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
	775543	A. BUILDING: _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS ALZHEIMER'S SPECIAL CARE CE	8525 URBANDALE AVENUE URBANDALE, IA 50322

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R 000	Initial Comments No deficiencies were cited during the investigation of Complaints #114075-C or #113978-C. The following deficiencies were cited during the investigation of Complaints #113615-C and #113952-C.	R 000		
R 222	481-57.6(1)d Special Classification - Memory Care 57.6(1) Memory care. d. Assessment prior to transfer or admission. Prior to the transfer or admission of a resident applicant to the memory care unit or facility, a complete assessment of the resident applicant's physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by facility staff and shall become part of the resident's permanent record upon admission. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the assessment completed prior to admission included the behavioral status for 1 of 3 residents reviewed (Resident #1). Findings include: On 7/12/23 record review revealed Resident #1 was admitted on 5/01/23. The behavioral status	R 222	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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R 222	Continued From page 1 section on the assessment form was left blank. The form was dated 5/01/23 which was the day he was admitted. Further review revealed Resident #1's history included incidents of inappropriate behavior at his prior placement as recent as 4/29/23. On that day Resident #1 had physically and verbally threatened a nurse. On 7/12/23 at 10:24 a.m. the Director of Nursing confirmed these findings.	R 222		
R 636	481-57.17(3)b Records 57.17(3) Incident record. b. Report of incidents shall be in detail on an incident report form. (III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure incident reports were completed in detail for unusual circumstances affecting 2 of 6 residents reviewed (Resident #1, #6). Findings include: 1. On 7/11/23 at 10:06 a.m. incident report review revealed on 6/12/23 at 7:35 am Resident #1 was in the common area ambulating around. Resident #1 went up to a resident and hit her in the head. The name of the resident was not on the form.	R 636		

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R 636	Continued From page 2 On 7/11/23 at 12:34 p.m. interview with LPN B revealed on the morning of 6/12/23 Resident #1 struck Resident #4 on the head and had also reached out with both of his hands and grabbed hold of LPN B's throat. Both she and Resident #1 fell backwards to the floor while he still had his hands around her throat. She reported this incident should have been noted in the incident reports and there had been written statements. LPN B reported Staff F was there and witnessed the entire incident. On 7/12/23 at 11:35 a.m. Staff F confirmed she had witnessed the incident that occurred on 6/12/23 involving Resident #1 striking Resident #4 in the head and grabbing LPN B by the throat. On 7/12/2023 at 2:58 p.m. the Director of Nursing confirmed the incident that occurred on 6/12/23 regarding Resident #1 grabbing LPN B's throat was not noted in the incident reports provided for review. 2. On 7/12/23 at 1:30 p.m. interview with LPN A revealed Staff D had found Resident #6 inside a closet used to keep resident care supplies on 6/20/23. LPN A was not sure of the time. She confirmed the closet was normally locked. She stated she had not completed an incident report but had documented it on a 24 nursing report sheet. LPN A said she didn't think she needed to complete an incident report because the resident was known to lay down on the floor. She believed Resident #6 had not fallen but laid down.	R 636		
R 830	481-57.22(3)a Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the	R 830		

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R 830	Continued From page 3 administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) a. The service plan shall include measurable goals and objectives and the specific service(s) to be provided to achieve the goals. Each goal shall include the date of initiation and anticipated duration of service(s). Any restriction of rights shall be included in the service plan. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure service plans included measurable goals and objectives to decrease aggression for 1 of 1 residents reviewed who displayed this type of behavior (Residents #1). Findings include: On 7/12/23 record review revealed Resident #1 was admitted to the facility on 5/01/23 with diagnoses including traumatic subdural hemorrhage, visual field deficits, anxiety, restlessness, agitation and dementia. Further review revealed Resident #1's history included incidents of inappropriate behavior at his prior placement as recent as 4/29/23. On that day Resident #1 had physically and verbally	R 830		

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R 830	Continued From page 4 threatened a nurse. On 7/11/23 incident report review revealed the following: - On 6/05/23 at 2:45 p.m. Resident #1 was hit with a closed fist by Resident #5. Resident #1 had pulled his penis out and started urinating. Resident #5 told Resident #1 that was wrong and hit Resident #1. The prevention section of the report identified to attempt to toilet Resident #1 more often. - On 6/08/23 at 1:00 p.m. Resident #1 hit LPN C in her chest while she was trying to give a medication, then bumped into Resident #3 and created a fall. Immediate prevention included calling for assistance, calling the police and the Nurse Practitioner. He was taken to the hospital - On 6/12/23 at 7:35 a.m. Resident #1 was in the common area ambulating around. He hit a resident in her head. The residents were separated and Resident #1 was placed on 1:1 supervision. - On 6/17/23 at 5:50 p.m. Resident #1 tried to take another's walker. The resident moved the walker and Resident #1 fell. The immediate prevention section of the form was blank. - On 6/22/23 at 6:20 p.m. Resident #1 put his hands on a female resident's arm causing her to scream at him to leave her alone. He became aggressive and was getting ready to twist her arm. Staff were able to intervene before Resident #1 twisted the female's arm. Staff separated the residents. - On 7/08/23 at approximately 2:30 p.m. in the back activity room Resident #1 bit into a snack and spit it at the staff hitting them in the forehead. As he walked out of the activity room Resident #7 walked in. Resident #1 grabbed her head with two hands and squeezed it. Both staff asked him to please let go. At that time a med aide took him	R 830		

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R 830	Continued From page 5	R 830		

back to his room. Resident #7 went to the nurses station to be looked at. She suffered what appeared to be a blood blister/or wine colored bruise on scalp .5cm in size. No open areas. When Resident #7 was being escorted from the area of incident, she had tears running down her face. The immediate prevention section was mostly covered by a sticky note but it appeared Resident #1 may have been taken to his room where he used the bathroom. He was also given an as needed medication to calm down.
- On 7/09/23 at 6:02 p.m. Resident #1 stepped on Resident #8's right foot. Resident #1 was redirected. No injury occurred to Resident #8.

