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
	S0269	A. BUILDING: _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS ASSISTED LIVING	**1000 WEST WASHINGTON JEFFERSON, IA 50129**

(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 disorder: 21 Number of tenants with cognitive disorder: 5 Total Population of Program at time of on-site: 26 The following regulatory insufficiencies were cited during the investigation of Complaint #104931-C, Complaint #97636-C and the recertification visit.	A 000		
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 interview and record review the Program failed to ensure incident reports were completed for unusual occurrences regarding 1 of 4 current (Tenant #2) and 1 of 1 former(Tenant C-1) tenants reviewed. Findings include: 1. On 6/13/22 review of Tenant C-1's record revealed an admission date of 9/19/18. On 4/20/21 Tenant C-1 was admitted to hospice and passed away on 5/21/21. Her service plan dated 4/21/21 revealed Tenant C-1 requested the	A 130	The Plan of Correction is attached.	

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

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A 130	Continued From page 1 program staff to administer all of her medications. Review of Tenant C-1's medication orders revealed an order for Lorazepam/Ativan Schedule IV dated 5/19/21. She was to be administered .25 ML (.5 MG) PO/SL every 2 hours as needed for anxiety, restlessness or agitation. The pharmacy delivered 30 ML of the medication in a bottle on the afternoon of 5/19/21 between the hours of 3:00 p.m. and 5:00 p.m. On the morning of 5/20/21 the former Registered Nurse (RN) noted the 30 ML of the medication and added it to the narcotics inventory sheet. Review of the narcotics inventory sheet revealed on 5/20/22 a staff person documented they had administered .50 ML of Lorazepam to Tenant C-1 and noted the remaining amount of the medication on the narcotics inventory sheet as 29.50 ML. (This was not consistent with C-1's Lorazepam order dated 5/19/21 which was for .25 ML.) The staff person who administered the Ativan on 5/20/21 had not signed off on the Medication Administration Record (MAR) and the staff person's initials on the narcotics inventory sheet were not legible. On 5/21/21 at 6:00 a.m. a staff person noted there was 29 ML remaining in the bottle. On 5/21/21 the former RN noted on the narcotics inventory sheet she had destroyed 29.50 ML of this medication after the tenant passed away. There was no record available for review that could explain these discrepancies in the amount of medication remaining in the bottle. On 6/14/22 at 9:29 a.m. the former RN was interviewed in an attempt to identify who was responsible for the errors on Tenant C-1's narcotics inventory sheet and C-1's MAR for May 2021. She could not recall the incident but added there should have been an incident report completed.	A 130		

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A 130	Continued From page 2 On 6/14/22 at 10:05 a.m. the corporate nurse confirmed she could not find an incident report for the medication errors identified on Tenant C-1's narcotics inventory sheet. 2. On 6/14/22 a review of incident reports revealed on 4/30/22 at 9:25 p.m. Tenant #2 had set off the exit alarms walking out of the Northeast exit door. Tenant #2 had walked a few feet out the door and remained on facility grounds. On 6/15/22 at 9:45 a.m. interview with Staff C revealed Tenant #2 was an exit seeker and often tried to find his car. He always tripped the alarm when he walked out. On 6/15/22 at 11:15 a.m. interview with Staff D revealed Tenant #2 often attempted to leave and had also set off the exit alarms when he was up earlier that morning around 4:00 a.m. On 6/15/22 at 12:15 p.m. the Director confirmed she had received a call from staff earlier in the day at 4:13 a.m. concerning Tenant #2 tripping the exit alarms looking for his car. The Director confirmed an incident report for this incident had not been completed.	A 130		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure the policy and procedure	A 150		

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A 150	Continued From page 3	A 150		

for accidents and emergency response related to head injuries had been followed regarding 1 of 4 tenants reviewed (Tenant #1). Findings include:

On 6/14/22 a review of incident reports revealed a report dated 6/1/22 at 7:25 a.m. indicating former Staff H transferred Tenant #1 from chair to walker with no problem. The tenant stated she didn't remember how to walk so the staff coached her through a few steps. While walking the tenant stumbled back and her arm knocked over the lamp causing her thumbnail to break. Former Staff H sat the tenant in her chair and left to help others get up for the day. When she returned Tenant #1 was on the floor laying down. The tenant requested a pillow. Former Staff H asked the tenant repeatedly to assist her in helping her up but the tenant just kept screaming at her. Staff C arrived and helped assist the tenant up. They changed her and helped her to the bathroom via a wheelchair. No injuries other than the broken thumbnail were noted on the form.

