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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
	S0306	A. BUILDING: _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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: 16 Number of tenants with cognitive disorder: 2 Total census of Assisted Living Program: 18 An onsite infection control survey was completed and no regulatory insufficiencies were identified. A comment was made to the Program regarding guidance recommended for personal protective equipment. The following regulatory insufficiencies were cited during the investigation of Complaint #91751-A and Incident #92151-M..	A 000	✓ 6/16/21 See Attached Plan of Correction 5-12-21 Agelle Ayr	
A 195	481-69.23(1)l 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: l. Requires maximal assistance with activities of daily living This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program retained a tenant that exceeded level of care, including requiring maximal assistance of activities of daily living (ADLs). This pertained to 1 of 2 tenants reviewed (Tenant #1). Findings	A 195		

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

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A 195	Continued From page 1 follow: 1. Review of Tenant #1's file revealed she was admitted to the Program on 7-5-16 and transferred to the attached care center on 7-2-20. Tenant #1's diagnoses included atrial fibrillation with rapid ventricular response, cerebrovascular accident, congestive heart failure, hypertension, chronic obstructive pulmonary disease, osteoporosis, vitamin D deficiency, peripheral neuropathy, history of pelvic ring fracture and left radial fracture and anemia. 2. When interviewed on 1-14-21 at 1:00 p.m. and 3:38 p.m. Staff A said at the end of March 2020 several staff had brought concerns to the Nurse regarding Tenant #1 needing a higher level of care. In April it was mandatory to use a gait belt with Tenant #1's transfers. At the end of April Tenant #1 could not pivot to lay down and was not able to reposition herself in bed. In May Tenant #1 required the assistance of two staff and a gait belt and the resident panicked when moved. Tenant #1 did not help with ADLs. Tenant #1 laid on her back and developed a pressure sore. The Nurse started taking total care of Tenant #1, one to one. The Nurse put Tenant #1 to bed after lunch. On second shift staff changed her, put her pajamas on and put her in bed for the night around 6:30 p.m. or 7:00 p.m. Staff checked on her every two hours. Tenant #1 was not out of bed until the Nurse got her up Monday through Friday. In June, Tenant #1 had increased level of care and some staff started to feed her. Tenant #1 chewed and pocketed her pills. She could not pick up a glass any longer. When interviewed on 1-21-21 at 2:31 p.m. Staff B said Tenant #1 was not able to get into the shower so bed baths were provided. Tenant #1	A 195		

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A 195	Continued From page 2 could not really help with bathing. Staff did everythg for her with dressing. Staff B always needed another staff to help pull the tenant's pants up while she stood her up. To get her ready for bed one staff had to hold her and one staff pulled up her pants and protective undergarment. In June Staff B started changing the tenant in bed as she was not able to get her off the toilet. The tenant needed two staff and a gait belt to transfer. It took both staff to get her to stand up and pivot. The tenant was transferred to a wheelchair for meals but generally ate in her apartment. Tenant #1 had lost weight and her strength had decreased. She often just picked at her supper. The tenant had a hard time taking her medications. Staff B went to the Nurse to discuss increased services and level of care issues. She was concerned about her nutrition as she wasn't eating meals, she was being changed in bed and she needed more help. She was also concerned about other tenants' care, as it took two staff over an hour to Tenant #1 ready for bed. Before being transferred to the care center, the tenant was so thin her pacemaker and spinal cord were visible. She had no fat and no muscle and Staff B was afraid to move her. When interviewed on 1-14-21 at 10:06 a.m. and 1-21-21 at 11:18 a.m. Staff C said Tenant #1 had a slow decline in the last couple of months before being transferred. When she was first admitted she pretty much did everything on her own. She began needing more assistance with showering and then dressing. It was a struggle to get her up to the bathroom in the last couple of months. Staff spent a significant amount of time in the morning doing her cares. Near the end the only thing the tenant could do was help wash her face. The tenant declined regarding transfers in the last several weeks before being transferred. She was	A 195		

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A 195	Continued From page 3 incontinent of urine and the last couple of months had a cream applied on her buttocks as she was not as mobile. Towards the end she pretty much stayed in her room and rarely went to the dining room. Staff had to cut her food and she would eat approximately half of it if she liked the meal. When interviewed on 1-19-21 at 11:50 a.m. the AL Manager said Tenant #1 was ill in March with bronchitis and went downhill during the May timeframe. Staff brought concerns regarding Tenant #1 needing more help with her cares. By the June timeframe Tenant #1 noticeably needed more cares. The Nurse was in her room helping a lot more. She often came early to help get the tenant up. At least three to four out of five days the Nurse completed Tenant #1's morning cares. The Manager stated Tenant #1 was a one person transfer with a gait belt. She used a walker and occasionally the wheelchair. Staff helped Tenant #1 with dressing, medications, toileting, hygiene, transfers and walking. When interviewed on 2-2-21 at 9:54 a.m. and 10:39 a.m. the care center Nurse said she completed the admission assessment to the care center for Tenant #1. She said Tenant #1 was in a wheelchair and did not talk much. She did not answer the orientation questions. Tenant #1 did not ambulate. She was very frail and was a two person transfer with a gait belt. At the time of the assessment Tenant #1 weighed 75 pounds. Staff propelled her in the wheelchair. Tenant #1 did not really eat or drink anything. She did not like the mighty shakes. Staff helped her eat but didn't eat much. She said Tenant #1 needed to be in the care center due to her mobility and not eating or drinking and she needed more staff intervention. Staff helped with dressing, toileting, bathing and eating. The tenant helped with cares a little but	A 195		

