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	IAALP013	A. BUILDING _____ B. WING _____	11/23/2020

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ARLINGTON PLACE OF RED OAK	800 EAST RATLIFF ROAD RED OAK, IA 51566

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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. General Population Program Number of tenants without cognitive disorder: 26 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 27 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 7 TOTAL census of Assisted Living Program: 34 The following regulatory insufficiencies were cited during the investigation of Complaints 94198-C, 94322-C, 91720-C, 93144-C, 94329-C, the Recertification survey and onsite infection control survey.	A 000	See attached doc POC 2/26/21	
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		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 observations, record review and interview the Program failed to ensure all personnel adhered to policies and procedures implemented to limit tranmission of Covid-19 and ensure proper infection control practices. This potentially affected 34 of 34 tenants residing at the Program. Findings include: On 11/04/20 at 11:15a.m the House Manager reported the Program had two positive Covid-19 cases in the building. (Residents #6 and #7) 1. Observation on 11/04/20 at 4:52p.m. revealed Staff D exited a Covid-19 positive tenant's room. When Staff D came out of the room Staff D removed the gown and threw it in the trash container, pulled off her mask and placed in the plastic bag outside of the room, removed her gloves and threw them away. Staff proceeded to walk away from the door towards the Bistro without using hand sanitizer or washing her hands. Staff D was questioned, "Aren't you going to wash your hands?" Staff looked towards the nearest sink located in the Bistro and said, "That sink doesn't have any soap at it, I usually walk back to the dining room and wash at that sink." 2. When interviewed on 11/04/20 at 4:08p.m. Staff F reported when caring for positive Covid-19 tenants, she would don a mask, gown, goggles and gloves. Staff F reported when her work was complete with the tenant she would attempt to refold her blue disposable gown and put back in the bag it came in along with her mask for reuse. Staff F reported she thought she was trained to	A 003		

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A 003	Continued From Page 2 do it this way. Record review on 11/04/20 at 2:56 p.m. revealed the Programs procedures Standard Precautions for Infection Control. The procedures directed after wearing a gown, they were to be removed promptly after use and disposed in the proper container. Precautions also directed staff to wash hands after removing gowns. Precautions also included washing hands immediately after gloves or gowns are removed. When interviewed On 11/04/20 at 5:03p.m. the Clinical Care Specialist/Staff C confirmed these findings and said staff should have used hand sanitizer and washed their hands at the nearest sink. Staff C confirmed there was no soap located at the nearest sink. Staff C also confirmed Staff F reused her disposable gown during when working with Positive Covid-19 Tenants. Both Staff D and Staff F were pulled to the side and immediately reeducated.	A 003		
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	A 037		

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A 037	Continued From Page 3 exhibited a significant change. This Requirement is not met as evidenced by: Based on interviews and record review the Program failed to consistently ensure completion of functional, cognitive, and health assessments as warranted by a change in tenants' cognitive status. This pertained to 1 of 7 tenants reviewed (Tenant #1). Findings follow: When interviewed on 11/05/20 at 9:09a.m. Staff E reported an incident on 10/24/20 where Tenant #1 walked out of an unlocked door and was later returned to the program. Staff E thought Tenant #1 had been gone 10 to 15 minutes but was not sure. Staff E reported the temperature was cold that day, in the low thirties. Tenant #1 had a sweater and leggings on, but no jacket. Staff E stated Tenant #1 was known to be confused. She would eat breakfast and come back and want to eat again because she had forgotten she already ate. Staff E stated Tenant #1 was not authorized to come and go from the Program on her own. She explained some tenants were able to do so, but Tenant #1 was not one of them. Staff E stated she would view the incident as an elopement. When interviewed on 11/12/20, a community member reported finding Tenant #1 on 10/24/20. The community member reported as they topped the crest of the hill the tenant was observed standing in the middle of the gravel road. The community member's truck passed the tenant still standing in the middle of the gravel road and as the truck stopped and backed up, the tenant moved to the side of the gravel road. He reported the tenant appeared out of place. Given the	A 037		

