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
	S0118	A. BUILDING: _____ B. WING _____	C 04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST LIBERTY AL RESIDENCES	1000 NORTH MILLER STREET WEST LIBERTY, IA 52776

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 14 Number of tenants with cognitive impairment: 3 Total census: 17 No regulatory insufficiency was cited during the investigation of Complaint #111893-C. The following regulatory insufficiency was cited during the investigation of Complaint #109582-C.	A 000	SEE ATTACHED POC	
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the program failed to ensure incident reports were completed regarding unusual occurences for 1 of 4 tenants reviewed (Tenant #1). Findings follow: 1. Record review on 3/29/23 revealed Tenant #1's admission date was 3/02/2020. 2. On 3/30/23 at 8:55 a.m. Staff A said she	A 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Clifford McFerren — TITLE: Administrator — (X6) DATE: 5/15/23

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A 130	Continued From page 1	A 130		

recalled an incident in December when Tenant #1 went outside unexpectedly. It happened on a Saturday, just after supper, around 5:30 p.m. Staff A recalled it was very cold outside. She said she was cleaning the dining room tables and Tenant #1 was walking around in the halls and seemed kind of agitated. Another tenant said Tenant #1 went out the door. Staff A ran out the door, right behind Tenant #1. Staff A asked Tenant #1 to come back inside. It was very cold and neither of them had a coat on. Tenant #1 was clothed and wearing shoes. Staff A stated Tenant #1 crossed the street and was almost hit by a car. The tenant began knocking loudly on neighbors' doors, as Staff A tried to convince her to return to the Assisted Living Program (ALP). She didn't try to physically direct Tenant A because she was very agitated and making paranoid statements about staff trying to kill her. Staff B stood near the front door of the Program and shouted back and forth with Staff A. Staff B ran to get Staff C. Staff C joined Staff A and Tenant #1 at a neighbor's front door and also tried to convince the tenant to return to the Program. Tenant #1 continued to be agitated and made paranoid statements about staff trying to kill her. Staff C called emergency services for assistance. The police and an ambulance arrived, but Tenant #1 refused to be transported to the Emergency Room (ER). The police/Emergency Medical Technicians (EMTs) escorted Tenant #1 back to her apartment. Her daughter arrived later and took Tenant #1 to the ER for an assessment. Tenant #1 had no injuries from the incident. The EMTs checked the tenant's vital signs and they were fine. Staff A said she had not known Tenant #1 to leave the facility in an unsafe manner prior to this incident.

3. On 3/30/23 at 9:05 a.m. Staff B said she remembered an incident in December regarding

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A 130	Continued From page 2	A 130		

Tenant #1 leaving the building. Staff B recalled she and Staff A were cleaning the dining room just after supper when they saw Tenant #1 go out the front door. Staff A and Staff B immediately went out the door also. Staff A followed Tenant #1 and tried to convince her to return to the building. Staff B stood near the front door. Staff A crossed the street with Tenant #1. Staff B ran to get Staff C. Staff C went outside with Staff A and Tenant #1. Tenant #1 continued to refuse to come back into the building. The police and ambulance arrived, but Tenant #1 refused to be transported. The police/EMTs brought Tenant #1 back to her apartment. Later in the evening, Tenant #1's daughter took her to the ER for assessment. Staff B said she didn't know of any previous times when Tenant #1 had left the building unexpectedly.

4. Based on staff interviews and review of the staff schedule and Tenant #1's chart, the incident occurred on the evening of 12/10/22. According to the state climatologist the temperature in West Liberty on 12/10/22 at approximately 5:30 p.m. was 38 degrees Fahrenheit, with a wind chill of 32 degrees.

5. Record review on 3/29/22 revealed nursing Progress Notes for Tenant #1. The Progress Notes contained no entries for 12/10/22. The entry dated 12/11/22 noted Tenant #1's Sertraline was increased, with no explanation given. The entry dated 12/12/22 indicated Tenant #1's daughter had transported her to the ER for evaluation due to increased confusion and the tenant had gone outside to get away from "dangerous people." The Progress Note didn't indicate when this had occurred. A late entry on 12/13/22 noted a Wanderguard had been attached to Tenant #1's walker due to increased

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A 130	Continued From page 3	A 130		

paranoia regarding "dangerous people" that wanted to hurt her. The entry also noted an increase in Sertraline and the addition of PRN (as needed) Trazadone. Another entry dated 12/13/22 noted a Change of Condition (COC) Assessment had been completed. A late entry on 12/16/22 noted Tenant #1 continued to display paranoia around supper time. The Program got a new order for Trazadone daily, in addition to PRN Trazadone. There was no Progress Note that provided information regarding the incident of Tenant #1 leaving the building on 12/10/22. A review of Incident Reports (IR) for Tenant #1 on 3/30/23 revealed no IR regarding the incident on 12/10/22, when the tenant left the building, displayed unsafe behavior and refused to return.

6. Additional record review revealed the RN/Assisted Living Coordinator (ALC) completed a new Comprehensive Assessment on Tenant #1 on 12/13/22, which noted Tenant #1 had increased paranoia and had exited the building to "Get away from dangerous people." A Wanderguard was added for safety. The RN/ACL also developed a new Service Plan dated 12/13/22, with the changes noted.

7. On 3/30/23 at 11:05 a.m., the RN/ALC acknowledged she was aware of the incident on 12/10/22 when Tenant #1 left the building unexpectedly. The RN/ALC said she went to the Program that evening after the incident happened. She said she should have written an Incident Report, but didn't think about it at the time. The RN/ALC said she had mentioned the incident in the Progress Notes, but when she reviewed the notes, she agreed they did not provide much information regarding the incident.

8. On 3/30/23 the the ALP policy entitled

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A 130	Continued From page 4 "Accidents and Incidents - Investigation and Reporting" was reviewed which indicated an accident or incident Report must be competed for all accidents or incidents. 9. On 4/3/23 at 9:10 am, the Administrator and the RN/ALC confirmed the above findings.	A 130		

May 15, 2023

West Liberty AL Residences
1004 N. Miller Street
West Liberty, IA 52776

Iowa Department of Inspection & Appeals
Deb Dixon, Program Coordinator, Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Complaint #111893-C
Tenant Rights: Not Substantiated

Complaint #109582-C

To Whom it May Concern,

Please consider this our plan of correction pertaining to regulatory insufficiency cited during 03/29/23-04/03/23 complaint investigation completed by the department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapter 481-69.

A130
481-67.2(3) Program Policies and Procedures
67.2(3) The program shall follow the policies and procedures established by the program.

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
   a. Administrator or designee will ensure an incident report is completed for Tenant #1 returning to prior apartment.

2. Measures taken to ensure the problem does not recur.
   a. Administrator and CEO / or designee will provide an in-service to staff to ensure understanding of incident report indicators and processes. Counseling and disciplinary actions were implemented to affected staff members.

3. How the Program plans to monitor performance to ensure compliance.
   a. Administrator and CEO / or designee will talk with a random sample of PCA and/or medication manager staff weekly for six weeks and as needed as determined by the Administrator and CEO to ensure incident reports have been completed for all known unusual occurrences.

4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will be corrected by 06/02/23.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Program 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.

Sincerely,

Clifford McFerren
Administrator

Cc:
Chad Thomas - CEO

✓ 5/19/23