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
	S0258	A. BUILDING: _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEELSON HARBOUR SENIOR LIVING MC	2810 AURORA AVENUE SPIRIT LAKE, IA 51360

(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. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 20 Total Population of Program at time of on-site: 21 TOTAL census of Assisted Living Program: 21 The following regulatory insufficiencies were cited during the investigation of Complaints 99431-C, 103563-C, 103566-C and 103675-C.	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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide adequate and appropriate services to 1 of 5 tenants reviewed (Tenant #1) and potentially affected all tenants in the memory care unit. Findings include: Review of Tenant #1's file on 4/5/22 revealed she was admitted to the assisted living on 5/14/21 and moved to the memory care unit on 2/2/22. Tenant #1's diagnosis included vascular	A 160		

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

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A 160	Continued From page 1	A 160		

dementia, Alzheimer's disease and Parkinson's disease. The service plan dated 2/2/22 indicated she required safety checks 8 times a shift and had a Global Deterioration Score (GDS) of 5 (moderately severe dementia).

An incident report dated 3/31/22 at 7:35 a.m. documented Tenant #1's unwitnessed fall. Staff found her laying on her right side with her head against the heat duct and noted discoloration and bleeding from her nose and forehead.

When interviewed on 4/05/22 at 6:32 a.m. Staff F confirmed she worked 6a.m. - 2p.m. on 3/31/22. She stated she found Tenant #1 in her room on the floor with her face pressed against the TV stand and the side of her face rested on the heat register. Staff F reported she found Tenant #1 between 7:20 and 7:25 a.m.. Staff F stated the heat register was cold to the touch and Tenant #1 was not burned. Staff F reported 911 was notified and transported Tenant #1 to the hospital for evaluation and returned the same day. Staff F confirmed rounds are completed right after report when coming on shift but that morning after 7:00 a.m. another tenant required their attention.

Review of the Elopement Policy on 4/06/22 revealed routine visual checks will be completed on residents with confusion at or above GDS Stage 4. Review of the Delegation visual checks form revealed visual checks are meant to be completed as close to the scheduled time as possible.

Accurate documentation concerning when Tenant #1 had last been visually checked could not be located. Staff H worked from 10:00 p.m. - 6:30 a.m. noted her visual check of Tenant #1 occurred at 4:34 a.m.. Tenant #1 was found by

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A 160	Continued From page 2 Staff F between 7:20 a.m. and 7:25 a.m.. Staff failed to provide hourly safety checks as required. The Portfolio Leader confirmed these findings on 4/06/22 at 9:14 a.m..	A 160		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the Program to initiate a discharge when a tenant exceeded the level of care criteria. This pertained to 1 of 1 tenants review with a history of verbal and physical aggressions (Tenant #2). Findings include: Observations in the morning on 4/05/22 revealed Tenant #2 got up and in the face of another tenant seated quietly in her wheelchair in the commons area of the memory care unit. Tenant # 2 approached her and started yelling "NO, NO, NO, that's all you ever say. I ought to slap you in the face." and walked away without doing so. Tenant #2 later entered the room of a male tenant and started yelling at him, "Get out of my house, get out of bed and get the yard mowed," and	A 160		

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A 160	Continued From page 3 walked out. She walked past the couch where tenants were seated, stopped and said "I'm going to spit in your face." and walked away without doing so. There were no staff in the area at this time of either incident. Further observations revealed a tenant seated in her wheelchair cried out in pain as Tenant #2 walked away. Staff G said to Tenant #2 "you don't hit" and reported Tenant #2 hit the other tenant in the back of the head. The staff attempted to redirect her but she walked away still upset. She reported Tenant #2 slapped another tenant on the left side of her face leaving red marks and another tenant stated, "I'm afraid of it." Record review revealed Tenant #2 was admitted to the Program on 3/03/22 with a diagnosis of dementia with behavioral disturbance. Record review of an incident report on 4/04/22 at 5:35 p.m. revealed Tenant #2 pushed another tenant and caused her to fall to the ground on her back. The date and time of this incident could not be confirmed as the information did not copy properly. Progress notes review revealed the following: a. On 3/04/22 noted increased escalated behaviors that included both verbal and physical aggression towards residents, residents visiting company and staff. She would go after staff as they assisted other tenants. b. On 3/16/22 at 11:13 a.m. noted increased behaviors of yelling at staff and residents, chasing and going after staff and visitors, and throwing items. Staff attempted PRN medication but she refused.	A 160		

