| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IAALP236 | A. BUILDING _____ B. WING _____ | 10/16/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FOUNTAINS ASSISTED LIVING | 3752 THUNDER RIDGE ROAD BETTENDORF, IA 52722 |

| (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<br><br>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.<br><br>General Population<br>Number of tenants without cognitive disorder: 46<br>Number of tenants with cognitive disorder: 11<br><br>Memory Care Unit<br>Number of tenants without cognitive disorder: 0<br>Number of tenants with cognitive disorder: 15<br><br>TOTAL Census of Assisted Living Program for People with Dementia: 72<br><br>The investigation of Incident #84556-I was completed and a regulatory insufficiency was identified. | A 000 | See attached POC 11/1/2020 | |
| A 013 | 481-67.3(2) Tenant Rights<br><br>481-67.3 Tenant rights. All tenants have the following rights:<br>67.3(2) To receive care, treatment and services which are adequate and appropriate.<br><br>This Requirement is not met as evidenced by:<br>Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate. This pertained to 1 of 1 tenant reviewed (Tenant #1). Findings follow:<br><br>1. Record review of a Tenant/Resident Incident | A 013 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IAALP236 | A. BUILDING _____ B. WING _____ | 10/16/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FOUNTAINS ASSISTED LIVING | 3752 THUNDER RIDGE ROAD BETTENDORF, IA 52722 |

| (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 013 | Continued From Page 1<br><br>report dated 7-22-19 indicated an abuse allegation was reported on 7-22-19 at 12:00 p.m. The date of the incident was 7-21-19, the location was in Tenant #1's apartment. The report indicated Tenant #1 had pain and had red marks or bruising. Tenant #1's physician and family were noted. Charting Notes attached to the incident report indicated the Director of Nursing (DON), Tenant #1, Tenant #1's family and the Assistant Director of Nursing (ADON) had a care conference as Tenant #1 had reported feeling rushed and said she was "pushed" into the shower in the evening on 7-21-19. Tenant #1 revealed after the shower was completed she was transferred from the shower to chair in a hurry, almost fell and Tenant #1's back rubbed against the wheelchair armrest. Tenant #1's back was assessed and a red mark was observed in the middle of the back. Tenant #1 reported pain in the back; however, it was below the location of the red mark.<br><br>Continued record review revealed Tenant #1 had diagnoses that included: cerebrovascular accident and falls. The service plan dated 7-17-19 reflected stand by assistance (SBA) with ambulation and staff was to use a gait belt when assistance with transfers was provided. Tenant #1 at times might attempt to self-transfer. Staff was to encourage her to call for assistance when needed. Tenant #1 had a history of falls and at times might ambulate without assistance. Tenant #1 used a walker for ambulation. The service plan was updated on 7-18-19 and reflected Tenant #1 had a wheelchair for longer distances or weaker days.<br><br>Further record review revealed a typed statement signed by the DON and ADON on 7-23-19 indicated the following: on 7-22-19 the DON and ADON were informed Tenant #1 wanted to speak with the nurses when she returned from a | A 013 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IAALP236 | A. BUILDING _____ B. WING _____ | 10/16/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FOUNTAINS ASSISTED LIVING | 3752 THUNDER RIDGE ROAD BETTENDORF, IA 52722 |

| (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 013 | Continued From Page 2<br><br>physician appointment. At approximately 12:00 p.m. Tenant #1, Tenant #1's family, the ADON and DON met in the DON's office. Tenant #1 said she requested a shower and the staff who assisted her "forced resident into the shower." Tenant #1 sat on the toilet where the staff assisted her with undressing. Tenant #1 said she felt as if she "pushed into the shower." Tenant #1 said the shower was "very rushed" and she was barely able to wash and rinse herself and it was over. Tenant #1 said staff assisted her out of the shower "forcefully" and did not allow herself to dry off prior to transferring to the wheelchair. When Tenant #1 transferred to the wheelchair, Tenant #1 said she started to fall back and her back brushed against the wheelchair armrest, which caused pain in her lower back. Tenant #1 felt the staff rushed her by not allowing her to ambulate with her walker and the use of the wheelchair. The ADON and DON assessed her back. A reddened mark was noted on Tenant #1's mid back. No open areas or signs or symptoms of infection were noted. Tenant #1 said again that she felt "forced and pushed into shower." When asked if a gait belt was used, Tenant #1 said no. When asked if Tenant #1 felt abused on 7-21-19, she said yes.<br><br>When interviewed on 10-16-19 at 9:05 a.m. the ADON stated staff reported to the DON and ADON Tenant #1 had stated she was abused and she wanted to talk to them after her appointment. When Tenant #1 returned, she and her family met with the DON and ADON. She said she had requested a shower and she felt like she was pushed into the wheelchair to get out of the shower and was not allowed time to dry off. She complained of lower back pain and she felt like her back brushed the arm of the wheelchair when she was transferred. When asked if she felt like she was abused she said yes. When observed there was a reddened area in the middle section | A 013 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IAALP236 | A. BUILDING _____ B. WING _____ | 10/16/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FOUNTAINS ASSISTED LIVING | 3752 THUNDER RIDGE ROAD BETTENDORF, IA 52722 |

