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
	S0232	A. BUILDING: _____ B. WING _____	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY ASSISTED LIVING	815 HIGH STREET NORWALK, IA 50211

(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: 46 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 46 No regulatory insufficiencies were cited during the investigation of Incident #107729-I. The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program and the investigation of Complaint #107728-C.	A 000		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to list the identified needs on the service plans of 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1) Record review on 1/31/23 revealed Tenant #1 had a service plan dated 1/1/23. According to his service plan, staff were to provide light housekeeping weekly. Tenant #1 had an outside	A 395	A395 The service plan for Tenant #1 was revised on 2/13/23 with interventions for resident's refusal to allow housekeeping, the need for a psychiatric nurse practitioner visits, and interventions related to the use of a urinal or other items as a urinal, and need for routine retrieval of facility food service items. Tenant #2 passed away on 2/2/2023. Tenant #3 had the service plan reviewed and updated on 2/10/2023 to include interventions to assist this tenant with their incontinence issues, removal of soiled briefs and clothing, and bathing refusals. Additional interventions added are referral to PT/OT and Deer Oaks psychiatrist. 2/2/2023-2/3/2023 : AL Director, SNF Administrator, corporate nurse meetings to review the service plan templates, format and availability to the Assisted Living department through the Point Click Care system that currently had not been available.	

ok 3/31/23

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A 395	Continued From page 1 provider for psychiatric medication, but no reason was given for the appointments. A Nurse Review dated 1/1/23 noted Tenant #1 saw a psychiatrist for his medication management. A medication change helped Tenant #1 appear more awake during the day and have fewer sexual behaviors. Tenant #1 was seeing his primary care provider due to his refusal of cares, treatments and assistance. On 1/30/23 at 3:00 PM, Staff A reported Tenant #1 refused cares at times. He would not let staff change his bedding or clean his room. He had an odor in his apartment. He cut the lid off milk cartons which were frequently found standing in his apartment full of urine. He refused the use of a urinal. Items from the dining room were found in Tenant #1's apartment. On 1/30/23 at 3:30 PM, Staff B stated Tenant #1 once showed her his penis during a shower. Staff B did not assist Tenant #1 with showers after this. Tenant #1 also took large numbers of dining room items to his room. Tenant #1 did not want Staff B to clean his room. These needs were not addressed on Tenant #1's service plan. 2) Tenant #2 had a service plan dated 1/16/23. Her service plan identified she was independent with grooming, hygiene, dressing and undressing, but may request help as needed. Tenant #2 had an overactive bladder and incontinence. It was noted in her service plan she was independent with toileting and self managing any incontinence. The Assisted Living Director wrote in a Nurse Review on 1/16/23 Tenant #2 had two fallsthe	A 395	System change 2/3/2023 allowed access to Point Click Care online Library to service plans allowing personalized interventions and goals. System change of communication of service plans to staff was implemented allowing each caregiver access to interventions in each service plan with staff inservice dates 2/2/2023 and 2/9/2023. The system changes and staff education will ensure accuracy of each tenant's service plan. Monitoring by staff input and meetings with manager will ensure ongoing accuracy. Compliance date 3/30/2023	

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A 395	Continued From page 2 previous week and was weaker. She had terminal cancer and less than six months to live. Staff on the overnight shift were checking on Tenant #2 and assisting her to the bathroom as well. Tenant #2's service plan did not address her need for increased supervision on the overnight shift or assistance to the toilet. 3) Tenant #3 had a service plan dated 10/17/23. Tenant #3 required stand-by assistance with bathing. She was noted to be independent with dressing and undressing. Tenant #3 was incontinent of bladder but capable of managing her cares on her own. A Nurse Review dated 10/17/22 noted staff offers Tenant #3 whirlpool baths and showers which she often declined. On 1/30/23 at 3:00 PM, Staff A reported Tenant #3 was scheduled to take a shower during the second shift. Tenant #3 would say she would shower by herself and refused to let anyone assist her. This resulted in the tenant having an odor due to her incontinence. Staff also tried to assist Tenant #3 with changing clothes but she said she could do it herself. They often saw Tenant #3 in the same clothing which were soiled. Tenant #3 hid her wet incontinence undergarments in her room, causing the apartment to have an odor. On 1/30/23 at 3:30 PM, Staff B said Tenant #3 would not take a shower with her, but believed she did change clothing every day. Tenant #3 did have an odor. The issues of refusing staff assistance with bathing, changing clothing, keeping soiled	A 395		

