V 4/27/18 OK 4/27/18

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
	S0351	A. BUILDING: _____ B. WING _____	C 02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY PLACE	901 SOUTH MENTZER ROAD ROBINS, IA 52328

(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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 29 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 17 TOTAL Census of Assisted Living Program for People with Dementia: 50 Complaint #74142-C was investigated and the following regulatory insufficiencies were cited:	A 000	See attached POC 4/1/18	
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:	A 003		

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A 003	Continued From page 1 Based on interview and record review the Program failed to follow policy and procedure for completion of incident reports, including timely completion and appropriate follow up to incidents. This affected 1 of 4 tenants reviewed (Tenant #2). Findings follow: Record review of Tenant #2's file revealed diagnoses included: contusion of the left foot and dementia without behavioral disturbances. Tenant #2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit and was discharged on 1-12-18. The service plan indicated Tenant #2 bruised easily. Tenant #2's Progress Notes indicated the following: a. On 12-18-17 (late entry 1-9-18) notes indicated a telephone call received from Tenant #2's family regarding concerns of bruising to Tenant #2's face. The family was concerned as to how it happened. The Nurse assessed the area to the left cheek and noted a slight yellowing of the skin. There were no open areas noted. Tenant #2 was unable to tell the Nurse how it happened. b. On 12-22-17 it was noted the bruised area near the eye healed. c. On 1-9-18 staff informed the Nurse Tenant #2 had allegedly been slapped across the face, on the left cheek by another tenant about a month ago. It was on or about 12-13-17. At that time Tenant #2 had a bruise to the left cheek. An incident report was filled out on 1-9-18 by staff. Staff was counseled regarding the importance of	A 003		

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A 003	Continued From page 2 filling out incident reports. Review of Incident Reports revealed the following: a. A handwritten incident report, dated 12-22-17, indicated comments made by Tenant #2's family regarding a bruise. Assessment revealed no bruising to the arm or foot. Both feet were checked and revealed no visible bruising. b. A handwritten incident report, dated 1-9-18, documented on 12-15-17 Staff A came into work and asked what happened to Tenant #2's face. Staff A was told Tenant #3 hit Tenant #2 in the face. It happened about a month ago and she thought staff completed an incident report. c. An electronic incident report, dated 1-9-18 (for Tenant #2), documented staff informed the Nurse Tenant #2 had allegedly been slapped across the face, specifically the left cheek, by another tenant. It occurred on or about 12-13-17. At that time Tenant #2 had a bruise on the left cheek. The incident report dated 1-9-18 indicated the physician was notified on 12-13-17 at 9:38 a.m. and the family was notified on 12-13-17 at 7:37 a.m. d. An electronic incident report dated 1-9-18 (for Tenant #3) indicated it was brought to the Nurse's attention that morning that Tenant #3 allegedly slapped another tenant across the face, which caused bruising to the face. It happened on or about 12-13-17. The incident report dated 1-9-18 indicated the physician was notified on 12-14-17 at 9:50 a.m. and substitute decision maker was notified on 12-14-17 at 9:53 a.m. An incident report was not completed on or about	A 003		

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A 003	Continued From page 3 12-13-17 when Tenant #3 allegedly struck Tenant #2 in the face. An incident report was not completed on 12-18-17 when Tenant #2's family initially reported and questioned the bruising of an unknown etiology. The incident reports completed on 1-9-18 documented dates and times of family/substitute decision maker notification and physician notification in December 2017; however, the incident was not reported and documented until 1-9-18. Additional record review revealed the Program's policy regarding incident reports indicated staff should notify the RN/Manager of any unusual resident behaviors or any unusual events. An incident report should be completed by the RN or Manager. The policy further directed witnesses of the incident should provide a factual statement on the incident form. The form should be turned into the RN as soon as possible, and be reviewed by the RN within 24 hours. Interview with Staff A on 2-20-18 at 9:55 a.m. revealed she came in on third shift and asked what happened to Tenant #2's face, as he/she had a bruise on the left cheek. Staff reported Tenant #3 hit Tenant #2. She thought staff reported it at that time. In January she asked why Tenant #2 moved out and was told Tenant #2's family had concerns with abuse by staff due to the bruise on Tenant #2's face. She reported the bruise on Tenant #2's face occurred when Tenant #3 hit Tenant #2. The Nurse was unaware of the incident. Staff A wrote an incident report. Tenant #2's family was contacted regarding the incident by office staff. Interview with Staff B on 2-20-18 at 10:13 a.m. revealed Tenant #3 had a bit of aggression and hit Tenant #2 on the cheek. Tenant #2 and	A 003		

