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
	S0079	A. BUILDING: _____ B. WING _____	C 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY RIDGE PLACE	5605 JERSEY RIDGE RD DAVENPORT, IA 52807

(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: 25 Number of tenants with cognitive disorder: 2 Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7 TOTAL Census of Assisted Living Program for People with Dementia : 34 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program for People with Dementia. There were no regulatory insufficiencies cited during the onsite infection control survey completed on 5/17/21. There were no regulatory insufficiencies cited during the investigation into complaint #92815-C. The following regulatory insufficiencies were cited during the investigation into complaints #96871-A and #96712-A.	A 000		
A 160	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.	A 160		

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A 160	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide appropriate treatment and services to 1 of 6 discharged tenants (Tenant C1). Findings follow: Record review on 5/10/21 revealed Tenant C1 was sent to the emergency department with a urinary tract infection on 1/29/21. While in the hospital, it was noted Tenant C1 had a high blood glucose level of 239. Tenant C1's daughter contacted the tenant's PCP (Primary Care Provider) on 2/1/21 asking if the doctor wanted to follow up with labs related to Tenant C1's high blood sugar. Documentation from the PCP's office indicated the PCP's nurse contacted the program DON (Director of Nursing) and asked her to check the tenant's HbA1c level (a measure of how well one's blood sugar has been controlled over a period of three months) and to check her blood sugar twice daily if possible. The DON documented on 2/2/21 she received these orders from the PCP's nurse. The DON then called the pharmacy and learned the tenant would have to pay out of pocket for her testing supplies as she did not have a diagnosis of diabetes. The tenant's family agreed to go ahead with the HbA1c according to the program notes but wanted to wait on the other. An HbA1c test was performed on Tenant C1 on 2/3/21 with a result of 6.0 which was high, with a normal range of 4.8 - 5.6. The DON wrote on the bottom of the test form "please sign and fax back that you're aware," indicating it was sent to Tenant C1's physician. However, there was no signature from the doctor on the form. The PCP's office reported they did not receive a copy of the HbA1c results from the DON. Tenant C1's daughter contacted the PCP's nurse about moving her	A 160		

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A 160	Continued From page 2	A 160		

mother to another facility on 2/12/21. The daughter reported her mother seemed to be doing better the last two days. The daughter asked if a urinalysis should be repeated to ensure she did not still have a urinary tract infection. The doctor responded a urinalysis should be done. The PCP also wanted to start the tenant on insulin for her diabetes, either Lantus or Levemir, and ensure her blood sugars were getting checked twice a day. The PCP's nurse documented she gave detailed instructions on this to the DON as well as to the tenant's daughter.

Continued record review revealed the program record contained no notes from 2/2/21 until 2/14/21. On 2/14/21, she noted Tenant C1 displayed mottling to her bilateral lower extremities. Her oxygen saturations were at 86% with room air. She was comfortable with no signs or symptoms of pain. Tenant C1 was comfortable with eating only a couple bites of food and minimal fluids. The DON contacted the family to come in for compassionate care visit. At 11:30 PM, Tenant C1's oxygen saturation rate was 97%. The record included no documentation Tenant C1's physician was notified of her change in condition. A "Late Entry," dated 2/15/21, noted the DON explained to the family another nurse noted Tenant C1's stool was slightly darker than usual. The DON explained to the family due to the tenant's low oxygen level, mental decline and possible bleed the tenant should be seen in the emergency room. She wrote the tenant's family requested the DON call the new facility to get them to take her early so that facility could administer oxygen to the tenant. The DON called the new facility but transfer was already scheduled for 2/16/21 at noon and could not be rearranged. On 1/16/21 at 1:25 AM, the tenant

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A 160	Continued From page 3	A 160		

was transferred to the emergency department due to a large amount of bleeding from her rectum. At the emergency department, Tenant C1 was diagnosed with acute kidney injury, dehydration, hyperkalemia, hypernatremia and gastrointestinal hemorrhage.

