CAC 10/5/16

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
	S0258	A. BUILDING: _____ B WING _____ DK 10/5/16	C 08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT KEELSON HARBOUR	2810 AURORA AVENUE SPIRIT LAKE, IA 51360

(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: 46 Number of tenants with cognitive disorder. 3 Total Population of Program at time of on-site: 49 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 19 Total Population of Program at time of on-site: 19 TOTAL census of Assisted Living Program: 68 The investigations of program self-reported incident 62305-I and complaints #61561-C, #61563-C, #62297-C, and #62298-C were completed 8-29-16 to 8-31-16. No regulatory insufficiencies were cited during the investigation of incident # 62305-I and complaints #62297-C and #62298-C. The following regulatory insufficiencies were cited during the investigation of complaints #61561-C and #61563-C:	A 000	See attached POC error cac ~~10/5/16~~ 10/21/16	
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	A 083		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 083	Continued From page 1 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 interviews and record review, the Program failed to ensure service plans were updated with changes and met tenants' specific service needs. Findings follow: 1. Tenant #1, an 86 year-old was admitted on 7-27-14 and had diagnoses of: hypertension, depressive disorder, macular degeneration, C.difficle diarrhea, and stasis dermatitis of both legs. Record review revealed the following: a. Clinical Update Summary (evaluation), completed 8-3-16, documented Tenant #1 required full assistance with bathing and showering with little or no participation from Tenant #1. Tenant #1 required the assistance of one person for transfers, and was to be offered toileting every two hours. b. Doctor visit/contact form, dated 8-3-16, documented Tenant #1 required the assist of two for transfer and exceeded criteria for retention in an assisted living program. The form reported Tenant #1 to be weaker.	A 083		

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A 083	Continued From page 2 c. Master Care Plan, dated 5-6-16, indicated Tenant #1 was independent with mobility and transfer and required no assistance with toileting. When interviewed on 8-29-16 the registered nurse (RN) stated the service plan had not been updated with changes following the 8-3-16 evaluations. 2. Tenant #4, a 95 year-old, was admitted on 1-7-08 and had diagnoses of: arteriosclerotic heart disease. Tenant #4 missed four of 10 questions on the mental status questionnaire. Tenant #4 moved into the secured dementia following a physician visit on 6-7-16. a. When requested, the RN could not locate a service plan for Tenant #4. During interview, the RN explained the service plan was computer generated and the information on the service plan came from the clinical updates. b. Record review of the most recent clinical update (evaluations), dated 6-6-16, revealed Tenant #4 required reminders to take medications, but otherwise self-administered medications. When interviewed on 8-31-16 at 2:45 p.m., the Staff Development RN reported Tenant #4 had not self-administered medications since moving into the dementia unit. c. Further review of Tenant #4's most recent clinical update, dated 6-6-16, revealed Tenant #4 received physical therapy. When interviewed on 8-31-16 at 3:30 p.m., the RN reported Tenant #4 had not received physical	A 083		

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A 083	Continued From page 3 therapy since February of 2015, more than a year ago. 3. Tenant #6, a 77 year-old, was admitted on 1-30-16 and had diagnoses of: Parkinsonism type illness, diabetes, and hypertension. a. Record review revealed resident notes dated 7-18-16 documented Tenant #6 received a 30-day notice for discharge related to chronic urination in socially unacceptable public places. The service plan dated 8-24-16 failed to identify interventions for chronic inappropriate urination. When interviewed on 8-29-16 the RN confirmed Tenant #6's service plan provided no interventions to address chronic inappropriate urination. b. Record review revealed an incident report, dated 8-18-16, documented Tenant #6 verbalized suicidal thoughts. Tenant #6 was sent to the hospital for evaluation. The service plan dated 8-24-16 failed to identify Tenant #6's history of suicidal thoughts. Furthermore, the service plan failed to identify interventions or direction to staff in the event Tenant #6 verbalized thoughts of self-harm. c. Record review revealed incident reports dated 8-20, 8-21, and 8-22-16 documented Tenant #6 fell. Resident notes dated 8-21-16 documented an ambulance was called because Tenant #6 had fallen and could not follow commands. Emergency room records dated 8-21-16 documented Tenant #6 required fall precautions. The program failed to update Tenant #6's service plan with interventions for fall precautions following three falls in three days, and requiring	A 083		