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A 003	Continued From page 4 Tenant #3 always bickered. Tenant #2 wanted to help others and Tenant #3 wanted Tenant #2 to leave them alone. Tenant #2 would yell at Tenant #3 and Tenant #3 would yell back. The bickering between them occurred on a daily basis. Interview with the Nurse on 2-20-18 at 1:35 p.m. revealed she received a telephone call on 12-18-17 from Tenant #2's family who noted a bruise on the left cheek when Tenant #2 was out with family over the weekend. The Nurse assessed Tenant #2 and noted slight yellow bruising to the left cheek. There were no complaints of pain. Staff observed him/her and Tenant #2 was assessed later in the week and the area was healed. Staff were asked what occurred and no one was aware. An incident report was not completed at that time regarding the bruising of an unknown etiology. In January the Nurse was in the dementia unit and it was discussed that Tenant #2's family thought he/she was hurt at the Program and were moving him/her out. Staff A reported she was told Tenant #2 was hit by another tenant. That was the first knowledge the Nurse had regarding the alleged incident. An incident report was completed at that time and an in-service held regarding incident reports. Tenant #2's family and physician were notified of the incident by the Nurse. In December 2017 Tenant #2 presented with bruising of an unknown etiology. Tenant #2's family called and voiced concerns regarding how the injury occurred. A Progress Note was completed as a late entry on 1-9-18 for 12-18-17. An incident report was not completed at that time when the injury was noted. In January 2018 it was revealed Tenant #3 allegedly struck Tenant #2 in the face about a month prior. At that time Tenant #2 was noted to have bruising to the left	A 003		

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A 003	Continued From page 5 cheek. Staff did not complete an incident report regarding the alleged incident until 1-9-18. The dates and times of family/substitute decision maker and physician notification were dated 12-13-17 and 12-14-17, nearly a month prior to the completion of the incident report on 1-9-18.	A 003		
A 026	481-67.4(5) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(5) When a tenant attempts suicide, regardless of injury. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to report an attempted suicide without injury to the Department within 24 hours or the next business day for 1 of 4 tenants reviewed (Tenant #1). Findings follow: Record review of Tenant #1's file revealed an admission date of 1-25-18 and a discharge date of 2-15-18. Tenant #1 had the following diagnoses: blepharitis eye/eyelid, peripheral opacity of cornea, corneal edema, open-angle glaucoma, astigmatism, presbyopia, blindness one eye, injury of eye and orbit, corneal transplant and presence of intraocular lens. The Comprehensive Assessment indicated Tenant #1 was blind. Tenant #1 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline and he/she resided in the dementia unit.	A 026		

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A 026	Continued From page 6 Incident report documentation indicated the following: a. A handwritten incident report dated 2-8-18 revealed at 2:00 a.m. staff completed a visual check and observed Tenant #1 with his/her blanket and pillow pushed against his/her face. When asked what Tenant #1 was doing he/she stated, "I am trying to kill myself." Staff called for assistance. Tenant #1 was again asked how he/she was doing and what was going on and he/she again stated he/she wanted to die and asked for a knife to stab himself/herself. Tenant #1 mentioned he/she had attempted to kill himself/herself many times and was not successful. Tenant #1 expressed he/she wanted to commit suicide by being smothered. Tenant #1 mentioned his/her spouse and how he/she could not see and so he/she just ate, slept and went to the bathroom. The Nurse was called and informed of the situation and staff stayed with him/her until he/she went to sleep. Staff looked around the room for sharp objects. b. An electronic incident report indicated on 2-8-18 at 2:00 a.m. when staff completed 30 minute checks Tenant #1 was found lying in bed holding his/her pillow over his/her face. Tenant #1 stated he/she wanted to die. Tenant #1 asked for a knife to stab himself/herself and a full search of the apartment was completed with no sharp objects found. Staff was instructed to remain outside Tenant #1's open door and complete checks every 15 minutes. The incident report indicated Tenant #1 said, "I just want to die, I have been wanting to for a long time. All I do is sit and listen to the radio." Tenant #1's family was called and did not want Tenant #1 transferred to the hospital until 6:00 a.m. No injuries were noted post incident.	A 026		

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A 026	Continued From page 7 2. Tenant #1's Progress Notes indicated the following: a. On 2-8-18 at 2:00 a.m. notes revealed Tenant #1 was found with a pillow over his/her head at the time of a visual check. Tenant #1's family did not want him/her sent out to the hospital at that time of the morning and would come to pick him/her up at 6:30 a.m. Staff checks every 15 minutes were put into place and staff would sit outside of the door. Tenant #1 fell back asleep with staff sitting outside the open door. b. On 2-8-18 at 5:50 a.m. notes revealed the Nurse assessed Tenant #1 and he/she told the Nurse he/she just wanted to die. Tenant #1 was informed his/her family was notified and would be coming to take him/her to the hospital and he/she stated "good." Family arrived and said Tenant #1 planned for a long time and just wanted to die. c. On 2-16-18 family reported Tenant #1 would be at the psychiatric unit of the hospital for a while and family moved out all belongings. Interview with Staff C on 2-20-18 at 1:05 p.m. revealed she received a telephone call from staff in the dementia unit and was asked to come to the dementia unit quickly. Staff had found Tenant #1 with a pillow over his/her head and he/she reported he/she had tried to smother himself/herself. Staff checked to ensure there was nothing around the apartment to harm Tenant #1 and nothing was found. The Nurse was contacted and staff was instructed to check on Tenant #1 every 15 minutes. There were no injuries noted to Tenant #1. Tenant #1 was taken out to the hospital to get help. An incident report and staff communication note were completed.	A 026		

