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 |
|---|---|---|---|
| | S0187 | A. BUILDING: _____ B. WING _____ | 10/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LELAND R SMITH ASSISTED LIVING RESIDENCES | 309 OVESEN DRIVE WILTON, IA 52778 |

| (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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site.<br>Number of tenants without cognitive disorder: 20<br>Number of tenants with cognitive disorder: 4<br>TOTAL census of Assisted Living Program: 24<br><br>There were no regulatory insufficiencies cited during the onsite infection control survey completed on 10/1/20.<br><br>The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program. | A 000 | See Attached POC 3/4/21 | |
| A 085 | 481-69.26(3) Service Plans<br><br>481-69.26(231C) Service plans.<br>69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the program failed to update 1 of 3 tenant's service plans following a significant change (Tenant #1). Findings follow:<br><br>Record review on 10/1/20 revealed a Progress Note dated 6/18/20 indicated Tenant #1's family moved her belongings into her apartment on that | A 085 | | |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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| A 085 | Continued From page 1<br>date. The family notified staff Tenant #1 was in the hospital due to fluid retention and low sodium levels. The RN Coordinator told Tenant #1's son his mother's condition would need to be reassessed prior to her admission. On 6/22/20, Tenant #1 was discharged from the hospital and arrived at the program via her son's vehicle. The RN Coordinator documented Tenant #1's assessments and service plans were updated and signed reflecting her use of a catheter.<br><br>A review of a hospital discharge summary for Tenant #1 dated 6/22/20 noted she had been admitted to the hospital on 6/17/20 for hyponatremia, urinary retention, hypervolemia and a urinary tract infection. A recommendation for Tenant #1 upon discharge was for her to have a 2 L fluid restriction daily to prevent future hypervolemia. It was also noted Tenant #1 had expressed several times she had become more forgetful and on 6/18/20 she was upset because she thought no doctors had visited her the previous day. Tenant #1 was encouraged to follow a cardiac diet upon discharge. At an entrance meeting with the RN Coordinator on 10/1/20 at 9:15 AM, she reported the program served special diets.<br><br>A task sheet dated June 2020 revealed staff had been directed to empty and measure urine from Tenant #1's catheter bag every shift. Staff members initialed they emptied the bag on 6/22/20 - 6/24/20.<br><br>A health status note dated 6/24/20 noted staff obtained Tenant #1's weight she had a significant weight gain from her hospital weight. Her abdomen was firm and distended with discomfort and she reported shortness of breath. Tenant #1's son transported her to the hospital. | A 085 | | |

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| A 085 | Continued From page 2<br><br>On 7/10/20 a health status note documented Tenant #1 returned to the program after a hospitalization and a stay at a skilled nursing facility with a diagnosis of chronic heart failure and fluid retention.<br><br>An interview with the RN Coordinator on 10/1/20 at 2:00 PM revealed Tenant #1's service plan and assessments had not been updated on 6/22/20 following her discharge from the hospital and the 6/11/20 service plan was used. This service plan indicated Tenant #1 was independent with toileting. It did not mention a cardiac diet. Her fluids had not been restricted to 2 liters. The RN Coordinator thought the staff had been measuring the urine output from the catheter bag but the documentation from this could not be found. | A 085 | | |

ok
3/12/21

Wilton Retirement Community
Leland R. Smith Assisted Living
309 Ovesen Drive
Wilton, IA 52778
Phone: 563-732-2086 Fax: 563-732-2465

Plan of Corrections 03/04/2021

The RN Coordinator corrected the service plan of tenant #1 immediately on 10/1/2020 to reflect a cardiac diet to include low sodium and a 2L fluid restriction.

The RN Coordinator created a nurse review check off sheet to be completed with all annual and significant change nurse reviews to ensure all tasks are completed. The RN Coordinator used this check off sheet to then audit all other tenant records without significant findings.

To improve quality assurance the DON and/or Administrator will perform a sample audit of tenant records on a quarterly basis.