On 7/11/23 at 1:16 p.m. interview with LPN C confirmed Resident #1 had punched her in the chest three times with a closed fist. It almost knocked the air out of her. Her chest hurt for a couple of days after. She stated Resident #1 triggered easily.

On 7/11/23 at 1:33 p.m. interview with Staff G revealed she assisted with Resident #1 on 6/8/23 immediately after he had punched LPN C in the chest and Resident #3 had fallen to the floor. Staff G reported she escorted Resident #1 to his bathroom. While trying to get him to sit down on the toilet, Resident #1 shoved her approximately 3-4 feet away into the wall. Staff G reported she hit the wall hard enough to cause her left arm to go numb. She thought she shattered her left elbow. Staff G reported the police and EMTs were called. He was transported to the hospital but later returned to the facility.

Nurses' notes review revealed Resident #1 was transported to Broadlawns Hospital on 6/8/23 following the assault on Staff G. Broadlawns refused to accept him so he was taken to

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R 830	Continued From page 6	R 830		

Methodist Hospital. A CAT scan showed no changes from previous studies. Lab tests were pending. He returned to the program within hours with no medication changes and no negative findings. The resident's doctor was informed of the day's events and ordered 2mg Ativan gel as needed for severe agitation and to check his Keppra level.

On 7/11/23 at 12:34 p.m. interview with LPN B revealed on the morning of 6/12/23 Resident #1 had reached out with both of his hands and grabbed hold of her throat and would not release her. This resulted in both falling to the floor with the resident landing on top of her. This information was not noted on the 6/12/23 incident report that involved a resident being struck in the head by Resident #1.

On 7/13/2023 at 2:20 p.m. the Administrator and the Director of Nursing confirmed these findings and said they felt a lot of Resident #1's exhibited behavior were the results of his disease process as well as staff approach which might trigger unwanted behaviors. The resident's Nurse Practitioner was also aware of Resident #1's behaviors and was working on medication adjustments as necessary.

Review of Resident #1's service plans dated 5/1/23 (initial) and 6/1/23 (30 day) revealed a service note indicating the resident was not aware of his safety boundaries. He would pace to the point of exhaustion. He would exit seek. He did not do well in an environment that was busy, loud or had a lot of people. He would become overwhelmed at times. The resident would try to hit staff at times when he frustrated. He did not like people telling him no, telling him he needed to complete a task, etc. Staff were to ask him for

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R 830	Continued From page 7 his help instead of telling him what to do. Staff were also to redirect him instead of telling him to not to do something. Instead, there were to direct his attention to something else that was safe for him. No measurable goal or objective to decrease aggression towards others was included in the plan.	R 830		

Glen Oaks Alzheimer's Special Care Center
Plan of Correction
August 30, 2023

On behalf of Glen oaks Alzheimer's Special Care Center, I respectfully submit our Plan of Correction for your approval. The response or provider's plan of correction contained herein shall not be considered or construed as an admission of the validity of the citation or alleged deficiency to which it is addressed.

R 222: Special Classification – Memory Care; Pre-admission assessment

Plan: The Community will ensure that a pre-admission assessment is completed for each resident applicant prior to admission and/or transfer to Glen Oaks.

The Pre-Admission Health Screen form will be completed, reviewed, and signed by the Health Services Director (HSD) or Designee. This form will become part of the resident applicant's permanent file at Glen Oaks.

HSD educated Executive Director (ED) and leadership team, as well as nurses on how to complete the pre-admission assessment tool so that the basic information is gathered and reviewed in the absence of the HSD.

ED and HSD or Designee will monitor to ensure ongoing compliance using the Community's Quality Assurance process.

Compliance Date: 8/18/23

R 636: Incident Records

Plan: The Community will ensure all incidents meeting the criteria for unusual circumstances have an incident report completed.

HSD educated all nurses and leadership team members regarding the requirements for completing Incident Reports, as well as expectations for completing, follow-up and filing of Incident Reports.

Health Services Director or Designee will monitor to ensure ongoing compliance using the Community's Quality Assurance process.

Compliance Date: 9/15/23

R 830: Orientation and Service Plan

Plan: The Community will ensure all Service Plans shall have measurable goals including date of initiation and anticipated duration of services, as well as restriction of any resident rights.

Executive Director (ED) educated HSD and leadership team members regarding what qualifies as "measurable goals" when writing a Service Plan. ED also educated the same group to include initiation date & anticipated duration of services on every Service Plan.

Executive Director or Designee will monitor to ensure ongoing compliance using the Community's Quality Assurance process.

Compliance Date: 9/15/23

ok