✓5/25/18

PRINTED: 04/30/2018
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
	S0139	A. BUILDING: _____ B. WING _____	04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD PLACE AL	4130 NORTHWEST BLVD DAVENPORT, IA 52806

(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: 51 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 9 TOTAL Census of Assisted Living Program for People with Dementia: 62 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 125	481-67.19(5) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(5) Employment prohibition. A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services. This REQUIREMENT is not met as evidenced by:	A 125	481-67-19(5) Records Checks Elements detailing how the program will correct the regulatory insuffiency. Staff E was removed from the schedule. On a criminal background check was resubmitted for Staff E. Criminal background check returned indicating Staff E was approved to work. Staff E returned to work on 04/18/18. What measures will be taken to ensure the problem does not recur and how program will monitor. Director of Human Resources will complete the criminal background check prior to hiring any applicant. If Iowa Record check returns requesting additional forms because of possible hits the Director of Human Resourses will submit all forms required. New staff will not begin employment until evaluation is completed indicating individual is eligible for employment. The date by which the regulatory insuffiency will be corrected. 04/18/18	

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

DD 5/25/18

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A 125	Continued From page 1 Based on interview and record review the Program failed to obtain an evaluation from the department of human services (DHS) to determine if employment was prohibited for 1 of 1 staff reviewed with a criminal conviction (Staff E). Findings follow: 1. Record review revealed Staff E's hire date as 8-2-17. A background check completed on 7-21-17 revealed further research was required for the criminal history background check. The abuse registries background check did not reveal any results. Iowa Record Check Request Form S revealed a criminal record was found on 7-26-17. An evaluation by the DHS to determine if employment was prohibited was not completed prior to employment and was not found at the time of the recertification visit. 2. Record review of Staff E's time card records revealed Staff E first worked on 8-2-17. 3. When interviewed on 4-11-18 at 1:35 p.m. the Director of Human Resources confirmed an evaluation was not found for Staff E.	A 125	481-67.9(6) Staffing Elements detailing how the Program will correct each regulatory insuffiency. Staff D is an as needed CNA. She was notified by a registered letter on 04/10/2018 that she would not be able to pick up any open hours until she had completed the 2 hour Dependent Adult Abuse training. On 04/14/2018 Staff D brought a copy of 2 hour certification for Dependent Adult Abuse completion date of 12/19/17. Measures taken to ensure the problem does not recur. Staff are instructed on the importance of completing the DAA training prior to the six month deadline. Dates and times for the current DAA inservice training are posted at the time clock. The Director of Human Resources monitors the due date of each staff. She notifies the department managers routinely of due dates. The department manager notifies and reminds staff this needs to be completed by a specific date to remain on the schedule. The department manager is responsable for removing the staff member from the schedule if not completed within the 6 months.	
A 149	481-67.9(6) Staffing 481-67.9(231B,231C,231D) Staffing. (6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 149		

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A 149	Continued From page 2 Program failed to ensure staff completed dependent adult abuse training within six months of employment for 2 of 6 staff reviewed (Staff D and F). Findings follow: 1. Record review revealed Staff D's hire date as 10-10-17. Staff D had not completed dependent adult abuse training. 2. Record review revealed Staff F's hire date as 7-8-16. Staff F completed dependent adult abuse training on 2-9-17. 3. When interviewed on 4-12-18 at approximately 10:30 a.m. the Nurse Manager confirmed Staff D had not completed dependent adult abuse training and was pulled from the schedule pending completion of the training.	A 149		
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 revlew the Program failed to develop service plans that reflected the tenants' identified needs for 4 of 6 tenants reviewed (Tenants #2, #3, #4 and #6). Findings follow: 1. Review of Tenant #2's file revealed the tenant	A 089		