On 6/15/22 at 9:45 a.m. interview with Staff C revealed she was present the morning Tenant #1 was found on the floor and confirmed Tenant #1 had developed a goose egg and bruising on her forehead. Staff C reported Tenant #1 had fallen twice that morning but the second fall had not been noted on the incident report. Staff C reported Tenant#1's first fall was at 7:25 a.m. There was a second fall between 7:30 a.m. and 8:00 a.m. She reported not being able to call the nurse for direction because she did not have the nurse's number. Instead of calling the Program Director for directives, Staff B and Staff H waited to ask the Activity Director when she arrived for work for the nurse's phone number. Staff C said she had not seen Tenant #1's head injury as significant. If she had thought it was significant

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A 150	Continued From page 4	A 150		

she would have called emergency services immediately. Once she got the number she called the nurse who directed her to keep doing vitals. If there was a significant change in her vitals, staff was to call 911.

Record of the completed vitals as directed by the nurse could not be located for review.

On 6/15/22 at 11:50 a.m. interview with the Program Director revealed she had received a text on the morning of 6/01/22 at 10:43 a.m. from the Activity Coordinator asking for the nurse's phone number.

On 6/15/22 at 12:24 p.m. interview with the nurse revealed she had received a call concerning Tenant #1's fall after staff had asked the Program Director for her phone number.

On 6/15/22 at 2:57 p.m. Interview with the Activity Coordinator revealed she reported to work at or around 9:00 a.m. on 6/01/22. She said the direct care staff had not approached her for the nurse's number until 10:43 a.m. which is when she texted the Program Director for the number.

On 6/15/22 a review of the policy regarding falls with head injuries revealed if a tenant reports a fall and states they hit their head, or if staff witnesses a tenant hit their head, the identified nurse was to be notified immediately. Although the tenant had no complaints of nausea or her head hurting and her vitals were reported as normal, the nurse was not immediately called per program policy.

On 6/16/22 at 2:30 p.m. the Program Director confirmed these findings. The nurse's phone number was posted the next day following this

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A 150	Continued From page 5 incident.	A 150		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure medications were administered as prescribed for 1 of 1 former tenants reviewed (Tenant C-1). Findings include: On 6/13/22 review of Tenant C-1's service plan dated 4/21/21 revealed she requested the program administer all of her medications. Review of Tenant C-1's medication orders revealed an order for Lorazepam/Ativan Schedule IV dated 5/19/21. She was to receive .25 ML (.5 MG) PO/SL every 2 hours as needed for anxiety, restlessness or agitation. Review of the narcotics inventory sheet revealed on 5/20/22 a staff person documented they had administered .50 ML of Lorazepam to Tenant C-1 instead of the prescribed .25 ML. On 6/16/22 at 2:30 p.m. the Program Director confirmed this finding	A 285		

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A 290	481-67.5(2)g Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure the narcotics medication management policy had been followed regarding 1 of 1 former tenants reviewed (Tenant C-1). Findings include: On 6/14/22 review of the narcotics medication management policy revealed narcotic counts would be conducted at least daily. Any discrepancies were to be reported immediately to the Registered Nurse. On 6/14/22 review of Tenant C-1's narcotics inventory sheet revealed on 5/20/21 former Staff F noted he administered Tenant C-1's morphine at 9:50 p.m. The count of syringes after that administration was listed as 3. On 5/20/21 at 10:00 p.m. former Staff F and Staff G completed a shift change count and initialed the narcotics inventory sheet with a remaining count of 2 instead of the amount of 3 that had been noted 10 minutes earlier by Staff F. Staff F documented he had administered morphine a total of three times on 5/20/21 on the narcotic inventory sheet (4:00 p.m., 6:45 p.m. and 9:50 p.m.). He had noted the administration of the morphine only one time on the tenant's medication administration and only two times on the PRN (as needed) medication Reason and Response form.	A 290		

