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
	S0090	A. BUILDING: _____ B. WING _____	C 01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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. Number of tenants without cognitive disorder: 8 Number of tenants with cognitive disorder: 12 Total Census of Assisted Living Program for People with Dementia: 20 The investigation of Complaint #79881-C resulted in the following regulatory insufficiency:	A 000		
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 review the Program failed to develop service plans that reflected the identified needs for 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review on 1-8-19 of Tenant #1's file revealed Nurse's Notes revealed the following: a. On 11-20-18 it was noted Tenant #1 had aggressive behaviors that morning. Tenant #1	A 089	Promise House Hiawatha will continue to provide service plans that are individualized and will identify the needs and preferences for the Tenants. Compliance shall be mantained by The Quality Assurance Committee periodically	01/18/19

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A 089	Continued From page 1 removed covers from another tenant in the common area. Tenant #1 started screaming, scratched and dug her nails into staff's arm. When staff attempted to redirect her to her apartment she became angry. b. On 11-27-18 it was noted a call was made to the doctor regarding Tenant #1's aggression and anxiety. Tenant #1 bent staff's fingers back, screamed at staff and was biting. New medication orders were received. c. On 12-5-18 it was noted staff was assisting another tenant getting ready for bed when Tenant #1 came in and refused to leave when asked. Tenant #1 put her fist in staff's face. d. On 12-29-18 it was noted Tenant #1 grabbed another tenant's walker and her shirt. Staff tried to walk Tenant #1 away from the other tenant and she grabbed staff, squeezed her hand and yelled at staff. e. On 12-30-18 it was noted Tenant #1 was becoming "unmanageable" and was "scaring" staff and tenants. f. On 1-3-19 it was noted Tenant #1 paced all shifts and tried going out the kitchen door several times. Haldol was given before bathing and two staff took Tenant #1 to the shower room. Staff activated the pull cord and when a nurse arrived Tenant #1 was screaming. It took three people to give the shower and Tenant #1 hit, kicked and tired to bite staff. Staff was unable to redirect Tenant #1 and she would not let staff put clothes on her. Staff was able to get some clothes on Tenant #1 and 911 was called. An ambulance arrived to take Tenant #1 to the hospital. Continued record review revealed the service plan dated 10-17-18 reflected behaviors including entering other tenant apartments and was difficult at times to redirect. The service plan did not	A 089		

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A 089	Continued From page 2 reflect the Tenant #1's physically aggressive behaviors and interventions related to the behavior. 2. Record review on 1-8-19 of Tenant #2's file revealed Nurse's Notes indicated the following: a. On 11-2-18 it was noted Tenant #2 was observed touching another tenant's private area. Staff redirected Tenant #2 and she became upset. b. On 12-7-18 it was noted Tenant #2 continued to seek out other tenants and displayed inappropriate behavior including holding hands, kissing on the mouth and touching. The doctor was notified and new medications orders were received. c. On 12-16-18 it was noted Tenant #2 tried to sit next to another tenant on a stool. Staff told Tenant #2 she could not do it and Tenant #2 yelled and shook her fists at staff. Continued record review revealed a fax sent to the doctor dated 12-7-18 indicating Tenant #2 continued to display inappropriate behavior with other tenants (one tenant in particular). Tenant #2 was "constantly" seeking the other tenant out, holding the other tenant's hand and kissing the other tenant. It made the other tenants uncomfortable. Staff attempted to intervene and Tenant #2 became angry. New orders were received to decrease the tenant's Depakote to 375 milligrams (mg) twice daily and increase Zoloft to 100 mg daily. Review of a Nurse Review and Assessment dated 12-18-18 reflected Tenant #2 had one tenant in particular she displayed inappropriate behavior with including kissing, holding hands, hugging and hovering over the other tenant.	A 089		

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A 089	Continued From page 3 Tenant #2 became defensive when staff attempted to separate and redirect. Other tenants, family members and staff were uncomfortable with the behavior. The doctor increased Depakote and Zoloft but staff had not seen much of a difference. The tenant's service plan dated 12-18-18 reflected Tenant #2 had inappropriate behavior with tenants and became frustrated when she was not able to sit by certain tenants telling staff to "mind their own business." The service plan included directives to monitor for inappropriate behavior and to separate and redirect. The service plan did not provide specific redirection related to Tenant #2's inappropriate tenant to tenant behaviors. The prior service plan was dated 9-23-18 and no updates were made to include the behavior until the 12-18-18 service plan update. 3. Record review on 1-8-19 of Tenant #3's file revealed an admission date of 11-26-18 and a diagnosis of vascular dementia with behavioral disturbances. Nurse's Notes indicated the following: a. On 11-30-18 it was noted Tenant #3 was physically and verbally "abusive", had slapped staff and redirection was not effective. An as needed medication was given as ordered. Tenant #3 took other tenants to her apartment and when staff tried to get the other tenants out of the apartment she used foul language and hit staff. b. On 12-1-18 at 8:00 a.m. it was noted the night prior (11-30-18) Tenant #3 called staff names and struck staff across the face which caused staff to fall on the bed. Tenant #3 then grabbed staff's pants and tried to pull them down.	A 089		

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A 089	Continued From page 4 Tenant #3 had another tenant come into her apartment and when staff attempted to remove the other tenant, Tenant #3 hit staff and threw things at them. c. On 12-1-18 at 8:40 a.m. it was noted Tenant #3 used foul language towards staff and refused cares. At 9:30 a.m. Tenant #3 continued to refuse cares and used foul language towards staff. Reapproach was attempted several times and was unsuccessful. At 12:30 p.m. a nurse attempted to sit with Tenant #3 and she became angry. Another staff entered the apartment due to the yelling. Three staff assisted Tenant #3 to the bathroom to get her cleaned up. Tenant #3 used foul language, hit, kicked and attempted to bite. d. On 12-1-18 at 1:10 p.m. it was noted an order was received to transport Tenant #3 to the emergency room via ambulance for a psychological evaluation. Continued record review revealed a narrative note dated 11-19-18 and 11-21-18 indicating at Tenant #3's prior placement, staff and family reported behaviors including use of profanity at times, resistance with cares, agitation at times and suspicion of others. The tenant's service plan dated 11-21-18 revealed behaviors including the use of profanity and agitation. It also reflected Tenant #3 might resist staff assistance with toileting. The service plan reflected encouragement to go to her apartment if agitated and to cue/redirect if using profanity in the common area. The service plan did not provide specific redirection for Tenant #3's agitation and aggressive behavior. 4. When interviewed on 1-8-19 at approximately	A 089		

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A 089	Continued From page 5 4:10 p.m. the Director and Assistant Director revealed all current service plan documents were provided for the tenants indicated above. Regarding Tenant #3, they were not aware of the behaviors and prior hospitalization until after Tenant #3 went to the hospital (12-1-18).	A 089		