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A 089	Continued From page 3 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #2 resided in the dementia unit. The March 2018 medication administration records (MARs) and health assessment dated 3-16-18 indicated a nutritional supplement was given four times per day. Further record review revealed the service plan did not reflect the nutritional supplement provided four times per day. 2. Review of Tenant #3's file revealed the tenant was staged at a three on the GDS, which indicated mild cognitive decline. Wound clinic documentation revealed Tenant #3 had wounds on the right heel, left heel and coccyx. The coccyx and right heel wounds were a stage 3 pressure injury and the left heel was a stage 2 pressure injury. Orders included a Prevalon boot to the left lower extremity while in bed and a Prafo boot to the right foot while in bed. March and April 2018 MARs reflected Tenant #3 refused the Prafo boot to the right foot while in bed and cushion boot to the left heel when in bed routinely. Tenant #3 also had an order for a skin barrier ointment to be applied topically to the skin surrounding the dressing on the coccyx every shift. The MARs reflected Tenant #3 routinely refused the treatment on third shift. Further record review revealed the service plan reflected an outside agency completed the wound care and Tenant #3 was seen at a wound clinic. The service plan reflected every shift staff applied the barrier ointment to the skin surrounding the dressing on the coccyx. The service plan did not reflect Tenant #3's refusals of	A 089	481-69.26(4)a Service Plans Elements Detailing how the program will correct each regulatory insuffiency. Tenant #2 RN manager reviewed physician order sheet, medication administration record and individual service plan. Tenant #2 service plan was updated after the review and updated that Tenant #2 receives a nutritional supplement four times a day on 04/12/2018. Tenant #3 RN manager reviews physician orders, treatment administration record and nurses notes related to Tenant #3 refusal of Prafo Boot for right foot, cushion boot for left foot also barrier crem. Reviewed Tenant #3's individual sevice plan noting that skin treatments were addressed for the treatments however Tenant #3's refussals where not. Tenant #3's individual service plan was updated on 04/12/2018. Tenant #4 Tenant returned from physician office on 04/02/18 after removal of a cyst on right shoulder. Returned after a follow up visit on 04/05/2018. RN removed dressing as instructed on 05/8/18. Received treatment order for the right shoulder on 4/10/18. Individual service plan was reviewed and updated on 04/06/18 to monitor for any sign or symptom of infection with the right shoulder. Treatment was completed by a nurse however the treatment was not added to the indivdual service plan. Service plan was reviewed and updated on 4/12/18 with the skin treatmentand instructions that CNA will be completing the treatment starting 04/14/18. Tenant#6 On 03/06/18 Familly of Tenant #6 arranged for a paid companion to spend time with Tenant #6 to visit and help improve quality of life. On 04/12/18 the paid companion was added to the individual service plan.	

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A 089	Continued From page 4 the skin barrier ointment on third shift or the routine refusals of the Prafo boot and cushion boot. The service plan also did not identify the wounds on Tenant #3's heels. 3. Review of Tenant #4's file revealed the tenant received hospice services. Resident Notes dated 4-2-18 indicated Tenant #4 had an appointment for a medium size cyst on right upper back. The area was lanced, drained and packed. Resident Notes dated 4-10-18 indicated orders were received for the treatment of the right upper back where the cyst was removed. Further record review revealed the April 2018 MARs reflected an order to cleanse the right upper back with saline, cover with 2 x 2 gauze and Tegaderm daily and as needed until healed. The service plan updated on 4-6-18 reflected to notify the nurse of any signs and symptoms of infection to the right upper back. The service plan did not reflect the orders for the treatment of the right upper back. 4. Review of Tenant #6's file revealed the tenant had a GDS of three, which indicated mild cognitive decline. Resident Notes dated 3-6-18 indicated family arranged for a paid companion to spend time with Tenant #6 to improve quality of life. The service plan did not reflect the companion services. 5. When interviewed on 4-12-18 at approximately 10:30 a.m. and 11:50 a.m. the Nurse Manager confirmed the service plans did not reflect the items indicated above. The items were added to the service plans with nurse reviews.	A 089	Continued from page 4 Measures taken to ensure the problem does not recur. Nurses will review tenant's individual service plan with any addition or changes to tenants cares or needs including if it does not trigger a significant change. Nurses will review the tenant's individual service plan while completing 90 day, annual, significant change of conditions to insure it includes additional information as routiine refusal of cares, treatments, also opportunities for tenant's that are provided by others outside of the program. How the program plans to monitor performance to ensure complience. The date by which the regulatory insufficiency will be corrected. Individual service plans for Tenant #3, Tenant #4 and Tenant #6 was updated on 04/12/18.	