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A 290	Continued From page 7 No documentation could be located that the nurse at the time had been notified of these discrepancies or if the number of syringes had been reconciled satisfactorily. On 6/14/22 at 12:15 p.m. the Director and the nurse confirmed these findings.	A 290		

The Gardens
ASSISTED LIVING AT JEFFERSON

On behalf of The Gardens of Jefferson, Iowa, I am submitting the Corrective Action Plan (CAP) required from recertification and investigation of complaints visits between 6/13/22 and 6/16/22. Recertification and investigation of Complaint #97636-C and Complaint #104931-C.

Program Policies and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
    - Tenant C1 has been discharged from the program.
2. Measures to ensure the problem does not recur
    - Staff will be retrained and educated to document all unusual accidents, incidents involving tenants, visitors, employees, or other persons within the assisted living facility or on the premises.
3. How the Program plans to monitor performance to ensure compliance
    - The Executive Director, Director of Nursing, and/or Nurse Designee will provide ongoing education to staff at least annually on the accident, incident, and medication error reporting policy.
    - At the time the Executive Director, Director of Nursing, and/or Nurse Designee become aware of any accident, incident, or unusual occurrence, they will ensure staff complete an incident report per the policy.
4. The date by which the regulatory insufficiency will be corrected
    - This regulatory will be corrected on or before July 27, 2022

Program Policies and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency, including the system level.
    - Tenant #1 has discharged from the program.
    - Staff will notify the nurse immediately with any incident that involves a tenant with possible head injury.
2. Measures to ensure the problem does not recur.
    - Staff will be retrained on requirements to notify the nurse on call for fall or other incident that may have included striking of the head on a hard object or surface with possibility of head trauma. The identified nurse in charge will be notified immediately.
3. How the Program plans to monitor performance to ensure compliance
    - The Executive Director, Director of Nursing, and/or Nurse Designee will provide ongoing education to staff at least annually on the accident, incident, and

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medication error reporting policy. This would include education regarding falls with potential head injury.

4. The date by which the regulatory insufficiency will be corrected
    - This regulatory insufficiency will be corrected on or before July 27, 2022

Medications

1. Elements detailing how the Program will correct each regulatory insufficiency, including the system level.
    - Tenant C-1 has been discharged from the Program.
2. Measures to ensure the problem does not recur.
    - Staff will be re-educated that medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner, or physician assistance. Staff administering medications will be educated on medication administration record (MAR) documentation and administer medications or treatments.
3. How the Program plans to monitor performance to ensure compliance
    - The Executive Director, Director of Nursing, and/or Nurse Designee will provide ongoing education to staff at least annually on medication administration.
4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected on or before July 27, 2022.

Medications

1. Elements detailing how the Program will correct each regulatory insufficiency, including the system level.
    - Tenant C-1 has been discharged from the Program.
2. Measures to ensure the problem does not recur.
    - Narcotic counts will be conducted a minimum of daily by licensed staff or by staff who have received proper delegation. Any discrepancies will be reported immediately to the RN. A controlled substance record will be used to count narcotics administered by the assisted living.
    - Staff will be re-educated on the procedure for controlled substance counts and to notify nurse of any discrepancies immediately.
3. How the Program plans to monitor performance to ensure compliance
    - The Executive Director, Director of Nursing, and/or Nurse Designee will provide ongoing education to staff at least annually on medication administration.
    - The RN will conduct ongoing audits of controlled substance records and observe for any discrepancies.
4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected on or before July 27, 2022.