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A 160	Continued From page 4 c. On 3/20/22 at 1500 documented physical aggression with another resident that resulted in a fall. While in an escalated state, she walked over to a tenant, engaged in verbal aggression, and pushed the tenant over which caused the tenant to fall to the ground on her back. The physician and family were notified and medications were ineffective due to refusals. d. On 3/21/22 at 10:28 a.m. she pushed another Tenant to the ground. Redirection was ineffective with and refused PRN medication. e. On 3/21/22 noted a discussion with family regarding treatment at Hope Harbor to stabilize tenant's moods and escalated states. The family agreed. f. On 3/21/22 at 1457 Tenant #2 walked around with a rock and hit the med cart, doors, walls, and other items. She threatened to beat people with the rock. Staff were unable to redirect, deescalate, or obtain the rock from her. She was transported to the ER via ambulance. She returned with new orders to increase bedtime quetiapine to 25 mg and Cephalexin 5mg twice daily. Follow up with physician for referral to Hope Harbor. g. On 3/23/22 the social worker at Hope Harbor reported due to her mood and behaviors had stabilized since ER visit, they preferred to see at least one more mood/behavioral episode before they admitted her. Review of the Service Plan on 3/24/22 revealed staff were to attempt 3 non-pharmaceutical interventions, included 1:1 interactions, before giving PRN anti-anxiety medication. Staff were to redirect to her room, turn the TV on low volume,	A 160		

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A 160	Continued From page 5 shut the lights off, and let her deescalate alone safely in her environment with familiar surroundings. When interviewed on 4/05/22 at 4:45 a.m. Staff E reported Tenant #2 had pushed other residents down, would throw things, and nothing calmed her down. She said last night Tenant #2 pushed another tenant and she would have fallen if staff hadn't caught her. Staff E confirmed Tenant #2 had a PRN (as needed) medication to use but she would not take it when she was escalated. The staff reported they attempted to keep other tenants away from Tenant #2 when she was like that for her to cool down. Staff E stated Tenant #2 acted like that from the day she was admitted When interviewed on 4/05/22 at 5:03 a.m. Staff H revealed Tenant #2 would be up most of the night trying to go in other tenants' rooms. She confirmed she worked the floor alone with 21 tenants. Staff H reported she provided interventions throughout the night to three tenants including Tenant #2 and she made it difficult to provide adequate supervision to the other tenants in the memory care unit. Staff H stated Tenant #2 was asleep in a recliner in another tenant's room. Staff H added she left her alone for fear she would escalate again. Staff H reported in the past Tenant #2 made other tenants' family members very uncomfortable when visiting loved ones. During report on 4/05/22 at 6:05 a.m. Staff H mentioned Tenant #2 punched her in the face and threw a clothing rack earlier in the evening evening. When interviewed on 4/05/22 at 7:33 a.m. the male tenant confirmed a female tenant entered his room and yelled at him. He stated he did not know why.	A 160		

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A 160	Continued From page 6 The Healthcare Coordinator confirmed on 4/05/22 at 8:02 a.m. staff informed her of Tenant #2's behaviors and she was working on it. She reported the Program attempted to get Tenant #2 to Hope Harbor but was denied because of the UTI. The Clinical Care Specialist stated on 4/05/22 at 3:30 p.m. the Program was working on a plan to address Tenant #2's behaviors and confirmed they now provided 1:1 staff with her.	A 160		
A 520	481-69.29(2) Staffing 69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s). This REQUIREMENT is not met as evidenced by: Based on record review and interview the Program failed to follow procedures to respond to emergency needs for 1 of 5 tenants reviewed (Tenant #1) and potentially affected all tenants in the memory care unit. Findings include: Review of Tenant #1's file on 4/5/22 revealed she was admitted to the assisted living on 5/14/21 and moved to the memory care unit on 2/2/22. Tenant #1's diagnosis included vascular dementia, Alzheimer's disease and Parkinson's disease. The service plan dated 2/2/22 indicated she required safety checks 8 times a shift and	A 520		