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A 037	Continued From Page 4 weather conditions, the driver felt that it did not look right and stopped to question the tenant. The tenant was reported to have a thin sweater and leggings on, no coat. The tenant was located down a gravel road approximately a half mile from the Program. The driver reported if they had been driving faster they could have hit the tenant, as she was not visible to the driver until they came over the hill. The driver reported Tenant #1 was cold and disoriented. The community member reported Tenant #1 told him her name and said she was from Arlington Place. She said she was headed to the other Arlington, pointing off in the Northwest direction leading into a pasture and out of town away from the Arlington of Red Oak Program. The community member, who lived in the area their entire life, wondered if there was another Arlington building over in the direction she pointed, but knew there wasn't and thought Tenant #1 was confused. The community member called his wife to tell her of the incident and she called the Program. The program staff confirmed she did live at the Program and were not aware she had left. The community member gave Tenant #1 a ride back to the Program. The community member reported when he gave his report to the staff concerning what had just transpired, he felt the staff would not inform the family of the incident and thought it would be swept under the rug. The community member reached out to Tenant #1's family to inform them of the incident. The family told him the tenant was an avid walker in the courtyard but not outside the building. The community member stated he thought the tenant was lost and was getting colder. She was very grateful he picked her up. According to the State Climatologist, on 10/24/20 at approximately 1:30 p.m. the temperature in Red Oak was 36 degrees Fahrenheit (F) and a wind chill of 29 degrees F. Conditions were clear with	A 037		

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A 037	Continued From Page 5 winds 9 miles per hour from the northeast. Record review revealed a late entry nurse's note effective 10/24/20 at 1:50 p.m. The note documented an assessment completed on Tenant #1 and the Global Deterioration Score (GDS) was noted to be 3. The note further documented, "Asked resident why she went outside why she went out without her coat. Stated I just went on a walk. No confusion noted. Resident's GDS is 3. Not an unusual occurrence for resident to ambulate outside. Didn't know why the man brought her back because she was just taking a walk. Resident was wearing appropriate shoe wear. VS (vital signs) stable." An additional late entry effective 10/24/20 at 1:50 p.m. indicated a call had been received from the staff at the Program regarding Tenant #1 going outside and being brought back by a man driving by. Tenant reported she was "going to the other Arlington Place." Tenant #1 reported she was walking on the side of the road and a man stopped and picked her up. Tenant #1 denied falling and no change in condition was noted. When interviewed on 11/19/20 at 11:30 a.m. Tenant #1 stated she was not to walk out front in the driveway, the street and or the sidewalk. The tenant said she was allowed to walk in the Gardens area. She explained when she first got to the Program (7/10/19) she would go out front and walk, but noted they no longer wanted her in front or on the street. She could go out back and walk in the Gardens area. The tenant stated on the date of the incident, she left Arlington Place on her way to the other Arlington Place to get something. She did not remember what it was. Tenant #1 stated, "They thought it was too cold to be out there. I'm glad they stopped. It was getting chilly."	A 037		

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A 037	Continued From Page 6 When interviewed on 11/05/20 at 9:47a.m. the Manager reported Tenant #1 went outside to walk all the time. She noted Tenant #1 had days of confusion. When asked if it was ok for Tenant #1 to leave the Program at any time, the Manager responded. "Yes." When interviewed on 11/19/20 at 11:03a.m. Tenant #1's family indicated Tenant #1 should not have left the Program at any time and noted she hadn't "done that for a long time." Additional interviews with Tenant #1's family revealed she was not to walk out front. She was to walk in the Gardens area. (Courtyard). A second member of the family expressed the same understanding. Record review revealed Tenant #1, 86 years old, was admitted to the Program in July 2019. Tenant #1's diagnoses included glaucoma, hearing loss of the right ear with restricted hearing on the contralateral side, hypertension, age related osteoporosis, a cardiac pacemaker and mental disorder due to known physiological condition. On 9/08/20 Tenant #1 was noted to have mild cognitive decline (early confusion). Continued review of Tenant #1's record revealed the following: a. A progress note dated 7/13/20 documented a change in condition assessment. Tenant #1 had increased issues with mental status, forgetfulness. The tenant's daughter called the Program concerned for her mother's "mentality and seeing things/people in her room, thinking she was in the basement, someone stealing her masks, etc." The Program obtained a urinalysis, which came back clear. The tenant continued to have issues over the weekend and was sent to the emergency room. The tenant was admitted for overnight observation after all tests came back clear. The tenant returned to the Program. Immediately upon returning from the hospital, Tenant #1 got her purse and said she was leaving for Stanton,	A 037		

