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
	S0347	A. BUILDING: _____ B. WING _____	C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN PLACE	1406 EAST 19TH STREET ATLANTIC, IA 50022

(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 Definition Number of tenants without cognitive disorder: 38 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 44 TOTAL census of Assisted Living Program: 44 A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. In addition to the recertification visit, Complaint #66805-C was investigated. The following regulatory insufficiencies were identified:	A 000	See attached POC 6/15/17	
A 012	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure all tenants treated with consideration, respect and full recognition of personal dignity and autonomy regarding their	A 012		

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A 012	Continued From page 1 safety. This potentially affected all tenants (census of 44). Findings follow: 1. A community meeting was held on 4-4-17 at 1:15 p.m. with 13 tenants in attendance. When asked about safety the majority of the tenants at the meeting said they did not feel safe and voiced concerns regarding a tenant who resided at the Program. The tenant they spoke of wandered the halls, went into other tenants' apartments and wiggled the door handles on those apartments that were locked. The tenants voiced they did not feel safe because of the tenant's behavior. Tenants were encouraged to lock their doors; however, the tenants did not feel they should have to lock their doors to feel safe. One tenant shared a specific allegation regarding the tenant who wandered and an alleged incident that occurred when the tenant entered his/her apartment. The tenant shared in front of the group of tenants at the meeting that he/she was "mauled" by the other tenant. 2. Record review of Tenant #2's file revealed Tenant #2 was admitted on 1-11-17 and had a diagnosis of dementia. Tenant #2 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. The service plan dated 2-13-17 reflected Tenant #2 had difficulty finding his/her apartment although it had improved as he/she adjusted to new surroundings. If staff noted Tenant #2 going into a wrong apartment they were to approach him/her with a smile and offer to show him/her the correct apartment or offer a distraction. Tenant #2 had difficulty finding the bathroom and had incidents of voiding in inappropriate (though private) areas. A toileting program had been started to help him/her find the bathroom when	A 012		

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A 012	Continued From page 2 needed. Resident Service Notes dated 4-5-17 indicated there was a plan to discharge Tenant #2 on 4-10-17. 3. Interview with Staff H on 4-4-17 at 6:01 p.m. revealed Tenant #2 wandered the halls, nearly every night and would go up to and wiggle door handles on apartment doors. If it was locked he/she would move on to the next door. Tenant #2 had gone into other tenants' apartments and most tenants now locked their doors. Staff H said Tenant #3 "freaks out" and had panic attacks about Tenant #2 coming into his/her apartment and was scared of Tenant #2. An incident had occurred when Tenant #3's family was in the apartment with the tenant and Tenant #2 came into the apartment uninvited. When interviewed on 4-4-17 at 5:39 p.m. Staff I said some tenants were a little nervous about Tenant #2 wandering around and wiggling the door handles. When interviewed on 4-5-17 at 9:01 a.m. Staff F revealed Tenant #2 wandered the halls in the evenings, but not as frequently during the day. She explained Tenant #2 attempted to shake the door handles and, on the second shift, had gone into other tenants' apartments. Tenant #3 was recently shaken up when a guest arrived and didn't lock the apartment door after entering, and Tenant #2 went into the apartment. Another tenant had told Staff F he/she was scared of Tenant #2. Staff F stated tenants now locked their apartment doors. When interviewed on 4-5-17 at 10:00 a.m. Staff G reported Tenant #2 generally wandered three	A 012		

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A 012	Continued From page 3 out of five nights. According to Staff G, Tenant #2 went into other tenants' apartment on second shift, but it didn't happened as much on third shift as everyone kept their doors locked. Staff G reported two tenants voiced they were afraid of Tenant #2.	A 012		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a criminal history background check and child and dependent adult abuse checks prior to employment for 1 of 6 staff files (Staff A). Findings follow: 1. Record review of Staff A's file revealed a hire date of 10-4-16. A criminal history background check and abuse registries check was completed on 10-31-16 and revealed no results for the abuse registries check and further research required for the criminal background check. After further research no record was found dated 11-3-16. A timecard exception document	A 118		

