STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD359 HFD	A. BUILDING _____ B. WING _____	09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEY SENIOR LIVING OF ANKENY	3602 NW 5TH STREET ANKENY, IA 50023

(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: 23 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 19 TOTAL Census of Assisted Living Program for People with Dementia: 50 The investigation of complaints #85213-C, 85158-C, and 85433-C resulted in a regulatory insufficiency.	A 000	The program will continue to ensure that, tenant rights to recieve care, treatment and services which are adequate and appropriate. Program Nursing staff reviewed regulations on 9/3/2019. Nursing staff educated on Arrow policy and procedure for Fall management and prevention.	9/3/2019
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 interviews and record review, the Program failed to ensure tenants consistently received prompt, adequate, and appropriate care	A 013		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joey Oxenfield RN/CD — TITLE: Executive Director — (X6) DATE: 9/3/2019

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A 013	Continued From Page 1 following injury. This pertained to 1 of 4 tenants reviewed (Tenant #1). Finding follows: Record review on 8/30/19 revealed an incident report completed for an incident on 7/6/19 (Saturday) at 6:45 p.m. According to the incident report, Tenant #2 called for help. Staff A arrived to find Tenant #1 holding Tenant #2's hands right outside of Tenant #2's room. Tenant #2 said Tenant #1 was in her room. Tenant #1's mouth was bloody, her lip bled, and her left front tooth was missing. When staff asked what happened, Tenant #1 stated, "He hit me." When staff asked who, Tenant #1 did not point anyone out. Staff asked Tenant #2 and her husband, who visited, what happened and they both stated Tenant #1 came into Tenant #2's room like that and walked toward the phone. Tenant #1 carried a pillow with her with blood on it and left a bloody hand print on Tenant #2's wall. Staff asked other tenants in the vicinity, but they could not say if they saw what happened. The incident report revealed Staff A notified the Director of Nursing (DON) on 7/6/19 at 6:45 p.m. Staff A also indicated first aid was provided. The incident report did not indicate family had been notified, nor did it indicate hospice had been notified. Further review of the incident report revealed on 7/8/19 (Monday), the Care Coordinator (CC) documented the DON had been notified on 7/6/19, as the on-call nurse. The CC indicated she assessed Tenant #1 that morning and notified her physician. Tenant #1's family called for a dental appointment. The CC further documented on the incident report Tenant #1 received ice and a pain pill on 7/6/9 for her injuries, as will as ice and analgesic on 7/7/19 and 7/8/19. The CC documented Tenant #1's vitals on 7/8/19 : blood pressure 134/70; pulse 72; respirations 16; temperature 98.6.	A 013	A policy and procedure for addressing falls was implemented 9/03/2019. Nursing staff education has been conducted. Nurse manager will review each incident at time of occurence. During working hours all resident falls will be assessed by licensed nurse. Nurse will contact family ,MD and other service providers as indicated. If serious injury has occured, staff will be directed to call 911 and notify family On call nurse managers will follow up with assessments that occur or carry over into the weekends. All falls will be reviewed Monday through Friday at daily meetings to monitor for compliance. Director of Wellness and/or designee will monitor and conduct audits monthly for the next 90 days to ensure compliance and as needed thereafter. Program insuffiency plan completed as of September 6th, 2019. Any concerns fromaudits/monitoring will be reviewed by program Wellness Director.	9/6/2019