Record review revealed Tenant C1 was admitted to the Program 1/30/17. She had diagnoses including, but not limited to: hyperlipidemia, transient cerebral ischemic attacks and related syndromes, gastro-esophageal reflux disease without esophagitis, and essential hypertension.

When interviewed on 5/13/21 at 9:55 a.m. and 5/17/21 at 4:10 p.m., the PCP's nurse reported she had telephone conversations with Tenant C1's daughter on 2/1/21, 2/5/21 and 2/12/21 about conducting blood glucose testing for her mother. The nurse did not recall the daughter stating the family was unwilling or unable to pay for the testing supplies. The nurse had a conversation with the DON on 2/12/21 about the PCP's wish to start Tenant C1 on insulin. She stated she would pass on verbal orders for medication or lab work from the PCP to the DON frequently. The DON knew to contact her if she had any questions and there was no record of the DON asking further questions. In this specific case, the PCP did not care which type of insulin the tenant used as they were interchangeable, but generally an insurance company would only pay for one type of insulin. The PCP's nurse stated she conversed with the DON as one professional to another and they both knew the insulin was to be delivered via an insulin pen from their conversation, as no one draws up insulin from a vial any longer. The PCP's nurse also let the DON know a new urinalysis was needed for Tenant C1. The PCP's nurse had given the DON

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A 160	Continued From page 4 orders for urinalysis in the past and had never ordered a plain urinalysis without culture and sensitivity. The PCP's office did not have a record of receiving the fax with the results of the HbA1c. They did not have any contact with the DON after 2/12/21. Tenant C1's daughter and Power of Attorney (POA) for medical decisions was interviewed on 5/11/21 at 1:12 p.m. and reported she did initially tell the DON she would like to see if insurance would pay for testing supplies. However, once the HbA1c was received, she knew the testing needed to be completed. She never refused to pay for the testing, as she knew it needed to be done. The POA also denied ever being told to take her mother to the emergency department on 2/15/21. When interviewed on 5/13/21 at 2:30 p.m. Tenant C1's other daughter reported she was never asked to take her mother to the emergency department on 2/15/21 due to low oxygen or a dark stool. She also denied she said she would not pay for the blood glucose checking supplies for her mother. When interviewed on 5/26/21 at 1:37 p.m. the Executive Director reported the DON should have followed up on the physician's orders within 24 hours and had been trained on this practice at orientation.	A 160		
A 340	481-69.25(2) Tenant Documents 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant.	A 340		

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A 340	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to retain tenant documents for three years. Findings follow: When intereviewed on 5/13/21 at 1:25 p.m. the DON (Director of Nursing) reported the program had internal documentation called task sheets for staff on which tenant's needs were listed. Staff would note changes in tenant care on these sheets such as tenants not eating or being unable to walk as normal. The DON said she passed this information on to the family or the physical therapist. When the documents were requested for review, task sheets were not available for tenants who had discharged from the program from three months to nine months prior.	A 340		

Jersey Ridge
Plan of Correction
5/12/2021

Re-education will be provided to nurses prior to their next shift regarding notification of a physician regarding a tenant's change of condition. The DON or designee will monitor for condition changes and notify the physician.
New orders will be noted timely upon receiving by the DON or designee.
Physician will be called for clarification of orders when needed. If no response is received by the end of the business day, the DON or designee will call the physician daily until a response is received.
DON and director will monitor for compliance.
Completion date: 5/12/21

Jersey Ridge
Notification of Physician of Change in Condition
5/12/21

Physicians will be notified promptly of the following:

- An accident of unusual incident which results in injury which may require physician intervention.
- A significant change in resident condition which is life threatening.
- A significant change in a tenant's condition which has the potential for clinical complication.
- A change in condition which requires a significant alteration in treatment.
- Death of a tenant.
- Discharge or transfer of a tenant.