7/1/19 OK 7/9/19

PRINTED: 06/19/2019
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
	S0361	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COBBLESTONE COURT ASSISTED LIVING	3187 140TH STREET SUMNER, IA 50674

(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: 32 Number of tenants with cognitive disorder: 0 TOTAL census of Assisted Living Program: 32 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	POC 7/2/19 1) insufficiency has been corrected and all staff is up to date. 2) An audit will be completed on or before the employees 90th day of employment to verify all classes have been completed. If uncompleted courses remain after 14 days employee will be required to complete before next shift.	
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 Program failed to ensure Dependent Adult Abuse (DAA) training was completed as required. This pertained to 1 of 2 staff employed six months or longer (Staff A). Findings follow: Chapter 235B required staff to complete two hours of training related to the identification and reporting of DAA within six months of employment and at least two hours of additional training related to the identification and reporting of DAA every five years.	A 149		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Admin. (X6) DATE 7/2/19

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
	S0361	A. BUILDING _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COBBLESTONE COURT ASSISTED LIVING	3187 140TH STREET SUMNER, IA 50674

(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 149	Continued From page 1 Record review on 5-14-19 of Staff A's training documents revealed a hire date of 1-22-18. Staff A's file lacked documented DAA training. When interviewed on 5-15-19 at 3:47 p.m. the Administrator confirmed the above finding.	A 149	3) An audit checklist with all new employees 4) Immediately	