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A 037	Continued From Page 7 Iowa. The note further documented, " ... Did call (nurse practitioner) and she was not willing to order a PRN (as needed medication) anti-anxiety med as it is considered 'a chemical restraint' Asked what to do if (tenant) decided to try and elope or get more upset as the evening went by, was instructed to send (tenant) the ER to be evaluated ..." Assessments were completed on 7/13/20 for change in condition because Tenant #1 stayed in the hospital overnight for observation due to altered mental status noted. At that time, Tenant #1 had a GDS of 3. The assessment indicated Tenant #1's orientation fluctuated and noted the tenant seemed more forgetful, but "does seem to be able to put on a pretty good façade. She has had more memory issues lately." The assessments further noted Tenant #1 would exit seek. A progress note completed 7/14/20 documented Tenant #1's daughter took her to see her primary care physician due to confusion/health status continued to decline. The note indicated, " ... He (physician) did order B12 shots weekly to become monthly, and just to monitor her condition, coming back for (follow up) visit on 7/29." b. A progress note completed 7/25/20 documented Tenant #1 packed her living room and part of her kitchen into boxes to move. It noted, " ... She does not know where she is going, but is frustrated as her husband (deceased) did not help at all with the packing. Call to daughter to notify, she is very (concerned of) this also, as her behaviors have changed drastically in the last few weeks, much more confused/forgetful, not able to figure out how to use her phone, etc." c. A progress note completed 7/29/20	A 037		

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A 037	Continued From Page 8 documented a nurse review and included, "(Daughter #1) has been visiting her mom almost daily, noting much more confusion each day. When she visited with her this week, along with (Daughter #2), (tenant) does not remember packing anything. Daughters requested we get her checkbooks and jewelry out of her apartment so it would be safe, as resident is hiding/moving things daily. Finally able to get it with (tenant's) assistance yesterday to daughters. (Daughter #1) notified me there was a missing tray of rings, will look for them tomorrow when (tenant) is at doctor (appointment) with daughter ... looked while (tenant) gone, found checkbooks that were missing, $1600 cash and some diamond rings, returned to (Daughter #1) this evening ..." d. A progress note entered 8/21/20 due to communication with Tenant #1's physician and discontinuation of Trazadone. The note documented, "(Tenant) has significant cognition deficit (related to) dementia. Does experience sun downers and becomes agitated and restless in the early evening and night time hours. Resident very forgetful during the day. Hiding things, accusing people of being in her apartment, etc ..." The note continued, "Since Trazadone has been discontinued resident is much more clear during the day. Daughter reports resident is calling her again. Found her phone cord she had hid. Noted resident is doing her own laundry. Overall condition has improved during the day. Resident continues with sun downers (signs and symptoms). Becomes agitated and verbally aggressive with staff during evening and night time hours ..." e. Assessments completed 9/8/20 for change of condition due to Tenant #1 fracturing her hand noted Tenant #1 to have a GDS score of 3. The assessment noted the tenant did not exit seek and	A 037		

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A 037	Continued From Page 9 was oriented to person, place, and time. f. An email from Tenant #1's family on 10/12/20, to the Program RN/Staff B warned of Tenant #1's declining memory. The family informed the Program the tenant called them at midnight and 1:00 a.m. worried she had missed her appointments. The family also warned the Program in the same email the tenant had mentioned to the daughter more than once leaving Arlington Place and walking to the Dollar General, so they should be aware. g. A progress note documenting a 90- day review completed 10/13/20 noted ... "(Tenant) has no attempts at elopement but did mention to daughter that she has thought about walking down to the dollar store. Affect is pleasant and (tenant) is generally happy. Does have periods of confusion and will come out to the dining room throughout the night and refuse to go back to her apartment ..." h. Tenant #1's most recent service plan (undated) noted Tenant #1 liked going on walks outside independently for an activity. Regarding cognition/mood, the plan noted Tenant #1 to be oriented and able to recall or obtain information and further indicated she, "May at times have some forgetfulness." The service plan also noted the tenant's goal to dress neatly and appropriately for the day and indicated the tenant dressed without staff assistance. When interviewed, Tenant #1's family reported they placed their mother in the Program in July 2019 due to increased episodes of confusion. The family thought their mother was leaving her home in the middle of the night. As a result, the family placed a tracker on their mom's car out of concern for her safety while living at home alone. The	A 037		