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A 013	Continued From Page 2 Additional record review revealed the following entries in nurses' notes: a. On 7/6/19 at 7:00 p.m. Nurse A received a call from memory care staff regarding Tenant #1 found in another tenant's apartment with swelling and bruising to her lips and a missing tooth. Staff did not witness the incident resulting in the injury. Nurse A instructed staff to apply ice and given Tylenol for pain. Staff continued to investigate how the incident happened and contact the DON with any further concerns. b. On 7/8/19 at 10:15 a.m., the CC documented, " (Tenant #1) sitting on the sofa in the lounge. Left chin has a bruise that is purple in color and left upper and lower lips are swollen. (Tenant #1) denies pain. Looked in louth at broken front left tooth. No other injury noted in mouth other than the broken tooth. Family were visiting this weekend and are aware of the injury. Staff report that daughter in law called this morning and said they will be trying to get a dental appointment set up today. This injury occurred on (Saturday) eve and was not witnessed. Fax sent to (Tenant #1's) doctor to notify of the injury. (Tenant #1) able to eat, drink, and speak and swallow without problems or discomfort. (Tenant #1) does take routine pain medication every (morning). This nurse asked the staff to provide a cool compress or ice pack for mouth to help alleviate any swelling or discomfort (Tenant #1) may have." c. On 7/8/19 at 3:30 p.m. the CC documented Tenant #1's physician faxed back regarding Tenant #1's injury to her mouth. Tenant #1's hospice provider was also notified and planned to see Tenant #1. d. On 7/9/19 at 3:15 p.m. the CC documented	A 013		

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A 013	Continued From Page 3 Tenant #1 returned from the dentist with no new orders. Tenant #1 was to return to the dentist 7/12/19. e. On 7/12/19 at 4:15 p.m. the DON documented, "(Tenant #1) went to the dentist and had a root canal and built up tooth for a crown. No (temporary) crown was placed due to management. (Tenant #1) will return in (two) weeks for final crown..." f. On 7/16/19 at 1:30 p.m. the DON documented, "(Tenant #1's) daughter in law wanted to meet with (Executive Director), charge nurse, and myself to discuss incident last (Saturday) night. We did some discussion and planned for how to communicate better in the future. We will make sure a call to hospice is the first thing done and they will communicate with the family. I will leave this information in the MAR (medication administration record) for all staff to be aware. Prior to meeting I did get to know (Tenant #1's) daughter in law better and we discussed my interactions with (Tenant #1) since (February) and her pain management that has improved her quality of life." When interviewed on 9/5/19 at 2:05 p.m. Staff A reported she came out of another tenant's room and heard Tenant #2 calling for help. When she arrived to Tenant #2's room she found Tenant #1 bleeding from her mouth. She asked Tenant #2 what happened, and was told Tenant #1 walked into Tenant #2's room that way. When she asked Tenant #1 what happened, Tenant #1 stated she did not know. Staff A recalled she checked Tenant #1's mouth and called the DON. The DON told her to put ice on Tenant #1's mouth and to try to find Tenant #1's missing tooth. The DON stated she would check her out the next day. Staff A stated she also gave Tenant #1 something for	A 013		

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A 013	Continued From Page 4 pain. Staff A reported the bleeding mostly came from a cut on Tenant #1's lip. Staff A reported she contacted the DON more than once, probably two or three times regarding Tenant #1's injuries. Staff A reported she gave the DON as many details as possible and felt someone needed to look at Tenant #1. She reported she did not tell the DON to come in to look at Tenant #1, as she felt that was not her place. She thought if she gave the DON enough details she feel the need to do so. When interviewed on 8/30/19 at 12:05 p.m. the Executive Director (ED) confirmed Tenant #1's family was not notified of Tenant #1's fall on 7/6/19. The ED stated she was not aware of the incident until the next Monday when Tenant #1's daughter in law called her regarding the tenant's injuries. The ED stated she asked Staff A why Tenant #1's family had not been notified of the incident and was told the DON stated she would notify the family Monday. The ED reported hospice should have been notified as well. The ED confirmed Tenant #1's injuries were not assessed by a nurse until 7/8/19 and confirmed a nurse should have come in to assess Tenant #1's injuries on 7/6/19.	A 013	Program Executive Director will be notified of all falls with serious injury, immediately following family notification. Executive Director and Wellness Director and/or designee will monitor falls weekly and monthly review to ensure compliance.	