OK 8/10/17

PRINTED: 07/27/2017
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
	S0078	A. BUILDING: _____ B. WING _____	C 07/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER RIDGE PLACE	205 EHLERS LANE MAQUOKETA, IA 52060

(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: 25 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 26 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 15 TOTAL census of Assisted Living Program: 41 No regulatory insufficiencies were cited during the Investigation of Complaint #68265-C. The following regulatory insufficiency was cited during the Investigation of Incident #68445-I.	A 000	See attached POC 7/11/17	
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.	A 012		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 012	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide treatment with consideration, respect, and full recognition of personal dignity and autonomy for 1 out of 1 tenant reviewed (Tenant #1). Findings follow: Tenant #1 was admitted 5-1-17 to the dementia unit and diagnoses included: Unspecified dementia, hypothyroidism, Essential Hypertension, Non-Hodgkin lymphoma, hyperlipidemia, osteoarthritis, and urinary incontinence. He/she was staged on the Global Deterioration Scale (GDS) at a level 5 on 4-28-17, which indicated Moderately Severe Cognitive Decline. According to Tenant #1's Service Plan dated 5-1-17 the staff were to provide assistance with medications, toileting, and recreational activities. He/she was noted to have moderate disorientation or difficulty recalling/retaining information and needed cueing and reorientation. The interventions listed for redirection included talking about his/her past, the great grandchildren, giving him/her a newspaper to read, getting a banana to eat, or try to play cards. According to the Staff Documentation/Communication to the Registered Nurse (RN) dated 5-14-17, Staff A documented Tenant #1 would not stop setting off the hallway door alarm, yelled and hit staff with a hanger. Staff A picked her up and put her in bed and shut the door. According to a statement signed by Staff A on 5-17-17 she admitted to putting her arm around the mid-section of Tenant #1 and with the other arm had a hold of the back of his/her pants, then walked behind him/her and had	A 012		

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A 012	Continued From page 2 him/her lay down. Record review revealed Staff A's statement to the facility, dated 5/17/17. The statement documented: "Approximately 8-9 P.M. (Tenant #1) was setting off the alarm at the Gardens entrance door. We had the conversation about not using this door as it makes terrible noise when you open it. Encouraged (him/her) to come to the kitchen to go through the other door that doesn't make a noise. (He/She) refused as (he/she) had seen people go out this door. Tried this 4 times. (He/She) was calling me a liar and hitting me with the hanger. Naturally I tried to dissuade this sating"I would like it if you didn't hit me with the hanger, will you hand me the hanger, etc. I then took the hanger and folded it in 1/2 and bent the edges so (he/she) could not get it back again, I then put it on the table behind me. Then (his/her) fists started to go, slapping, kicking, and hitting. I was trying to get (him/her) to walk down the hallway and (he/she) was flailing. I then put my arm around (his/her) mid-section both arms were down and with my other arm I had ahold of the back of (his/her) pants. I walked behind (him/her) and had (him/her) lay down and (he/she) was fine and quiet." Review of the Program's "Resident Rights" included, "The right to be treated with respect and to be addressed in a manner which is appropriate to the consumer's chronological age." According to an interview with the Administrator on 7-5-17 at 3:55 PM, she stated when she reviewed the Communication report, the words "picked (him/her) up" caught her attention and met with Staff A to discuss what occurred. The Administrator stated Staff A felt there was no	A 012		

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A 012	Continued From page 3 other option. The Administrator stated she felt staff just did not get it when it came to working with people with dementia and the administrative team agreed termination would be best.	A 012		

Clover Ridge Place

ASSISTED LIVING & MEMORY CARE

8/11/17 OK 8/11/17

HEALTH FACILITIES

AUG 11 2017

August 9, 2017

Complain Intake # 68445I-I

Plan of Correction (POC) Submitted for:

Investigation Date: July 5, 2017

Regulatory Insufficiency A012 – Tenant Rights: 481-67.3(1) *Insufficiency: A012 481-67.3(1): To be treated with consideration, respect and full recognition of personal dignity and autonomy.*

Program Plan of Correction:

1. **Elements detailing how insufficiency was corrected for resident:**

   Resident had been given a 15 day corrective action on June 19, 2017 to correct behaviors related to verbal and physical aggression and that her needs were beyond our scope of abilities to serve. June 26, 2017, resident was admitted to the hospital for psychiatric care. Resident returned July 7, 2017. Resident was discharged July 27, 2017 due to need for higher level of care.

2. **Action program is taking to protect tenants in similar situations:**

   a. The program RNs and Manager provided training with team members to notify the program RN for unusual resident behaviors via RN communication, incident report, phone call and/or in person. This reeducation was provided on 6/29/2017.
   b. Team members were all reeducated individually immediately, on or prior to 5/18/2017 by the Program RN regarding approach to service, assistance from co-workers as an intervention, personal space, role playing, and ability to call 911.
   c. The program RNs and Manager will continue to provide hands on assistance and training with team on re-approach, redirection and trading positions and restraint training ongoing.

3. **Measures taken to ensure this problem does not reoccur.**

    a. The program RNs and manager will conduct random visual checks on approach to services with team members and provide one-on-one training as needed beginning on 7/1/2017.
    b. The program RNs will continue to provide training to team on approach to services for residents to include behaviors and solutions for refusals. This will be completed annually and randomly as needed.
    c. In-service education provided to team members discussing each of the Community Rules of Conduct and Resident Rights, annually and ongoing.

Disclaimer for POC

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the program of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law