1/30/17

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
	S0168	A. BUILDING: _____ B. WING _____	C 12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS ASSISTED LIVING	512 13TH STREET WELLMAN, IA 52356

(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: 3 Number of tenants with cognitive disorder: 9 Total Population of Program at time of on-site: 12 TOTAL census of Assisted Living Program: 12 An investigation of Complaint #63353-C was completed and there were regulatory insufficiencies identified.	A 000		
A 003	481-67.2 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview the Program failed to follow their policy and procedure for the completion of incident reports	A 003	See attached Plan of Correction DOC 1/31/17	

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

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A 003	Continued From page 1 for unusual occurrences related to 1 of 3 tenants reviewed (Tenant #1). Findings follow: 1. Record review of Tenant #1's file revealed a diagnosis of dementia. The tenant was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Review of Tenant #1's Nurse's Notes indicated the following incidents: - On 8-4-16 (late entry for 8-2-16) Tenant #1 used his/her full body weight to hit the door with their shoulder in an attempt to leave the building. This occurred on two different doors. - On 8-6-16 Tenant #1 went to the west door and tried to leave. The alarm sounded and the tenant was asked to step away from the door. Tenant #1 then quickly headed to the staff with their fist/arm drawn back as if to hit the staff. Tenant #1 stopped and then walked up and down the hall looking out doors. - On 8-12-16 staff noted an electrician was working on a door and asked the electrician not to let anyone through the door when the electrician left. Staff walked by Tenant #1 coming down the hallway, turned around to check on him/her again, Tenant #1 became angry and pulled his/her fist/arm back as if to hit staff. Staff turned and began walking away and Tenant #1 came after staff. Staff ran up the hallway and yelled for other staff. Tenant #1 ran after staff and staff went into another room. Tenant #1 paced in the hallway for approximately five minutes and then sat in the common area. - On 8-14-16 Tenant #1 said there had been an accident, someone had died and he/she was going to the hospital to identify the person. Tenant #1 appeared panicked and nervous. Tenant #1 wanted to leave and staff let Tenant #1 into the courtyard. Tenant #1 became angry as	A 003		

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A 003	Continued From page 2 he/she could not get the gate open and then rushed back to the door and came inside. Tenant #1 continued to exit seek and door alarms sounded. Staff let Tenant #1 back into the courtyard and Tenant #1 was looking for a car to leave. When staff said there were no keys Tenant #1 raised his/her right fist over his/her head and shook it at staff. Tenant #1 was back in the building and continued to set off the door alarms for approximately 20 minutes. - On 8-19-16 Tenant #1 was trying to hit and kick staff. Staff left the area to get the portable phone and Tenant #1 came after staff with his/her fist raised. Staff put an office chair between them and called for assistance. Tenant #1 kicked the chair with fists raised. - On 9-22-16 Tenant #1 was sitting in a common area where he/she had sat all night refusing to go to their apartment. The tenant's pants were wet with urine. Two staff attempted to help the tenant go to their apartment. The tenant stood up and hit both staff with his/her fists. Once in the aparmtnet, the tenant continued to hit and kick all staff who attempted to help him/her change clothes. - On 9-23-16 Tenant #1 tried opening the door to the east while carrying some of his/her belongings. When the alarm sounded staff intervened. The tenant pulled back an arm with a fist as if to punch staff in the face. - On 9-23-16 a nurse was summoned to the area via phone as the direct care staff stated Tenant #1 was "out of control." Tenant #1 tried to hit staff and attempted to leave the building. The nurse tried to redirect Tenant #1 and he/she ran towards the nurse with double fists and chased the nurse out of the door. The nurse came back inside through another door. Tenant #1 saw the nurse and chased after her with both fists raised and shouted, "I outta kill you."	A 003		

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A 003	Continued From page 3 A review of Incident Reports (IR) dated from 1-15-16 to 10-13-16 revealed none of the above incidents were documented on an IR form. 2. An interview with the Director of Nursing on 12-22-16 at 12:40 p.m. revealed the charting for behaviors was completed in Nurse's Note/Progress Notes. 3. The Program's policy and procedure regarding incidents indicated a licensed nurse would document all unusual occurrences on an incident report and in the Nurse's Notes.	A 003		
A 040	481-69.23(1)c(1) 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: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharge 1 of 1 tenants reviewed who demonstrated aggression towards others and exit seeking behaviors (Tenant #1). Findings follow: 1. Review of Tenant #1's file revealed a diagnosis	A 040		

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A 040	Continued From page 4	A 040		

of dementia and a GDS score of six which indicated severe cognitive decline. Tenant #1 transferred to a higher level of care on 10-17-16.