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A 083	Continued From page 4 an emergency room visit.	A 083		
A 096	481-69.27(1)c Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(1)c To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status; and This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the Program failed to ensure completion of nurse reviews with changes of condition to assess and document the health status of each tenant, and to monitor progress related to previous recommendations with changes of condition. Findings follow: 1. Record review revealed the following: a. Record review revealed a doctor visit/contact form, dated 6-24-16, documented Tenant #1 had a weeping right eye and crust on his/her eyelid. According to the contact form, the eye appeared as if a blood vessel had broken and the left eye	A 096		

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A 096	Continued From page 5 was also red and crusty. The contact form requested an antibiotic. The physician signed the form and ordered an antibiotic to the affected eye for five days. Further record review revealed the Program failed to complete a nurse review to assess and document the health status of the eye and monitor progress of the eye following the completion of the eye antibiotic. b. A physician's order, dated 6-28-16, ordered an antibiotic for five days for an infection. Further review revealed a nurse review dated 6-30-16 documented the antibiotic ordered for an upper respiratory infection. The nurse review further documented Tenant #1 reported a change in health status with the respiratory infection; however, documentation of an assessment of the respiratory status could not be located. The program failed to complete an assessment and documentation of the health status of Tenant #1 following the upper respiratory infection and to monitor progress following completion of the antibiotic. c. A physician's order, dated 7-8-16, documented Tenant #1 ordered an antibiotic. Further review revealed resident notes, dated 7-8-16, documented the antibiotic ordered for a urinary infection. The program failed to complete a nurse review to assess and document Tenant #1's health status and monitor progress of the urinary infection following completion of the antibiotic.	A 096		

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A 096	Continued From page 6 2. Record review revealed the following: a. An incident report, dated 8-18-16, documented Tenant #6 verbalized suicidal thoughts and was sent to the hospital for evaluation. Further record review revealed Tenant #6's clinical record lacked documentation of a nurse review upon his/her return to the Program to assess and document his/her health status and to monitor progress following the verbalization of suicidal thoughts on 8-18-16. b. Incident reports dated 8-20, 8-21, and 8-22-16 documented Tenant #6 fell. Further record review revealed resident notes, dated 8-21-16, documented an ambulance was called because Tenant #6 fell and was unable to follow commands. Emergency room records, dated 8-21-16, documented Tenant #6 had been seen in the emergency room a few days earlier following verbalization of suicidal thoughts. At that time, a urinary tract infection (UTI) was discovered, and the tenant was prescribed the antibiotic Levaquin. During the emergency room visit of 8-21-16 Tenant #6 was noted to have a cough with grayish mucus and low oxygen saturation. He/She #6 complained of generalized weakness, and was ultimately diagnosed with bronchitis. Tenant #6 was discharged from the emergency room with instruction to discontinue the Levaquin and start the antibiotic Bactrim. Tenant #6 was to be on fall precautions, and respiratory symptoms were to be monitored closely. The Program failed to complete a nurse review following three falls in three days, a visit to the	A 096		

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A 096	Continued From page 7 emergency room for UTI with a change in antibiotic, and a new diagnosis of bronchitis to assess and document Tenant #6's health status and monitor progress.	A 096		
A 116	481-69.29(2) Staffing 481-69.29(231C) Staffing. 69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s). This REQUIREMENT *is not met as evidenced* by: Based on interview and record review, the Program failed to ensure a system in place to meet the emergency needs of tenants with cognitive impairment who resided in the general population. This affected 1 of 3 tenants (Tenant #5) with a Global Deterioration Scale (GDS) score of five or above. Findings follow: Tenant #5, a 79 year-old, was admitted on 5-28-16 and had diagnoses of: Alzheimer's dementia, chronic obstructive pulmonary disease, depressive disorder, and hypertension. Tenant #5 resided in the general population. Record review revealed staff communication forms dated 6-15-16, 6-18-16, and 7-20-16. According to the forms, on 6-15-16 Tenant #5 could not use the phone and required staff help to	A 116		

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A 116	Continued From page 8 dial the phone; on 6-18-16 Tenant #5 called 911 by mistake looking for "contacts" on the phone, and also required help to turn on the television; on 7-20-16 Tenant #5 could not remember living at the Program and staff had to direct Tenant #5 to his/her apartment. Additional record review revealed Tenant #5's Master Care Plan, dated 6-26-16. The plan documented Tenant #5 at five on the GDS, which indicated moderately severe cognitive decline. Tenant #5 was not aware of date or time and required more direction such as reminders for meals. Tenant #5 could not use a cell phone. The Master Care Plan failed to identify a system to meet the emergency needs of Tenant #5. When interviewed on 8-29-16 Staff A reported Tenant #5 was often confused and wandered frequently. When interviewed on 8-29-16, Staff B reported Tenant #5 had a memory of "10 minutes" and staff failed to routinely check on the tenant. Staff indicated no restrictions on Tenant #5 leaving the building. When interviewed on 8-30-16, Staff C reported Tenant #5 had walked to a local shopping area. Staff C reported Tenant #5 went out of the building but did not know which way to go once outside. She reported Tenant #5 could not find the dining room. Staff C reported staff did not check on Tenant #5 routinely. When interviewed on 8-30-16, the registered nurse (RN) stated tenants have been encouraged to use the phone for non-emergencies and use the call pendant for emergencies.	A 116		

