completion of an occurrence report. Notification would be made by the Unit Director. If the occurrence required emergency services and the staff involved was unavailable, notification would be made by the direct caregiver.	A 003		
A 058	481-67 9(4)a Staffing 481-67 9(231B,231C,231D) Staffing.	A 058	Promise House Hiawatha will continue to assure compliance with nurse delegation procedures, assuring that all staff is trained to	5/31/2016

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50090	A. BUILDING: _____ B WJNG	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIPCODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(X4) JD 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 058	Continued From page 13 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program ' s newly hired registered nurse shall within 60 days of beginning employment as the program ' s registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on review of a staff file and review of Program documents the Program failed to have the Program's newly hired registered nurse (RN) within 60 days of employment document a review to ensure that staff were sufficiently trained and competent in all tasks that were assigned or delegated for Staff A. One staff did not have a documented review to ensure staff was sufficiently trained and competent in all tasks within 60 days of the RN's employment. 1. Staff A, a certified nursing assistant (CNA), was hired on 11-12-09. Staff A did not have a review documented by the Director, who was also a RN, within 60 days of the Director's employment to ensure Staff A was sufficiently trained and competent in all tasks assigned or delegated. The Assistant Director, a licensed practical nurse (LPN), completed a Medication Distribution Certification Form dated 7-1-15. The tasks listed included: hand washing, dispensing procedure, medication pass procedure, eye drop procedure, blood sugar training, wound care,	A 058	meet the needs of the tenants. Staff A has been trained and competency demonstrated for all delegated tasks. Compliance shall be maintained by the Quality Assessment & Assurance Committee monitoring all employee files to assure proper training has been completed.	

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
	S0090	A. BUILDING. _____ B WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 058	Continued From page 14 inhalers and diskus training and nebulizer training. The form indicated the undersigned had performed return demonstration of how medications were appropriately distributed. The form was not completed by an RN and was not completed within 60 days of the Director's employment. 2. According to the ALP Monitoring Entrance form, the Director was the delegating RN. According to a staff list, the Director was hired on 7-28-14.	A 058		
A 039	481-69.23(1)b Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on review of tenant files, observations, staff interviews and review of Program documents, the Program failed to follow admission and retention criteria for one of four tenant files reviewed (Tenant #2). One tenant exceeded the criteria for retention by requiring a routine two-person transfer with standing, transfers or evacuation. 1. Tenant #2, a 72 year old, was admitted on 1-18-15 and diagnoses included moderate Alzheimer's disease, cardiomyopathy, hypertension and carotid bruit. Tenant #2 was	A 039	Promise House Hiawatha will continue to comply with the criteria for admission/retention of tenants. All tenants will be evaluated and reviewed to assure they do not exceed the level of care criteria for Promise House Hiawatha. A waiver for Tenant #2 has been requested. We are asking for a Hospice referral. The Quality Assessment and Assurance Committee will assure compliance by reviewing tenant records to assure tenant is still appropriate for Promise House Hiawatha.	5/31/2016

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
	S0090	A. BUILDING: _____ B WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 CORRECTNE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 039	Continued From page 15 staged at a seven on the Global Deterioration Scale (GDS), which indicated very severe cognitive decline. According to a Nurse Review dated 3-15-16, the review was completed due to a significant change in Tenant #2. Tenant #2 had rapidly declined in all aspects of cognitive, physical and functional abilities. Tenant #2 was a GDS of seven and required total assistance with all aspects of activities of daily living (ADLs) due to the decline in cognition. Tenant #2's was oriented to self only and had garbled words. Tenant #2 had days when Tenant #2 was very lethargic and other days when Tenant #2 was very much alert. Tenant #2 had periods of agitation, which occurred normally in the late afternoon or evening. The periods of agitation had become less frequent, were decreased in intensity and had a shorter duration. Tenant #2 had a Haldol rub which seemed to be effective most of the time. Tenant #2 was minimally weight bearing and at times not at all. Tenant #2 was an assist of two with a gait belt for all transfers and staff propelled Tenant #2 in a wheelchai r. Tenant #2 was unable to make Tenant #2's needs known and was incontinent of bladder and bowel. Regarding meals, Tenant #2 needed cueing, was at times fed and had a decreased appetite overall. Tenant #2 had shown a rapid decline due to Tenant #2's disease process and had been changed to comfort care. According to a Health Status Review dated 3-15-16, Tenant #2 was transferred with assistance of two and was propelled in a wheelchair by staff. Staff was to perform all ADLs and allow Tenant #2 to do what Tenant #2 could do. According to a Geriatric Activities of	A 039		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()(2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	S0090	A. BUILDING: _____ B. WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA52233

()(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(JG) COMPLETE DATE
A 039	Continued From page 16 Daily Living Functional Assessment dated 3-15-16, there were scores for ADLs including: a score of two, which indicated able to perform task without assistance, a score of one, which indicated able to assist with the task and no more than one assistant needed and a score of zero, which indicated unable to give any assistance or required more than one assistant. Tenant #12 received zeros in all categories including: bathing, eating, dressing/grooming, transfer, ambulation, bowel/bladder continence and mental status. According to the service plan dated 3-15-16, Tenant #2 was alert and oriented to self only. Tenant #2 was incontinent of bladder and bowel and staff managed. Regarding mobility, Tenant #2 was a two assist with transfers. Tenant #2 had days where Tenant tl2 might be able to take a few steps or transfer but it was very rare anymore. Staff was to transfer and propel Tenant #12 in the wheelchair Staff was to assist/feed Tenant #2 as needed at meals. Tenant tl2 was bathed twice a week, staff was to encourage Tenant #12.'s participation with baths and allow Tenant tl2 to do whatever Tenant #12 could do. For grooming and personal hygiene Tenant tl2 received total assistance. Tenant #2 started on comfort care on 3-14-16 and Tenant #2 would remain comfortable and stay at the Program utilizing comfort care status. 2. According to observation on 3-30-16 at 11.35 a.m., Tenant #12 was transferred from a wheelchair to a dining room chair with two staff and a gait belt. According to observation on 3-31-16 at 4:38 p.m., Tenant #2 was transferred from a wheelchair to a dining room chair with two staff and a gait belt.	A 039		

DEPARTMENT OF INSPECTIONSANDAPPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50090	A BUILDING: _____ B.WING	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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 039	Continued From page 17 3. According to an interview with Staff A, Tenant #2 was a two person transfer all of the time, for the past one to two weeks. Tenant #2 did not help with cares. According to an interview with the Assistant Director, Tenant #2 was always a two person transfer. Tenant #2 had been a two person transfer for the past week or so. It was dependent on the day if Tenant #2 could bear weight. Tenant #2 used a wheelchair. According to an interview with the Director, Tenant #2 took two people to transfer 80% of the time and basically used two people to transfer most of the time. Tenant #2's weight bearing status was day to day. 4. According to the Program's protocol regarding level of care, the Program would not knowingly admit or retain a tenant who required a routine, two-person assistance with standing, transfer and evacuation.	A 039		