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A 520	Continued From page 7 had a Global Deterioration Score (GDS) of 5 (moderately severe dementia). An incident report dated 3/31/22 at 7:35 a.m. documented Tenant #1's unwitnessed fall. Staff found her laying on her right side with her head against the heat duct and noted discoloration and bleeding from her nose and forehead. When interviewed on 4/05/22 at 6:32 a.m. Staff F confirmed she worked 6a.m. - 2p.m. on 3/31/22. She stated she found Tenant #1 in her room on the floor with her face pressed against the TV stand and the side of her face rested on the heat register. Staff F reported she found Tenant #1 between 7:20 and 7:25 a.m.. Staff F stated the heat register was cold to the touch and Tenant #1 was not burned. Staff F reported 911 was notified and transported Tenant #1 to the hospital for evaluation and returned the same day. Staff F confirmed rounds are completed right after report when coming on shift but that morning after 7:00 a.m. another tenant required their attention. Review of the Elopement Policy on 4/06/22 revealed routine visual checks will be completed on residents with confusion at or above GDS Stage 4. Review of the Delegation visual checks form revealed visual checks are meant to be completed as close to the scheduled time as possible. Review of Safety checks form for March 2022 revealed entries for 8 times a shift. On 3/31/22 Staff H documented she completed a visual check of Tenant #1 at 4:34a.m.. The next entry of a visual check for 6:00 a.m. was completed at 9:26 a.m.. The 7:00 a.m. check was noted to be completed at 9:29 a.m. and the 8:00 a.m. check was completed at 9:35 a.m.. Note, Hospital	A 520		

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A 520	Continued From page 8 discharge records noted Tenant #1 was being seen in the emergency room on the morning of 3/31/22 at 0805a.m.. On 4/06/22 at 9:14a.m Portfolio Leader/Staff A said the 8 times per shift was not to be documented in the time slots as noted on the form. Staff A said staff have an hour before and and hour after to do the checks. Accurate documentation concerning when Tenant #1 had last been visually checked could not be located. Staff H worked from 10:00 p.m. - 6:30 a.m. noted her visual check of Tenant #1 occurred at 4:34 a.m.. Tenant #1 was found by Staff F between 7:20 a.m. and 7:25 a.m.. Staff failed to provide hourly safety checks as required. The Portfolio Leader confirmed these findings on 4/06/22 at 9:14 a.m..	A 520		
A 710	481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Program failed to ensure the building was maintained in a clean, safe and sanitary manner. This pertained to 1 of 1 tenants reviewed with an unclean environment (Tenant #3). Findings include: Observations on 4/05/22 at 5:32a.m. revealed a	A 710		

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A 710	Continued From page 9 urine soaked recliner and reusable incontinence bed pad lying on the floor next to Tenant #3's recliner. At 2:36 p.m. the urine soaked recliner and reusable incontinence bed pad lying on the floor next to the recliner remained untouched and in the same condition from the previous observation. On 4/05/22 at 2:36 p.m. the Assistant Manager confirmed this finding.	A 710		

OK
5-2-22

Keelson Harbour

2810 Aurora Ave W. Spirit Lake, IA 51360

Date: 5/1/2022

Complaint Intake #: Complaints 99431-C, 103675-C, 103563-C and 103566-C

Plan of Correction (POC) Submitted For:

- Investigation Date: 4/4/2022-4/6/2022
-

POC:

A. **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. Regulatory Insufficiency: Based on record review and staff interview, the facility failed to provide adequate and appropriate services to 1 of 5 tenants reviewed (Tenant #1) and potentially affected all tenants in the memory care unit.

Program POC:

1. Elements detailing how this was corrected for residents:
   a. Inservice completed with staff on 04/06/2022; Review of visual check expectations and how to appropriately perform and document.

2. Actions program taking to protect tenants in similar situations:
   a. Tenant charts were reviewed to ensure appropriate visual checks are in place.

3. Measures taken to ensure problem does not recur:
   a. Monitoring visual check documentation weekly, monthly, or as needed and providing staff education when these expectations are not met.

4. Program plans to monitor performance to ensure compliance:
   a. Director and/or nurse will monitor visual check documentation weekly, monthly, or as needed.

