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
	S0273	A. BUILDING: _____ B. WING _____	C 12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY	**1801 EAST KANESVILLE BLVD CO BLUFFS, IA 51503**

(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	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. Number of tenants without cognitive disorder: 17 Number of tenants with cognitive disorder: 4 TOTAL census of Assisted Living Program: 21 The following regulatory insufficiency was cited during the investigation of Complaint #71199-C.	A 000		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a comprehensive assessment and to update the service plan following a change in condition for 1 of 2 tenants reviewed (Tenant #1). Findings include:	A 083		

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

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
	S0273	A. BUILDING: _____ B. WING _____	C 12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY	1801 EAST KANESVILLE BLVD CO BLUFFS, IA 51503

(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 083	Continued From page 1 On 12/12/17 at 10:00 a.m. record review revealed Tenant #1 was admitted to the Program on 6/11/14 with a diagnosis of Alzheimer's disease. Tenant #1's most recent service plan revealed he/she had fallen one time in the past year prior to the development of the plan on 2/10/17. A review of nurses' notes and incident reports revealed the tenant fell on 2/26/17, 3/01/17, 3/02/17, 3/13/17, 3/17/17 and 3/21/17. A nurse review was completed by the Director of Nursing on 3/24/17 to address the falls. The nurse review revealed some of the falls occurred when the tenant was returning from the bathroom between 6:30 p.m. and 7:00 p.m. Staff already assisted the tenant with ambulation to and from the bathroom and would be instructed to be with the tenant during that time frame to assist and prevent attempts at independent ambulation. Orders for PT/OT services were also obtained from the tenant's physician which were expected to be short term in nature. A comprehensive evaluation of Tenant #1's health, cognitive and functional status was not completed following the 3/24/17 nurse review even though the tenant had experienced a significant change. Tenant #1's service plan dated 2/10/17 was not revised to include the mobility management interventions noted in the nurse review. On 12/12/17 at 12:53 p.m. the Executive Director and the Director of Nursing confirmed a comprehensive evaluation had not been completed following a significant change and the service plan was not modified to include mobility management interventions.	A 083		

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
	S0273	A. BUILDING: _____ B. WING _____	C 12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY	**1801 EAST KANESVILLE BLVD CO BLUFFS, IA 51503**

(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