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A 037	Continued From Page 10 family reported when Tenant #1 was first placed at the Program, she left the facility at 3:30 a.m. driving her own car. She became confused and drove around on gravel roads near the Program for 45 minutes. She eventually found her way back, re-entered the building and went back to her apartment with no staff aware she had left. When the family member woke up and checked their phone, they saw their mother had left the Program driving in her car via the tracker signal being sent to the cell phone. The Program was contacted by family. The Program told the family that the alarms had been turned off when a family was moving in. Tenant #1's family indicated Tenant #1 should not have left the Program at any time and noted she hadn't "done that for a long time." Additional interview with Tenant #1's family on 11/12/20 at 10:28 a.m. revealed an incident on 10/14/20 involving Tenant #1 becoming disoriented. The family had received a voicemail to call the program nurse. When the family called, the nurse reported Tenant #1 exited the Program and set off the door alarms while trying to go to the beauty shop. She was found on the property trying to get back in another door. Record review on 11/16/20 failed to produce an incident report or progress note regarding the incident on 10/14/20. When interviewed on 11/16/20 at 1:27p.m. the House Manager confirmed there should have been something in the nurses' notes concerning the 10/14/20 incident. The Manager reported she did not know about this incident. The Manager confirmed the Program did not have an incident report for the 10/14/20 incident. When interviewed on 11/16/20 at 1:46 p.m. the Registered Nurse (RN) reported staff were with Tenant #1 the entire time on 10/14/20 and	A 037		

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A 037	Continued From Page 11 followed her out of the Program. She was on her way to the beauty shop. A follow up interview with Tenant #1's family on 11/19/20 at 11:03 a.m. confirmed the nurse did not tell them staff followed their mother when she left the Program on 10/14/20. When interviewed on 11/05/20 at 9:09a.m. Staff E revealed Tenant #1 was known to be confused. She would eat breakfast and return to the dining room, wanting to eat again, as she had forgotten she'd already eaten. Staff E reported Tenant #1 should not come and go from the Program. She explained some tenants were permitted to do so, but Tenant #1 was not one of them. Staff E said she would view the incident on 10/24/20 as an elopement. Staff E explained Tenant #1 does everything independently, she is just not mentally able to go for walks for fears she would get lost. When interviewed on 11/11/20 at 3:01p.m. Staff D reported Tenant #1 would go out for walks in the parking lot. Tenant #1 would let staff know she was going and staff let her out the door. Staff D reported lately Tenant #1 walked back in the Gardens area. When Staff D was asked how many times Tenant #1 had walked outside alone, she reported she could not answer. She stated she had never let Tenant #1 walk outside in front of the Program alone, but reported she heard of other staff allowing Tenant #1 to do so. Staff D explained if the Tenant asked her to open the door to let her out to walk she would suggest the tenant go walk in the enclosed gardens area so staff could keep a closer eye on her. Staff D explained it would be safer for her in there to keep her from falling or becoming disoriented. Staff D stated Tenant #1 would become confused more often at night than during the day. When interviewed on 11/17/20 at 10:20 a.m. Staff	A 037		