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A 118	Continued From page 4 indicated Staff A first worked on 10-4-16. Staff A also had nurse delegation training documented on 10-4-16 and dementia training on 10-28-16. Staff A had training and received paid wages prior to the completion of the criminal history background check and abuse registries check. A background check was not completed prior to employment of Staff A. 2. A statement from the Area Manager of Operation dated 4-5-17 indicated when Staff A was originally hired the background check was completed and reviewed as indicated with no results found. Staff A was scheduled and began orientation. When the New Hire binder was being put together it was discovered further research was needed. Staff A was pulled from the schedule for the next three weeks until a cleared background check came through. The check was completed during the orientation of a new management assistant which might have contributed to the oversight. 3. An interview with the Area Manager of Operation on 4-5-17 at 2:39 p.m. revealed no additional information was found regarding Staff A's background check.	A 118		
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	A 089		

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A 089	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to indicate tenants' identified needs for 2 of 5 tenant files reviewed (Tenants #1 and #5). Findings follow: 1. Record review of Tenant #1's file revealed diagnoses including senile dementia and staged him/her at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 received Hospice services. Tenant #1's service plan, dated 2-13-17, reflected staff assisted him/her to the bathroom by a pivot transfer from the wheelchair to the toilet with the use of the safety railing and a gait belt. Tenant #1 was able to stand and pivot onto the toilet. The service plan indicated Tenant #1 required physical assistance with transfers with one staff and a gait belt. An interview with Staff F on 4-5-17 at 9:01 a.m. revealed Tenant #1 required two people to transfer approximately 10% of the time, and it was dependent on his/her mood. During toileting with Tenant #1, one staff transferred and one staff assisted with pulling up and down pants. Tenant #1 could not grab the bar and could not tell staff he/she needed to go. An interview with Staff G on 4-5-17 at 10:00 a.m. revealed staff changed Tenant #1 in bed on third shift. An interview with Staff I on 4-4-17 at 5:39 p.m. revealed two staff assisted Tenant #1 with toileting. An interview with Staff J on 4-5-17 at 1:40 p.m.	A 089		

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A 089	Continued From page 6	A 089		

revealed Tenant #1 required one person to transfer; depending on Tenant #1. When he/she grabbed or pinched, Staff J preferred to have a second staff at those times. Staff J was more comfortable with a second staff in the room to spot. During toileting one staff did the transfer and one did the cares for Tenant #1. Tenant #1 could lean forward for staff to assist with cleaning him/her but could not pull up pants. Tenant #1 could grab the bar and voided when on the toilet.

When interviewed on 4-5-17 at 11:47 a.m., the Nurse reported Tenant #1 required two people to assist with transfers approximately 40 to 50% of the time. The nurse indicated when on the toilet Tenant #1 would attempt to wipe himself/herself and grab the bar. The nurse stated staff repositioned and checked Tenant #1 every two hours during the night.

Further record record review revealed Tenant #1's service plan failed to reflect Tenant #1 required the assistance of two staff for transfers at times. The service plan did not reflect staff assistance with toileting, including the use of two staff at times. The service plan also did not reflect staff repositioned, checked and changed Tenant #1 in bed on third shift. The service plan failed to adequately reflect the identified needs of Tenant #1.

2. Record review of Tenant #5's file revealed the service plan, dated 1-11-17, reflected the tenant transferred with assistance of one staff and a gait belt.

When interviewed on 4-5-17 at 9:01 a.m. Staff F reported Tenant #5 required two people to assist with transfers approximately 50% of the time. At times Tenant #5 would bear weight, and

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A 089	Continued From page 7 sometimes Tenant #5 would grab the bar to assist with toileting. An interview with Staff G on 4-5-17 at 10:00 a.m. revealed Tenant #5 had a significant decline and approximately 80% of the time required two staff to transfer Tenant #5. When interviewed on 4-4-17 at 6:01 p.m. Staff H reported Tenant #5 sat during the middle of transfers in the last couple of weeks. An interview with the Nurse on 4-5-17 at 11:47 a.m. revealed transfers were getting more difficult and two staff were used part of the time. Tenant #5 recently had two urinary tract infections. Tenant #5 did not routinely require a two person transfer, but required the assistance of two approximately 25 % of the time. Further record review revealed Tenant #2's service plan dated 1-11-17 did not reflect Tenant #2 required assistance of two staff for transfers at times. The service plan failed to adequately reflect the identified needs of Tenant #2.	A 089		
A 107	481-69.28(5)a(3) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully	A 107		