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A 026	Continued From page 8 Interview with Staff B on 2-20-18 at 10:13 a.m. revealed she came in on first shift and third shift staff reported Tenant #1 had not called for assistance as much that night. When completing checks staff found him/her with a pillow and blanket over his/her head trying to kill himself/herself. The Nurse and Staff B went into Tenant #1's apartment at 6:30 a.m. and the blanket was over his/her head and the pillow was behind his/her head. Staff assisted Tenant #1 to get up, showered and dressed. Family told staff Tenant #1 had talked about it (suicide) before; however, staff was not made aware of that prior to the incident with Tenant #1. Tenant #1 had not made any comments regarding self-harm prior to the incident. Tenant #1 spent a lot of time in his/her room by himself/herself including for meals. Further record review revealed the Program's policy and procedure regarding Notification to DIA of Program Incidents indicated the Department needed to be notified within 24 hours or the next business day when a tenant attempted suicide, regardless of injury. Interview with the Nurse on 2-20-18 at 1:34 p.m. revealed she received a telephone call from staff who indicated Tenant #1 was found while doing checks with a pillow over his/her face. Tenant #1 said he/she wanted to die and had wanted to do it for sometime. Checks every 15 minutes were initiated and staff sat outside his/her door. She arrived at 5:45 a.m. and his/her head was covered up with blankets (she did not view it as another attempt). Tenant #1 reported he/she was depressed and did not want to live anymore. Tenant #1's family came in at 6:30 a.m. and he/she was transported to the hospital, was	A 026		

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A 026	Continued From page 9 admitted and remained on the psychiatric unit. Tenant #1's family reported he/she talked about it for years. There was no prior information provided to the Program regarding any suicidal ideations. The incident with Tenant #1 was not reported to the Department. The Nurse acknowledged it should have been reported; however, she was unaware of the requirement to report a suicide attempt with no injury.	A 026		

dlc
✓ 4/27/18

Emery Place

901 S. Mentzer Rd.
Robins, Iowa 52328
Ph: 319-536-0045

Complaint Intake #: 71245-C

Plan of Correction (POC) Submitted For:
- Investigation Date: 2/19-2/20/18

A. Program notification to the department. 67.4(231B,231C,231D) *The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available*

Program POC:

1. Elements detailing how insufficiency was corrected for residents:

a. Tenant #1 was sent to Emergency Room and admitted for treatment of harmful thoughts on the day of the incident, 2/8/18.

2. Actions program taking to protect tenants in similar situations:

a. The Program RN has provided training with staff to ensure that paper incident reports are completed at time of incident, or the shift. For emergent incidents, staff are to call the Program RN immediately and if life threatening, to call 911.Training completed with staff on March 22, 2018.

b. The program RN and Manager will continue to provide ongoing training regarding incident reporting compliance with staff with any new hire and as needed.

c. Retraining and counseling was conducted with staff regarding policies and procedures for timely reporting and completion of incident reports on March 22, 2018.

d. The program RN and manager to ensure timely follow up and self-reporting to DIA are completed

3. Measures taken to ensure problem does not recur:

a. The Program RN and Manager will meet daily to review Incident Reports as needed.

b. The Program RN and Manager will complete self-reporting within 24 hours of reportable incidents per regulatory compliance and policies and procedures.

B. Policies and Procedures*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 incident including allegations of dependent adult abuse.*

Program POC:

1. Elements detailing how insufficiency was corrected for residents:

a. Incident report was completed 1/9/18 when notified of reported incident with Tenant # 2.

2. Actions program taking to protect tenants in similar situations:

a. The Program RN will continue timely entry of nurse notes and reviews noted to begin 1/10/2018.

b. The program RN and Manager will provide timely follow up and investigation as needed regarding unknown incidents.

c. The Program RN and Manager will review incident reports daily as needed.

d. Incident Report training provided to staff on March 22, 2018. This will continue annually and at random as needed. This will include completion of incident reports at time of incident or shift.

3. Measures taken to ensure problem does not recur:

a. The Program RN and Manager to ensure timely follow up to incidents and/or concerns.

b. The Program RN and Manager to ensure incident reports are completed for incidents or unusual occurrences by staff present during incident.

c. The Program RN and Manager will provide follow up training and counseling to staff as needed to ensure compliance.

The Program will be in substantial compliance by 4/1/2018.

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