B. **481-69.23(1)c(1) Criteria for Admission / Retention of Tenants**

69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression81-67.3(2)

a. Regulatory Insufficiency: This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the Program to initiate a discharge when a tenant exceeded the level of care criteria. This pertained to 1 of 1 tenants review with a history of verbal and physical aggressions (Tenant #2).

Program POC:

5. Elements detailing how this was corrected for residents:
    a. Tenant #2 was provided 1:1 care until placement in Geriatric Psych could be found.

6. Actions program taking to protect tenants in similar situations:
    a. Nurse will provide interventions to staff via ISP for all tenant's to address behaviors. When interventions are unsuccessful alternative placement will be sought.
    b. Nurse and Director will meet weekly to review at risk tenants and implement interventions and discharge notice as appropriate.

7. Measures taken to ensure problem does not recur:
    a. Nurse and Director will meet weekly to discuss at risk tenants and implement interventions and discharge notice as appropriate.

8. Program plans to monitor performance to ensure compliance:
    a. Nurse and Director will meet weekly to discuss at risk tenants and implement interventions and discharge notice as appropriate.

C. 481-69.29(2) Staffing 69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s).

a. Regulatory Insufficiency: This REQUIREMENT is not met as evidenced by: Based on record review and interview the Program failed to follow procedures to

respond to emergency needs for 1 of 5 tenants reviewed (Tenant #1) and potentially affected all tenants in the memory care unit.

Program POC:

1. Elements detailing how this was corrected for residents:
   b. Inservice completed with staff on 04/06/2022; Review of visual check expectations and how to appropriately perform and document.

2. Actions program taking to protect tenants in similar situations:
   c. Tenant charts were reviewed to ensure appropriate visual checks are in place.

3. Measures taken to ensure problem does not recur:
   d. Monitoring visual check documentation weekly, monthly, or as needed and providing staff education when these expectations are not met.

4. Program plans to monitor performance to ensure compliance:
   e. Director and/or nurse will monitor visual check documentation weekly, monthly, or as needed.

D. 481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary

a. Regulatory Insufficiency: This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Program failed to ensure the building was maintained in a clean, safe and sanitary manner. This pertained to 1 of 1 tenants reviewed with an unclean environment.

Program POC:

5. Elements detailing how this was corrected for residents:
   f. Training completed with staff on 4/29/2022 at RA meeting in regards to cleanliness expectations for tenant rooms.

6. Actions program taking to protect tenants in similar situations:
   g. Leadership staff will do walking rounds daily, weekly, monthly and as needed of environment to ensure compliance.

7. Measures taken to ensure problem does not recur:

respond to emergency needs for 1 of 5 tenants reviewed (Tenant #1) and potentially affected all tenants in the memory care unit.

Program POC:

1. Elements detailing how this was corrected for residents:
   b. Inservice completed with staff on 04/06/2022; Review of visual check expectations and how to appropriately perform and document.

2. Actions program taking to protect tenants in similar situations:
   c. Tenant charts were reviewed to ensure appropriate visual checks are in place.

3. Measures taken to ensure problem does not recur:
   d. Monitoring visual check documentation weekly, monthly, or as needed and providing staff education when these expectations are not met.

4. Program plans to monitor performance to ensure compliance:
   e. Director and/or nurse will monitor visual check documentation weekly, monthly, or as needed.

D. 481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary

a. Regulatory Insufficiency: This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Program failed to ensure the building was maintained in a clean, safe and sanitary manner. This pertained to 1 of 1 tenants reviewed with an unclean environment.

Program POC:

5. Elements detailing how this was corrected for residents:
   f. Training completed with staff on 4/29/2022 at RA meeting in regards to cleanliness expectations for tenant rooms.

6. Actions program taking to protect tenants in similar situations:
   g. Leadership staff will do walking rounds daily, weekly, monthly and as needed of environment to ensure compliance.

7. Measures taken to ensure problem does not recur:

h. Nurse or Director will address concerns from walking rounds with staff daily, weekly, monthly and as needed.

8. Program plans to monitor performance to ensure compliance:
   i. Director and/or nurse will review walking rounds with staff daily, weekly, monthly and as needed to ensure compliance.

Amber Raveling, Director 5/2/2022

Amber Raveling

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.