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
	S0191	A. BUILDING: _____ B. WING _____	07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINNWOOD ESTATES	700 NORTH LINN STREET GLENWOOD, IA 51534

(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	481-69 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: 26 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 27 TOTAL census of Assisted Living Program: 27 The following insufficiencies were cited during the recertification to determine compliance with certification for an Assisted Living Program:	A 000	See attached POC 9/5/16	
A 092	481-69.26(4)d Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant ' s abilities and personal interests This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to provide a list of person-centered planned and spontaneous activities for 1 of 1 tenant with a Global Deterioration Scale (GDS) score of 4 or higher.	A 092		

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

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
	S0191	A. BUILDING. _____ B. WING _____	07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINNWOOD ESTATES	700 NORTH LINN STREET GLENWOOD, IA 51534

(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 092	Continued From page 1 Findings follow: Tenant #1 had a diagnosis of allergies and back pain with GDS score of 5. Review of Tenant #1's service plan revealed no list of preferred or suggested activities. When interviewed on 7/29/16 at 2:00 p.m., the Registered Nurse (RN) confirmed activities were not addressed in Tenant #1's Service Plan.	A 092		

CAC 8/11/16

8/11/16

The following constitutes Linwood Estates responses to the regulatory deficiencies Noted on the annual inspection conducted 07/27/2016.The facility does not admit to truth or accuracy of the statements or allegations contained in the statement of deficiencies; however the facility remain committed to the delivery of high quality health care and services and will continue to make whatever changes and improvements that may be necessary to satisfy that objectives.

Please consider this response our credible allegation of compliance. Effective 09/05/2016

A 092

Tenant #1 Services plan has been updates to reflect a list of preferred Activities. 08/12/2016

Any Tenant with a GDS score of 4 or higher will have a list of preferred activities addressed on their service plan.

At this time we do not have any other tenants with a GDS score of 4 or higher.

When the tenants are evaluated at a change of condition and or quarterly the Service plans will include a preferred list of activities for those tenants that score 4 or higher on their GDS score. This will be monitored upon the changes of the services plans by the Program RN/ designee to assure compliance and report the results to the QA of the findings monthly for 3 months then quarterly for 1 year.