A review of Nurse Reviews revealed the following:

- The review dated 3-12-16 revealed Tenant #1 had been set to move to a nursing facility on 1-15-16. However, the Program had recently amended the occupancy agreement/contract to include individuals with a GDS of 6 or lower. As a result, Tenant #1 was allowed to remain in the Program.
- The review dated 6-30-16 revealed a black toilet seat was installed in order to help the tenant see the toilet better and stop urinating in the garbage can. The family also replaced a recliner that had been ruined due to the tenant's incontinence. In addition the tenant had displayed unmanageable aggression towards staff and other tenants.
- The review dated 7-17-16 revealed Tenant #1 required an increase in reminders and cueing for activities of daily living. In addition the tenant had displayed unmanageable aggression towards staff and other tenants. Staff had tried interventions without relief. On 7-11-16 Tenant #1 had displayed exit seeking behaviors by pushing on various doors in the building.
- The review dated 9-13-16 revealed Tenant #1 had displayed unmanageable aggression toward staff and other tenants. Staff had tried interventions without relief. Tenant #1 also had unmanageable incontinence and refused to change wet clothes. The tenant often became angry with cueing and hit their fist in their hand. Tenant #1 refused showers by staff (family assisted) and often refused to come out for meals. Tenant #1 had attempted to choke and hit staff. He/she had also hit the glass in the doors

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A 040	Continued From page 5 and had hit walls. A review of Nurse's Notes revealed several entries regarding aggression and exit seeking behaviors including the following: - On 6-30-16 a call was made to Tenant #1's legal representative regarding an increase of behaviors and the need to move to a higher level of care as he/she was no longer appropriate for assisted living. - Exit seeking behaviors were displayed on 8-2-16. - Exit seeking behaviors were displayed on 8-6-16. In addition the tenant walked toward staff with his/her arm drawn back as if to hit staff. - Attempted aggression toward staff occurred on 8-12-16. - Multiple attempts to leave the Program occurred on 8-14-16. In addition, the tenant shook their fist at staff. - Aggression toward staff occurred on 8-19-16. - Exit seeking behaviors and aggression to staff occurred multiple times on 9-23-16. 2. Nurse Reviews and Nurse's Notes documented conversations with Tenant #1's family, legal representative, the Ombudsman and administrative staff regarding the need to transfer Tenant #1; however, no 30 day discharge notice was ever given to Tenant #1 or his/her legal representative regarding the need for transfer. 3. An interview with Staff A on 12-22-16 at 1:24 p.m. revealed Tenant #1 exceeded the level of care due to unmanageable incontinence, refusal to allow assistance with managing his/her incontinence, refusal to allow staff to assist with showers, refusal of meals at times, and having delusions. These types of behaviors had occurred for 8 to 10 months prior to the tenant's	A 040		

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A 040	Continued From page 6 discharge. An interview with the Director of Nursing (DON) on 12-22-16 at 12:40 p.m. revealed there had been meetings regarding level of care including concerns regarding unmanageable incontinence, cognitive level and behaviors. Behaviors started to make a difference with cares in December of 2015. Medication changes had occurred but were not effective and the behaviors were unchanged. An interview with the AL Director on 12-22-16 at 2:27 p.m. revealed Tenant #1 had exceeded level of care due to incontinency, and verbal and physical aggression. Tenant #1's behaviors were mostly directed towards staff; however, other tenants were scared of him/her. There was no written notice given regarding transfer to Tenant #1 or Tenant #1's legal representative. An interview with the Administrator on 12-22-16 at 3:00 p.m. revealed Tenant #1 had exceeded the level of care. The biggest concern with Tenant #1 was the fear of him/her acting out towards other tenants. Tenant #1 had displayed exit seeking behaviors, incontinence and behaviors towards staff. An involuntary discharge notice was not given to Tenant #1 or Tenant #1's legal representatives as the Program was working with the family to find an appropriate placement. 4. The Program's Occupancy Agreement indicated under certain circumstances a significant change in the tenant's condition might result in the need for the provision of services that exceeded the type or level of services permitted in an assisted living program or permitted per the occupancy agreement. In those circumstances the Program would provide written notice to the	A 040		

