Cac 12/30/16

PRINTED: 12/19/2016
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
	S0107	A. BUILDING: _____ B. WING _____	C 12/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW LODGE	312 SOUTHBROOKE DR WATERLOO, IA 50702

(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. TOTAL census of Assisted Living Program: Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 10 Number of tenants with cognitive disorder: 39 Total Population of Program at time of on-site: 49 TOTAL census of Assisted Living Program: 49 The following regulatory insufficiencies were cited during the recertification conducted to determine compliance with certification for an Assisted Living Program(ALP) and the investigation of complaint #65528-C:	A 000	See attached POC 12/27/16	
A 004	481-67.2(1)a Program policies and procedures 481-67.2(231B,231C,231D) Program policies 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. 67.2(1) The program ' s policies and procedures on incident reports, at a minimum, shall include the following: a. The program shall have available incident report forms for use by program staff.	A 004		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 004	Continued From page 1	A 004		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the Program failed to complete incident reports for unusual occurrences in accordance with Program policy. This affected 2 of 2 tenants who reported missing money.

Finding follows:

Record review on 12/15/16 revealed the Program indicated Tenant #1 experienced a theft.

Further record review revealed incident reports could not be located regarding the missing money. When requested, the Program was unable to provide incident reports.

Additional record review revealed the Program's policy and procedure for reporting incidents and abuse reporting. According to the policy, any unusual occurrences should be reported as an incident report, and would be completed by the completed by the person in charge at the time of the incident.

When interviewed on 12/6/16 at 9:45 a.m., the Director confirmed Tenant #1 and Tenant #2 had reported missing money. The Director stated incident reports had not been completed, but should have been completed following reports.

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A 147	Continued From page 2	A 147		
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, staff failed to give medication as the physician prescribed. As a result, 2 of 5 sample tenants (Tenant #4 and Tenant #5) received the incorrect medication. Findings follow: 1. Record review on 12/5/16 revealed an incident report dated 11/12/16 documented Tenant #4 was given the wrong medications including a blood pressure medication, and a dose of warfarin (blood thinner) in a dose different than prescribed. 2. Additional record review on 12/5/16 revealed an incident report dated 11/12/16 documented Tenant #5 given the wrong medications including finasteride for prostatic enlargement and a dose of warfarin in a dose different than prescribed. When interviewed on 12/5/16 at 10:40 a.m., the registered nurse (RN) stated Tenants #4 and #5 resided in the same apartment and the staff had punched the pills out of the bubble pack at the	A 147		

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A 147	Continued From page 3 same time for each of the tenants. The RN stated the staff should have punched pills out for one tenant at a time. The RN confirmed medications were not given as prescribed.	A 147		
A 226	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to consistently ensure staff received minimum annual training required for a dementia-specific program. This pertained to 3 of 3 staff employed for more than a year. Findings follow: Record review on 12/5/16 revealed Staff A, Staff B, and Staff C's personal records lacked documentation of dementia training completed in the past year. Additional record review revealed the following: 1. Staff A was hired 12/19/11 and employed as direct-care staff. 2. Staff B was hired 8/28/15 and employed as direct-care staff.	A 226		

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A 226	Continued From page 4 3. Staff C was hired 9/24/15 and employed as direct-care staff. When interviewed on 12/6/16 at 8:50 a.m. the Director confirmed Staff A, Staff B, and Staff C were direct-care staff and had not received eight hours of dementia training in the last year.	A 226		

CAC 12/30/16

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MyLife Retirement Living

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December 27, 2016

Catie Campbell, Program Coordinator

Adult Services Bureau

Health Facilities Division

Re: Lakeview Lodge Investigation #65528-C

Lakeview Lodge

Plan of Correction

A 004 – 481-67.2(1)a Program Policies and Procedures

1. Incident reporting forms will be completed for all unusual occurrences within the program.
2. Incident reporting policies and procedures were reviewed at a staff inservice on 12/13/16.
3. Program director and nurse coordinator will discuss each incident report at time of incident awareness to determine if notification to the department is necessary.
4. Date insufficiency will be corrected – 12/27/16

A 147 – 481-67.5(6)d Medications

1. When administering medications in a room with double occupancy staff will administer medications to one resident at a time.
2. Medication administration policies and procedures were reviewed at a staff inservice on 12/13/16.
3. Aside from deeming staff competent in medication administration upon initial orientation and annual review, program nurse coordinator will also observe staff medication pass periodically in rooms with double occupancy.
4. Date insufficiency will be corrected – 12/27/16

Continued, page 2.