| (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 013 | Continued From Page 3 | A 013 | | |

of her back. Tenant #1 complained of pain in her lower back, lower than the reddened area on her back. She talked more about being rushed and she wanted to walk in and out of the bathroom with her walker. She said she was transferred quickly into the wheelchair and pushed into the chair. Tenant #1 said a gait belt was not used. Staff who worked were contacted. Staff C who worked said Staff A gave the shower and Tenant #1 had not voiced any complaints and was not upset. Staff A said the wheelchair was used as Tenant #1 was unsteady and she was worried Tenant #1 was going to fall. Tenant #1 was stuck when getting out of the shower and she cued her to take steps and assisted her out of the shower. Tenant #1 was mad she did not walk into the bathroom. Staff A also said Tenant #1 plopped down when she sat down.

When interviewed on 10-16-19 at 1:17 p.m. the DON revealed on 7-22-19 she was made aware Tenant #1 wanted to speak to her. Tenant #1 and Tenant #1's family spoke with the ADON and DON in her office. Tenant #1 said staff had given her a shower and she felt it was abuse. She was wheeled into the bathroom, transferred to the toilet, undressed and then got in the shower. The shower was quick. When she stood up to transfer back to the wheelchair she was wet and she fell back and her back rubbed on the armrest of the wheelchair. Her back was assessed and there was a red mark noted on her mid to lower back. Nothing was open and it looked like a bruise was forming. Tenant #1 did not know the name of the staff that provided the shower. The DON called all staff that worked and she met with Staff A in person with the ADON also present. Staff A said Tenant #1 felt rushed and the length of the shower was not enough time. Staff A was upset, caught off guard and denied the allegations. Staff A was suspended pending investigation and had not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IAALP236 | A. BUILDING _____ B. WING _____ | 10/16/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FOUNTAINS ASSISTED LIVING | 3752 THUNDER RIDGE ROAD BETTENDORF, IA 52722 |

| (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 013 | Continued From Page 4<br><br>worked since then. Staff A provided a written statement. Tenant #1's service plan indicated the use of a gait belt and per Tenant #1 it was not used.<br><br>When interviewed on 10-16-19 at approximately 1:38 p.m. Staff A said Tenant #1 was going to get into the shower and was wobbly. She attempted to use the wheelchair and Tenant #1 got mad and refused. Staff A was afraid Tenant #1 was going to fall. Tenant #1 felt rushed with the use of the wheelchair. Tenant #1 went into the bathroom with her walker and was in the shower. When going to get out of the shower she was wobbly again and she held onto her. She walked back with her walker to the chair she had previously been seated in and was dressed there. A wheelchair was not used and a gait belt was not used. Staff A said the use of the gait belt was not in the chart for Tenant #1 and there was not a gait belt in Tenant #1's apartment. She was asked to write a statement (regarding the shower) and a write up. She did not not sign the write up because it was not accurate.<br><br>Continued review revealed Staff A was hired on 4-16-19 and had nurse delegations completed including a delegations for Procedure for Transferring a Resident to a Wheelchair, Procedure for Assisting with a Walker, and Procedure for Assisting with Ambulation dated 5-15-19. The delegations included: to apply the gait belt, if needed or to ensure the tenant wearing his/her gait belt, if needed, for ambulation and transfer assistance noted above.<br><br>In summary, Tenant #1's service plan reflected when staff provided transfer assistance a gait belt was to be used. Per interviews and written statements, a gait belt was not used when Tenant #1 was assisted with transfers during the shower | A 013 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IAALP236 | A. BUILDING _____ B. WING _____ | 10/16/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FOUNTAINS ASSISTED LIVING | 3752 THUNDER RIDGE ROAD BETTENDORF, IA 52722 |

| (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 013 | Continued From Page 5<br><br>process on 7-21-19, including when she reported she started to fall back and brushed her back against the armrest of the wheelchair. Services were not provided in accordance with Tenant #1's service plan. | A 013 | | |

ok 11/29/2020

✓ 2/3/20

**Plan of Correction**

**In Response to**

**Self-Report Visit**

**Dated 10/15/2019-10/16/2019**



Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

**Regulatory Insufficiency: Interview and record review revealed a concern in the area of tenant rights regarding failure to provide appropriate care, treatment and services to a tenant. Specifically, staff failed to utilize a gait belt with a tenant as directed by the service plan.**

1. **Elements detailing how the Program will correct each regulatory insufficiency.**
   The program will implement a process when a care plan is completed that staff will be notified of changes. DON/ADON will communicate with staff members what is being changed and what cares are needed to be provided residents.
2. **Measures taken to ensure the problem does not recur.**
   Redelegation on gait belts completed as part of corrective action plan at time of self-report. Education on care plans including purpose and location is presented at orientation and with annual education.
3. **How the Program plans to monitor performance to ensure compliance.**
   Random reviews of documentation will be completed to ensure education on care plans has occurred at time of orientation and annual education
4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency to be corrected on or before Wednesday, January 1st, 2020.