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
	S0288	A. BUILDING: _____ B. WING _____	C 10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF MUSCATINE	**3515 DIANA QUEEN DRIVE MUSCATINE, IA 52761**

(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: 44 Number of tenants with cognitive disorder: 5 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 10 TOTAL Census of Assisted Living Program for People with Dementia : 59 The following regulatory insufficiency was cited during the investigation into Incident #106819-I.	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 interview and record review, the program failed to provide proper care to 1 of 1 discharged tenants reviewed (Tenant C1). Findings follow: Record review on 10/11/22 revealed an incident	A 160		

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A 160	Continued From page 1	A 160		

report for Tenant C1 dated 8/6/22. According to the incident report, Tenant C1 fell in the common bathroom while the LPN (Licensed Practical Nurse) assisted with toileting. Tenant C1 slipped with her feet coming out in front of her. The LPN grabbed Tenant C1's head and neck to keep her head from hitting the grab bar. Tenant C1 fell to the floor onto the left side of her buttocks. Tenant C1 cried out in pain with any movement.

Additional information in Tenant C1's progress notes from the LPN indicated Tenant C1's walker went out from in front of her.

A progress note dated 8/8/22 revealed Tenant C1 had a change in condition due to a left hip fracture. She required one to two staff assistance for all of her activities of daily living. She required two staff to assist her with rolling to change incontinence products and for repositioning. Bed baths would be given as she was unable to ambulate.

Multiple entries dated 8/8/22 - 8/11/22 noted Tenant C1 screamed and fought with staff when they changed her bedding due to incontinence because of her pain.

Tenant C1 died on 8/16/22.

A review of Tenant C1's service plan dated 5/10/22 noted she wished to remain as active as possible with stand by assist help from staff. Tenant C1 wished staff to stand by assist her while ambulating with her walker. Tenant C1 preferred to have staff assist her to the bathroom and change her incontinence undergarments as needed. Tenant C1 was incontinent of bladder.

The program had a policy regarding Transferring

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A 160	Continued From page 2	A 160		

a Resident, which directed staff were to stand facing a resident using proper body mechanics. Staff should pivot turn or assist the resident in turning, slowly help the resident lower into the chair, and position the resident comfortably and in good body alignment.

When interviewed on 10/12/22 at 7:10 PM, the LPN recalled she walked with Tenant C1 to the bathroom. The LPN had her body between the bathroom door and Tenant C1 was at the toilet. The LPN said she either stepped or looked away for a short amount of time to get another tenant out of the bathroom. Tenant C 1 turned her body and lined herself up to the toilet and that was when the LPN saw Tenant C1 falling. The LPN grabbed Tenant C1 by her neck, to keep her head from hitting the wall. The LPN did not recall if Tenant C1's pants were down. The LPN confirmed Tenant C1 was a stand by assist. The LPN said she knew right away Tenant C1 fractured her hip. Tenant C1 went to the hospital for an evaluation and on her return, it was awful. Staff had to keep turning Tenant C1 to keep her dry and she suffered from incontinence, but you couldn't just turn her on one side. Tenant C1 would scream out in pain and grab out arms.

On 10/12/22 at 1:15 PM, Staff A reported she was called back to help fix the TV on the date of the incident. She witnessed another tenant displaying a behavior by the refrigerator. The LPN peeked her head out of the bathroom. When the LPN went back in, Tenant C1 was on the floor. When Staff A entered the bathroom, the LPN was trying to position Tenant C1 in a manner in which the tenant would be comfortable. The walker was on the floor. Tenant C1's pants were down and she had urinated on the floor. Staff A always used a gait belt with the tenants in the

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A 160	Continued From page 3 locked memory care unit to prevent falls. On 10/12/22 at 1:50 PM, Staff B stated a stand by assist with Tenant C1 meant you walked beside her. Staff B was not present for the incident. She would not have taken her hands off of Tenant C1 if she was standing up. She would have gotten Tenant C1 seated on the toilet. If she had a partner on the memory care unit, she never would have left the bathroom for the other tenant. On 10/17/22 at 11:50 AM, the Community Director confirmed the LPN should have remained by Tenant C1's side during the toileting process.	A 160		