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A 037	Continued From Page 12 J revealed once or twice a week Tenant #1 would come to her to let her know she was going for a walk. Staff J said she would unlock the door and Tenant #1 would walk out in front of the Program alone with no staff along. Staff J reported Tenant #1 would usually walk to the gravel road. When interviewed on 11/17/20 at 10:42 a.m. Staff K revealed Tenant #1 liked to walk and had always walked outside. Tenant #1 would go out the front door down to the gravel road, turn around and come back. After Covid-19, the doors were locked, so Tenant #1 would ask staff to open them for her to go out. In summary, the Program failed to complete health, functional, and cognitive assessments when Tenant #1was found in the middle of the gravel road, not dressed for the weather, and expressing to go to another Program that didn't exist. The tenant had a noted history of confusion, some times worse than others. On 10/14/20 it was initially reported to Tenant #1's family she left the Program and set off door alarms while trying to locate the beauty shop. She was found on property, trying to get in a locked door. This incident was not documented on an incident report or in progress notes. On 10/24/20 the tenant was located in the middle of the gravel road approximately one-half mile from the program. The temperature was 36 degrees F with a wind chill of 29 degrees F and the tenant did not wear a coat. The tenant reported she was glad the Interviews with staff revealed the tenant frequently walked outside; however, interviews with the tenant's family and staff revealed the tenant generally walked in the secured courtyard. Two staff reported the tenant used to walk at the front of the program, but indicated she would walk to the gravel road and turn around. Progress notes indicated the RN assessed the tenant upon her	A 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP013	A. BUILDING _____ B. WING _____	11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF RED OAK	800 EAST RATLIFF ROAD RED OAK, IA 51566

(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 037	Continued From Page 13 return to the Program and documented a GDS of 3. The Program reported the RN had a conversation with the tenant and asked questions to determine her orientation status. The resident answered the questions appropriately and was alert and oriented x3. However, the program was unable to produce documentation of cognitive, functional, and health assessments completed after the occurrences on 10/14/20 and 10/24/20, which marked a change in tenant condition.	A 037		

ok
3/2/21

Arlington Place of Red Oak

800 E Ratliff Rd. Red Oak IA 51566

Date: 2/25/2021

Complaint Intake #: 94198-C, 94322-C, 91720-C, 93144-C, 94329-C, Recertification survey and onsite infection control survey.

Plan of Correction (POC) Submitted For:

- Investigation Date: 11/03/2020-11/23/2020
- Monitors: Mike Rohner

POC:

A. 481-67.2(1)e Program Policies and Procedures

481-67.2(231B, 231C, 231D) Program policies and procedures, including those for incidents reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow polices 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. Regulatory Insufficiency: The program failed to ensure all personnel adhered to policies and procedures implemented to limit the transmission of COVID-19 and ensure proper infection control practices. This potentially affected 34 of 34 tenants residing at the program.

i. Program POC:

1. Elements detailing how insufficiency was corrected for policies and procedures to limit the transmission of COVID-19 and ensure proper infection control practices.

a. Training with all staff on PPE and infection control completed 11/13/2020. Policy and procedures in relation to prevention of person to person transmission, gloving and handwashing, hand hygiene technique, dietary sanitation, altered dining practices, environmental rounds and visitor restrictions reviewed with all staff 11/13/2020

2. Measures taken to ensure the problem does not recur:

a. Daily, weekly, monthly, or as determined by Director and/or designee environmental rounds being completed.

3. How the program plans to monitor performance to ensure compliance:

a. Weekly, Monthly, or as determined by the Director and or Designee infection control audits.

4. Date by which the regulatory insufficiency will be corrected:

a. Education and training completed 11/13/2020.

D. 481-69.22(2) Evaluation of Tenant

481-69.22(231C) 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.

a. **Regulatory Insufficiency:** The program failed to consistently ensure completion of functional, cognitive, and health assessments as warranted by a change in tenants' cognitive status. This pertained to 1 of 7 tenants reviewed.

i. **Program POC:**

1. Elements detailing how insufficiency was corrected:

a: Education and training conducted with Healthcare Coordinator on proper documentation for Change of Condition Assessments completed.

b. Education and training with Healthcare Coordinator done 11/13/2020, reviewed qualifications for change in condition assessments and evaluation of tenant's functional, cognitive, and health status.

2. Measures taken to ensure the problem does not recur:

a. Healthcare coordinator will monitor residents' conditions and ensure change of condition assessments are completed.

b. Healthcare Coordinator will perform change of condition assessments on resident utilizing change of condition indicators in a timely manner.

3. How the program plans to monitor performance to ensure compliance:

a. Healthcare Coordinator will monitor assessment due dates in PCC and ensure accuracy.

4. Date by which the regulatory insufficiency will be corrected:

a. Training and education with Healthcare Coordinator will be completed by 2/26/21.

Kristy Etzen RN 2/26/21

Di Smith, Director 2/26/21

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 regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.