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
	S0168	A. BUILDING: _____ B. WING _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS ASSISTED LIVING	**512 13TH STREET WELLMAN, IA 52356**

(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 visit. Number of tenants without cognitive disorder: 7 Number of tenants with cognitive disorder: 7 Total Census of Assisted Living Program for People with Dementia: 14 THIS IS AN AMENDED REPORT The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure medication administration and treatments were completed in accordance with the Program's medication administration guidelines and training. This potentially affected all 14 tenants who received Program administered medications. Findings follow: Observation on 4-17-19 at 12:18 p.m. revealed Staff A giving medications to eight tenants from a medication cart off of the dining room. The following incidents were noted: - When medications were given to Tenant #3 it was noted the medication administration record (MAR) reflected she was to receive a 2000 microgram capsule of Cholecalciferol one time per day at 12:00 p.m. The pharmacy label on the bubblepack indicated the medication was to be given once per day in the morning. Staff A administered the medication at noon according to the MAR. - Medications were given to Tenant #4 in the dining room. The med cart was left unlocked in the side area off of the dining room. - When administering medications to Tenant #5, Staff A prepared the oral medication at the med cart and placed it in a cup. Staff A retrieved Tenant #5's eye drops from the cart and proceeded to Tenant #5's apartment. Staff administered one drop in the right eye without sanitizing her hands or donning gloves. She then administered the oral medication from the cup without sanitation of the hands. The MARs reflected an order for Refresh Liquigel Solution	A 003		

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A 003	Continued From page 2	A 003		

1%, one drop in both eyes three times per day. The pharmacy label on the bottle reflected gel drops were to be instilled two to three times daily in the right eye and one to two times daily in the left eye. The observation of the instillation of the eye drop, the order as transcribed on the MAR and the label on the bottle were inconsistent.

- Medications were then administered to Tenant #6. It was noted his morning medications were not signed off as given. Staff signed off on the morning meds at the same time she administered the noon meds.
- When administering meds to Tenant #7 in the dining room Staff A locked the med cart but left the keys in the lock. The cart was located in the side area off of the dining room.
- Medications were then administered to Tenant #2. Her morning meds were not signed off as given. Staff signed off on the morning meds at the same time she administered the noon meds.

Observation on 4-18-19 at approximately 8:35 a.m. revealed Staff A administered insulin to Tenant #8. She prepared the insulin at the medication cart located in a side area off of the dining room. Tenant #8 was seated at the dining room table for breakfast with three other tenants. Staff A injected the insulin in Tenant #8's abdomen at the dining room table. Tenant #8's abdomen was not wiped with alcohol prior to the insulin administration and Staff A had not donned gloves prior to the administration of the insulin.

When interviewed on 4-17-19 at 1:25 p.m. and 4-18-19 at 8:35 a.m. Staff A confirmed medications for Tenants #2 and #6 were administered on the morning on 4-17-19 but not marked off as given until later. She confirmed there was no hand sanitation or donning of

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A 003	Continued From page 3	A 003		

gloves prior to the administration of Tenant #5's eye drops. She said Tenant #8's insulin was given at the table as the tenant requested it be given right before the meal.

Record review on 4-17-19 and 4-18-19 revealed the Program's Medication Guidelines indicated the following:
- documentation of the medication would be done after administration of the medication
- staff were to check the MAR, check the pharmacy label and check the MAR again prior to administration

The Medication Pass Monitoring Tool identified the following steps:
- the order on the MAR was to be compared to the label on the medications
- the medication cart was to be locked when not in view and/or when away from the cart
- the administration of medication was to be documented immediately following the administration

The Insulin Vial training document indicated staff were to wash hands, apply gloves and cleanse the skin with alcohol prior to administration of insulin.

When interviewed on 4-17-19 at 3:08 p.m. and 4-18-19 at 11:35 a.m. the Director of Nursing revealed staff were to document medications after observing the tenants take them, the med cart was to be locked when staff were not next to it and hand washing and donning of gloves should occur prior to the administration of eye drops. Insulin administration should be offered in tenant apartments and gloves should be worn when completing the task.

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A 036	481-69.22(1) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to utilize the Global Deterioration Scale (GDS) during an annual evaluation for 1 of 2 tenants reviewed with cognitive decline (Tenant #1). Findings include: Review of Tenant #1's file on 4-18-19 revealed a functional and health evaluation completed on 8-24-18. A Cognitive Ability Assessment completed on 8-24-18 indicated high risk of decline. The prior Cognitive Ability Assessment completed on 10-4-17 indicated moderate risk of decline. Although a cognitive evaluation was completed on 8-24-18, the GDS was not used	A 036		

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A 036	Continued From page 5 which was required due to the fact the prior cognitive evaluation (10-4-17) indicated a moderate risk of cognitive decline. On 4-18-19 at 11:10 a.m. the Director of Nursing confirmed there was no GDS completed for Tenant #1 in August 2018.	A 036		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations annually for 1 of 2 tenants reviewed (Tenant 2). Findings follow: Review of Tenant #2's file on 4-18-19 revealed	A 037		

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A 037	Continued From page 6 evaluations were completed on 4-17-19 due to a significant change of condition. The last evaluations completed prior to that were dated 12-10-17. Cognitive, health and functional evaluations were not completed annually. On 4-18-19 at 11:30 a.m. the Director of Nursing confirmed evaluations were not completed annually for Tenant #2.	A 037		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as required for 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow: 1. Review of Tenant #1's file on 4-18-19 revealed an unsigned service plan with an initiation date of 2-19-18. The service plan was not based on evaluations as the most recent evaluations were completed on 10-4-17 and 8-24-18.	A 083		

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A 083	Continued From page 7 An Iowa AL Nurse Review document dated 2-22-19 revealed Tenant #1 had falls and required a four wheel walker for safety. Staff assisted Tenant #1 with blood glucose monitoring and he was not cooperative with the task. The tenant's service plan initiated 2-19-18 did not reflect Tenant #1's refusals of blood glucose checks or falls with interventions. 2. Review of Tenant #2's file on 4-18-19 revealed an unsigned service plan with an initiation date of 5-10-18. The service plan was not based on evaluations as none had not been completed since 12-10-17. A Weight Summary document reflected Tenant #2 had an eight pound weight loss in the previous two months. The service plan did not reflect the weight loss or interventions. 3. When interviewed on 4-18-19 at 11:30 a.m. and 1:42 p.m. the Director of Nursing confirmed these findings.	A 083		
A 125	481-69.30(5) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program. This REQUIREMENT is not met as evidenced by:	A 125		

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A 125	Continued From page 8 Based on interview and record review the Program failed to ensure hands on training was included in dementia-specific training for 6 of 6 staff reviewed employed longer than 30 days (Staff B, D, E, F, G and the Director). Findings include: Review of employee files on 4-18-19 revealed the following: - Staff B had a hire date of 7-24-18. Staff B completed dementia education on 7-24-18 - Staff D had a hire date of 3-8-19. Staff D completed dementia education on 3-25-19. - Staff E had a hire date of 3-5-19. Staff E completed dementia education on 3-5-19. - Staff F had a hire date of 3-5-19. Staff F completed dementia education on 3-5-19. - Staff G had a hire date of 1-4-19. Staff G completed dementia education on 1-18-19. - The Director had a Program start date of 1-1-19. Dementia education was completed on 1-2-19. There was no documentation of any hands on training completed during dementia-specific training for any of these staff. When interviewed on 4-18-19 at 11:35 a.m. and 1:42 p.m. the Director of Nursing confirmed there was no documentation of hands on training for these staff.	A 125		