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A 395	Continued From page 3 incontinence briefs in her apartment were not addressed on Tenant #3's service plan. The Assisted Living Director confirmed these findings on 2/1/23 at 7:30 AM.	A 395		
A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to supervise 1 of 1 discharged tenants reviewed according to her service plan (Tenant C1). Findings follow: Record review on 1/31/23 revealed Tenant C1 scored a 5 on the Global Deterioration Scale on 7/5/22, indicating moderately severe dementia. A Nurse Review with the same dated identified	A 530	A 530 Tenant C1 was discharged from the facility. 2/2/2023-2/3/2023 : AL Director, SNF Administrator meeting to discuss achievable goals and interventions for supervision of assisted living tenants. System change 2/3/2023 tenant service plans reviewed to ensure personalization as it relates to the supervision of the tenants. RN will ensure goals are not too restrictive for assisted living environment. System change of communication of service plans to staff was implemented allowing each caregiver access to interventions in each service plan with staff inservice dates 2/2/2023, 2/9/2023. The system changes will ensure staff are providing supervision as outlined on the service plan. Supervision will be monitored by RN on each tour of duty. Compliance date 3/30/2023	

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A 530	Continued From page 4 Tenant C1 was alert, but not oriented to place or time. Tenant C1 was content with living at the assisted living program but required a higher level of care related to her diagnosis of dementia. At the time of the Nurse Review, the program believed the tenant's family had found placement for Tenant C1 in a memory care unit. The program learned on 8/18/22 Tenant C1 was not accepted to the memory care unit. Prior to 9/9/22 the tenant was able to leave the program and go to nearby businesses (within 500 feet) without any staff supervision needed. A document completed by the Registered Nurse on 9/14/22 revealed the following - On 9/9/22 at approximately 10:00 AM, Tenant C1 went for a walk outside in the front area of the building. Tenant C1 was 413 feet from the program at a nearby restaurant and unable to recall how to return to the building. The weather on 9/9/22 was sunny with a high of 86 degrees. On her return to the building, Tenant C1 was noted to have no injuries. On 9/9/22, Tenant C1's service plan was updated to note she could no longer go outside without staff. - On 9/14/22 at 10:00 AM, the Assisted Living Director saw Tenant C1 watching television in the lobby. The program was notified at 10:15 AM, Tenant C1 was located in the nearby Taco John's parking lot which was 358 feet away. She did not know how to return home. The weather on 9/14/22 was sunny with a high of 88 degrees. Tenant C1 had no injuries. She told staff she went for a walk. Staff C provided a written statement dated 9/14/22. She recalled Tenant C1 was sitting on the couch in the lobby area at 10:00 AM on 9/14/22. Staff C went to take a break and Tenant C1 was still on the couch. When she returned	A 530		

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A 530	Continued From page 5 from her break at 10:30 AM, the police were in the building and had returned with Tenant C1. On 1/31/23 at 3:30 PM, the Assisted Living Director recalled seeing Tenant C1 sitting on the couch in the lobby the morning of 9/14/22. She reported looking up and noting Tenant C1 was gone from the couch at the same time she was notified Tenant C1 was in the restaurant parking lot. According to progress notes Tenant C1 was on 1:1 supervision with assistance from family until being discharged on 9/20/22. On 2/1/23 at 7:30 AM, the Assisted Living Director confirmed the program did not ensure Tenant C1 only left the building with staff on 9/14/22.	A 530		