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A 116	Continued From page 9 When interviewed the Administrator stated tenants in the dementia unit were checked every two hours. She stated Tenant #5 was not on two hour checks and did not reside in the dementia unit. The Program provided a policy "Memory Care Tenant Safety." The Program failed to provide a policy for the emergency needs of tenants with cognitive impairment in the general population.	A 116		

CAC
10/6/14 ✓ 10/5/16

ID Prefix Tag A083 Service Plans

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - The Director of Health Services or designee will re-evaluate each tenant cited (if still residing in the program) and, based on the specific needs of the tenant, develop interventions with each tenant in their service plan.

2. What measures will be taken to ensure the problem does not recur.
    - The Executive Director and the Director of Health Services or designee will review the related Policies and Procedures to assure the process of identifying necessary changes in the Service Plan are completed when the evaluation of the tenant indicates the need for a change and how to communication these changes to the staff.
    - The Director of Health Services or designee will educate all staff regarding the completion of evaluations and the development of service plans. Staff will be trained to report changes in condition to the Director of Health Services or designee and that the Nurse will address necessary changes identified through evaluation and in the service plan.

3. How the Program plans to monitor performance to ensure compliance.
    - The Executive Director or designee will conduct an audit of each tenant's record following a change in functional, cognitive or health status, comparing the Nurse evaluation of the tenant to the service plan developed with the tenant.

4. The date by which the regulatory insufficiency will be corrected.
    - Keelson Harbour will be in compliance by October 21, 2016.

ID Prefix Tag A096 Nurse Review

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - The Director of Health Services or designee will assess and document the health status of each tenant cited (if still residing in the program), make recommendations and referrals as appropriate and monitor progress related to recommendations. The assessment will be completed at least every 90 days and when the tenant experiences a change in health status.

2. What measures will be taken to ensure the problem does not recur.
    - The Executive Director and the Director of Health Services or designee will review the related Policies and Procedures to assure the process of identifying tenants that require a Nurse Review includes a re-evaluation identifying necessary changes in the Service Plan and the communication of these changes to the staff.
    - The Director of Health Services or designee will educate all staff regarding the completion of evaluations and the development of service plans. Staff will be trained to report changes in condition to the Director of Health Services or designee and that the Nurse will address necessary changes identified through evaluation and in the service plan when there is a change in condition.

3. How the Program plans to monitor performance to ensure compliance.
    - The Executive Director or designee will conduct an audit of each tenant's record following a change in health status, comparing the documented Nurse Review of the tenant to the service plan developed with the tenant.

4. The date by which the regulatory insufficiency will be corrected.
    - Keelson Harbour will be in compliance by October 21, 2016.

ID Prefix Tag A116 Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - The Director of Health Services or designee will re-evaluate each tenant cited (if still residing in the program) and develop interventions with each tenant for their service plan based on the specific needs of the tenant, including those needs related to cognitive disorders.

2. What measures will be taken to ensure the problem does not recur.
    - The Executive Director or designee will review current policies and procedures that address the care of tenants with cognitive disorders and assure that staff procedures address how the program will respond to the emergency needs of the tenant.
    - The Director of Health Services or designee will educate all staff regarding the completion of cognitive evaluations and the purpose of additional supervision and/or emergency services for those tenants who demonstrate a cognitive disorder. Staff will be trained in regard to policies and procedures that address response to the emergency needs of tenants with cognitive disorders.

3. How the Program plans to monitor performance to ensure compliance.
    - The Executive Director or designee will conduct an audit of service plans for each tenant demonstrating a GDS score of 4 or greater to make sure the service plan addresses the emergency needs of the tenant. All staff will be advised of audit results and any resulting updates to policies or procedures as a result of these audits.

4. The date by which the regulatory insufficiency will be corrected.
    - Keelson Harbour will be in compliance by October 21, 2016.