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A 107	Continued From page 8 completed a state-approved food protection program by: (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program ' s curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have anyone responsible for food preparation complete a state approved food protection program. This potentially affected all of the tenants (census of 44). Findings follow: 1. Staff B, a chef, was hired 12-27-16. 2. Staff C, a chef, activity staff, direct care staff, and maintenance staff, was hired 9-6-15. 3. Staff D was no longer employed by the Program effective 11-22-16 and had a Servsafe certificate. Staff E was no longer employed by the Program and had a Servsafe certificate. Servsafe certificates were provided for two former staff (D and E); however, no current staff had completed a state approved food protection program.	A 107		

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A 107	Continued From page 9 4. An interview with the Area Manager of Operation on 4-5-17 at 2:39 p.m. revealed no current staff with Servsafe training. Staff B was in charge of ordering and preparing meals. There were no major complaints with food and there had been no food bourne illnesses. 5. The Program's policy regarding food service indicated a minimum of one person on staff at the Program should complete a state approved food protection program by obtaining a certification as a dietary manager or food protection professional, or the successful completion of a course meeting the requirements for a food protection program in the Food Code adopted pursuant to Iowa Code Chapter 137F.	A 107		

April 26th, 2017

Ms. Linda Kellen, Bureau Chief

Adult Services Bureau

Iowa Department of Inspections and Appeals

Lucas State Building

321 East 12th Street

Des Moines, IA 50319-0083

RE: Allen Place Plan of Correction

Dear Ms. Kellen

Enclosed is the required "Plan of Correction" regarding the Recertification Monitoring Evaluation Report at Allen Place which was conducted on April 4th-April 5th, 2017. Submission of this response of the Plan of Correction is not a legal admission that a deficiency exists, or that the Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response on the Plan of Correction. In addition, preparation and submission of the Plan of Correction does NOT constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

IAC r 481-67.3(1) – Resident Rights

- Tenant #2 was moved, as planned, to a Memory Care Center on April 10th, 2017.
- During monthly Resident Council Meetings, the Executive Director will specifically address safety and encourage residents to bring any concerns to her attention immediately.
- During quarterly assessments the Care Services Manager/Designee will ask residents if they have any safety concerns and address them promptly working in conjunction with the Executive Director.
- After review of tenant records by the Executive Director on April 5th, 2017 there were no other residents found to have wandering, intrusive behaviors.

IAC r 481-67.19(3) – Records Check

- The Executive Director completed an audit of employee files to ensure background checks were completed and met Iowa regulations. This was done on April 14, 2017. Other background checks were in compliance with state guidelines.
- The Executive Director will conduct a monthly audit to ensure background checks meet the Iowa Regulations for the next 6 months.
- The Executive Director will complete state of Iowa Criminal History Record check by Iowa division of criminal investigation for new staff effective April 14, 2017. Results will be in hand prior to offering a position.

- The Regional Director of Care Services provided the Executive Director with additional training on the Iowa background check process on April 5th, 2017. The Program Executive Director was then delegated as the primary owner of the background check process.

IAC r 481-69.26(4)a – Service Plans

- Tenant #5 had a new cognitive, physical and functional assessment completed on 4/10/17. A service plan was then updated to reflect the Tenants specific needs.
- Tenant #1 will have a new cognitive, physical and function assessment completed by 4/28/17. A new service plan will then be created to reflect the Tenants needs.
- The Care Services Manager and/or designee will conduct a monthly audit to ensure care plans reflect Tenants current needs. This will be done for three months then quarterly until the end of the year.
- Staff will be re-educated regarding the importance of notifying the Care Services Manager of any changes in resident condition/function that are not in line with what is outlined on the service plan. This will be completed by 4/30/17.
-

IAC r 481-69.28(5) - Food Services

- The Area Manager of Operations educated the Executive Director on the requirements of completing initial food service training. This was completed on April 5th, 2017.
- Staff will complete initial food service training by April 28th, 2017. This will be completed by the Executive Director or designee.
- The Executive Director and/or designee will conduct a quarterly audit of new employees to ensure training is competed. This audit will be completed quarterly for the remainder of the year.
- The Executive Director registered for Iowa Serve Safe training on April 25th, 2017 and will attend Iowa Serve Safe training on June 5th, 2017.

Date of completion for the Plan of Correction is April 30th, 2017.

Sincerely,

Wendy Richter

Executive Director/Allen Place