OK 12/9/2020

PRINTED: 12/06/2019
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
	S0242	A. BUILDING: _____ B. WING _____ 12/3/20	C 10/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUSKAMP HAVEN	300 RIVERVIEW DIRVE ALGONA, IA 50511

(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: 14 Number of tenants with cognitive disorder: 0 TOTAL census of Assisted Living Program: 14 The following regulatory insufficiencies were cited during the investigation of Incident 85848-I and Complaint 58777-C:	A 000	"Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual.	
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure tenants received care, treatment and services that were adequate and appropriate. This affected 1 of 1 tenant (Tenant #1) identified in incident investigation 85848-I. Finding follows: Record review on 10/28/19 revealed an Incident Report dated 9/13/19 which noted Staff A went to Tenant #1's room/apartment at 5:25 p.m. to notify	A 013	A 013 This has the potential to affect all residents/tenants. The facility falls procedure was updated to notify the nurse immediately upon a resident/ tenant fall. The procedure was also updated stating to call 911 if the family does not respond within 15 minutes of a fall.	

POC 12/11/19

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A 013	Continued From page 1 him it was time to eat. At 5:45 p.m. after serving the evening meal to everyone Staff A returned to Tenant #1's room and found him on the floor in his bedroom between his bed and bathroom entrance. The report noted the tenant bled from his wrist, so staff put a bandage on it. Further review revealed Tenant #1 was sent to the Emergency Room (ER) at 6:35 p.m. The report further documented the executive director, administrator, or senior living manager was contacted on 9-13-19 at 8:30 p.m., but did not specify who. When interviewed on 10/29/19 Staff A said due to Program policy he could not assist Tenant #1 up as he requested. He asked Tenant #1 if he wanted him to call the ambulance and Tenant #1 said no. He attempted to contact Tenant #1's son who lived in town and listed as his emergency contact. Staff A admitted he left Tenant #1 lying on the floor in his room while he attempted to contact Tenant #1's son to determine what needed to be done next. Staff A also acknowledged he should have tried to contact the nurse sooner. Additional record review revealed the Program's policy regarding safe practices and procedures for residents and direct care employees while assisting a resident who has fallen, issued May 2017 and revised July 2019. According to the policy, staff may not provide tenants with "hands on" assistance without a nurse first completing an evaluation of the tenant. The policy instructed staff to contact 911 if the tenant could not get themselves up, unless the tenant requested a family member/responsible party be contacted first. The policy also directed staff to contact the nurse. When interviewed on 10/29/19 at the Program	A 013	Each staff member and resident/ tenant was re-educated and signed off to understing of the new procedure. Education was completed on 9/23/19. The facility will review the procedure with staff monthly x 3, quarterly x 2 and annually thereafter. Each tenant will review and sign annually. All issues will be resolved By 12/11/2019	

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A 013	Continued From page 2 nurse confirmed Staff A notified her Tenant #1 had fallen but did not call when he found him on the floor and could not notify his son or ask his preference for treatment. When interviewed on 10/29/19 at 3:20 p.m. the Program Administrator and Nurse explained the Program made changes to protocol on staff response to tenant falls. They also said Tenants had been notified and staff trained to follow the revised protocol.	A 013		