√ AK 12/9/14

PRINTED: 12/08/2016
FORM APPROVED

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
	S0331	A. BUILDING: ______ B. WING ______	11/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF DUBUQUE	**3390 LAKE RIDGE DRIVE DUBUQUE, IA 52003**

(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: 73 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 73 TOTAL census of Assisted Living Program: 73 The following regulatory insufficiency was cited during the Recertification conducted to determine compliance with certification for an Assisted Living Program.	A 000		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on record reviews, the Program failed to address the tenant's identified needs and preferences for assistance in the service plan for 4 of 7 tenants reviewed (Tenant's #1, #2, #3 & #4). Findings include: 1. According to Incident Reports dated between 9-28-16 and 10-27-16, Tenant #1 had four falls.	A 089	At the suggestion of the surveyor, sample service plans were obtained from other AL's. These were utilized to develop a more comprehensive form that will be used going forward. Staff have been educated on the new form. The nurses have a weekly conference and will include reviewing service plans from weekly charts on a rotating basis.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 12-9-16

STATE FORM 6899 3PRP11 If continuation sheet 1 of 4

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A 089	Continued From page 1 Tenant #1 denied any pain or injury. According to an Emergency Department report dated 10-24-16, Tenant #1 had a fall, leg pain and hand pain. Diagnoses indicated a closed displaced fracture of shaft of fifth metacarpal bone of left hand and a closed fracture of proximal end of right fibula. According to Clinical Notes dated 10-24-16 staff reported Tenant #1 complained of pain in left hand and right leg. Family transported Tenant #1 to the ER. The tenant returned later in the day wearing a soft cast on left hand and a boot on the right leg. Tenant #1's service plan was not updated to indicate fall interventions, the need for a hand cast and leg boot or cares related to the cast and boot. 2. According to Clinical Notes dated 9-6-16, a tenant reported Tenant #2 was in the apartment the previous day, sitting in a chair with closed eyes and unresponsive. Tenant #2's hands were quivering. The episode lasted between three and five minutes. After the incident Tenant #2 responded to the other tenant, but their talk was gibberish. Tenant #2's physician was notified. According to an Incident Report and clinical notes dated 10-26-16 at 8:15 a.m. while in the whirlpool, Tenant #2 was responding to staff. The tenant then closed his/her eyes and became nonresponsive. No eye movement or other repetitive movement was noted. The tenant remained nonverbal for 5-10 minutes. When starting to respond, the tenant was unable to state place or day. A call was made to 911. The tenant was sent to the hospital for assessment. According to an Incident Report dated 10-26-16 at 5:10 p.m., Tenant #2 was shaking, did not appear to be "with it," did not understand what was being said, didn't know the year, day, location, or son's name and kept pulling at things	A 089	Tenant #1 has transferred to a higher level of care for therapy. If tenant returns the new service plan form will be utilized to include all identified needs. 12-6-16 Tenant # 2 A new service plan has been developed using the new form. the new plan identifies Seizure precautions and safety measures along with personal hygiene measures. 12-5-16	

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A 089	Continued From page 2 on the table. Tenant #2 was sent to the ER and admitted to ICU due to having seizure activity, elevated temperature and a cloudy lung. According to Clinical Notes dated 10-31-16, Tenant #2 had a short hospital stay for a diagnosis of seizures. Home health aide services were being provided to maintain safety measures and to provide personal hygiene. The service plan was updated on 10-31-16 indicating assistance with bathing three times per week. The service plan did not indicate services to maintain safety measures or to provide personal hygiene. Seizure precautions were not reflected in the service plan. 3. According to a 90 Day Nurse Review dated 10-5-16, Tenant #3 received housekeeping weekly, followed a low salt diet to control edema, was independent in applying support stockings daily and was aware of leg elevation when sitting, had ongoing chronic back pain and took pain relievers as needed. The service plan was updated on 10-13-16 reflecting Tenant #3's admission to hospice. The service plan did not reflect what services would be provided by the hospice program, nor did the service plan indicate a low salt diet to control edema, the use of support stockings, the need to elevate legs when sitting or the ongoing chronic back pain and pain medication as needed . The 90 day review indicated housekeeping weekly, the service plan indicated light housekeeping every other week. 4. According to a physician order, Tenant #4 would be undergoing eye surgery on 10-20-16 and was to use eye drops for at least one month post-operatively, three types of eye drops with different dosing schedules. According to an Eye	A 089	Tenant # 3 the new form was utilized to develop a new service plan which was reviewed with Tenant # 3. The new plan identifies services provided by hospice, diet, support stockings, leg elevation and pain / pain medication and housekeeping frequency 12-7-16	

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A 089	Continued From page 3 Drop Form, staff assisted Tenant #4 with eye drops from 10-28-16 through 11-18-16. The service plan was not updated to reflect the additional services of Tenant #4's need for assistance with eye drops post surgery. The service plan indicated no medication services were provided.	A 089	Tenant #4 - the eye drop regimen is furnished. Staff is no longer assisting with medications 12-7-16	