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A 040	Continued From page 7 tenant of the need for discharge. The Program would terminate the occupancy agreement and initiate procedures to ensure a safe and orderly transfer of the tenant if the tenant met one or more of the following conditions including: was dangerous to self, other tenants or staff and had unmanageable incontinence despite an individualized toileting program. The Program reserved the right to determine appropriate level of care for the tenant based on history, interventions and GDS score.	A 040		
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 interview and record review the Program failed to develop a service plan that reflected identified needs for 1 of 3 tenants reviewed (Tenant #1). Findings follow: Record review of Tenant #1's file revealed he/she had a diagnosis of dementia and was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. A review of Nurse Reviews dated 6-30-16, 7-17-16 and 9-13-16 and Nurse ' s Notes dated 8-2-16, 8-6-16, 8-12-16, 8-14-16 and 9-23-16 revealed Tenant #1 had issues regarding exit seeking behaviors and aggression/threats of	A 089		

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A 089	Continued From page 8 aggression towards others. In addition, the Nurse review dated 9-13-16 revealed Tenant #1 had unmanageable incontinence and refused to change wet clothes or allow staff to assist with changing. Tenant #1 often became angry with cueing and hit his/her fists in his/her hand. Tenant #1 refused showers by staff and often refused to come out for meals. Interviews with Staff A (12-22-16 at 1:24 p.m.), the DON (12-22-16 at 12:40 p.m.), the AL Director (12-22-16 at 12:40 p.m.) and the Administrator (12-22-16 at 3:00 p.m.) revealed concerns regarding aggression towards others, exit seeking behaviors, incontinency, refusal to cooperate with staff to change wet clothes or to shower, and meal refusals. The most recent service plan dated 7-17-16 was not amended to address aggressive and exit seeking behaviors, the routine nature of refusals of assistance with managing his/her incontinence and the periodic refusals of meals.	A 089		

1/30/17

A000

Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency.

Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of appeal of these matters solely because of the requirements under State and Federal law that mandate submission of a plan of correction within ten (10) days of the receipt of survey findings. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admission by the facility.

A003

a. All incident reports of unusual occurrences will be documented in the nurse's notes and on an incident report.
b. The Administrator, Assisted living director, assisted living staff and the Director of nurses has been educated on when to document on incident reports.
c. The Assisted living director will Audit incident reports weekly for 3 months. Results of the audits will be taken to QAPI for review / revision as appropriate.
d. This will be completed by January 27, 2017

A040

a. All tenants were reviewed to assure they meet care criteria for Assisted living per policy.
b. The Assisted living director has been re-educated on the admission/retention policy.
c. Retention and Admission of residents will be monitored by the assisted living director through assessments indicating appropriateness. Residents who do not meet the criteria will have their responsible party contacted for appropriate placement. The Assisted living director will Audit incident reports weekly for 3 months.
d. Results of the audits will be taken to QAPI for review / revision as appropriate.
e. This will be completed by January 27, 2017.

A089

a. All Service plans in Silver Ponds will be reviewed and updated. The service plan shall be individualized and shall indicate, at a minimum, the tenant's identified needs and preferences for assistance.
b. The Administrator, Assisted living director and the Director of nurses has been educated on service plans as of 01/11/2017.
c. The Assisted living director will Audit service plans weekly for 3 months. Results of the audits will be taken to QAPI for review *I* revision as appropriate.
d. This will be completed by January 27, 2017.

1/30/17