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A 195	Continued From page 4 not very much. 3. Review of the Staff Communication Reports indicated the following: - The report dated 11-28-19 reflected a change incontinence for Tenant #1. The report indicated Tenant #1 was not getting up on her own to go to the bathroom, was helped off the couch and was "soaking wet." She was given a shower and placed into bed. - The report dated 11-29-19 reflected a change in urinary frequency. The report indicated staff checked on Tenant #1 during the day and asked her if she needed help to use the restroom. She said she had been to bathroom. At 1:30 p.m. she paged and staff found her "completely wet." She had not gone to the bathroom that day like she had said. She had wet through her protective undergarment, pants and on the couch. Staff got her to her bathroom, changed her and gave her a sponge bath. At 1:30 p.m. the staff assumed she was done with her lunch and realized she was not able to stand up by herself. Two staff helped her get up and go to the restroom.. - The report dated 12-1-19 reflected a change in urinary frequency. At 11:20 a.m. staff checked on her to see if she was coming for lunch and a strong urine odor was noted. Tenant #1 was lying in bed, said she was "soaked" and could not get out of bed. She was assisted out of bed, her clothes were changed and she was washed up with disposable wipes. - The report dated 1-5-20 reflected several changes including frequency in incontinence, decreased appetite, increased disorientation and agitation, refusal of dressing and increased bathing services. The report indicated Tenant #1 was intermittently confused, easily agitated, refused shower and bathroom assistance. She also had a low grade fever.	A 195		

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A 195	Continued From page 5 - The report dated 5-17-20 reflected changes regarding increased fatigue (leaning towards the right), more disorientation, not responding to questions and refusal of medications/treatments. At 5:00 p.m. staff went in to help her get ready for supper. She kept pushing the staff away, did not respond and had no facial expressions. The AL Manager came in and they were able to help her sit up as she could not do so on her own. They asked if she hurt but did not receive a response. They offered her a sandwich and received no response. At 5:30 p.m. staff attempted to give her the 6:00 p.m. medications. The medications dropped out of her mouth. A nurse was called and her temperature was 98.5 and her blood glucose was 121. She was still not responding and was put back bed at 6:50 p.m. - The report dated 6-19-20 reflected Tenant #1 was choking on her bottom denture. At 1:45 p.m. two staff went to check on her and she was not talking, had a blank stare and had food down her shirt. Staff tried to give her a drink of soda and she let it "drool out of her mouth." Staff asked her to open up her mouth and staff observed her dentures were in sideways. Staff pulled them out and she was much better and began talking. 4. Review of the Program's Tenant Health Requirement policy (in the Occupancy Agreement) indicated the tenant's must "qualify as a person capable of assisted living" including the following: a tenant could not require a routine two person assistance with transfer, standing or evacuation, could not require maximum assistance with ADLs and the tenant would be continent or responsible for self-care with assistance. 5. When interviewed on 3-22-21 at 2:28 p.m. the AL Manager stated Tenant #1 exceeded level of	A 195		

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A 195	Continued From page 6 care at the beginning of June and was transferred to the care center in early July.	A 195		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were updated as needs changed for 1 of 2 tenants reviewed (Tenant #1). Findings follow: 1. Review of Tenant #1's file revealed she was admitted to the Program on 7-5-16 and transferred to the attached care center on 7-2-20. 2. When interviewed on 1-14-21 at 1:00 p.m. and 3:38 p.m. Staff A said at the end of March 2020 several staff had brought concerns to the Nurse regarding Tenant #1 needing a higher level of care. In April it was mandatory to use a gait belt with Tenant #1's transfers. At the end of April Tenant #1 could not pivot to lay down and was not able to reposition herself in bed. In May Tenant #1 required the assistance of two staff and a gait belt and the resident panicked when moved. Tenant #1 did not help with ADLs. In June, Tenant #1 had increased level of care and some staff started to feed her. Tenant #1 chewed and pocketed her pills. She could not pick up a glass any longer.	A 350		

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A 350	Continued From page 7 When interviewed on 1-21-21 at 2:31 p.m. Staff B said Tenant #1 was not able to get into the shower so bed baths were provided. Tenant #1 could not really help with bathing. Staff did everything for her with dressing. Staff B always needed another staff to help pull the tenant's pants up while she stood her up. To get her ready for bed one staff had to hold her and one staff pulled up her pants and protective undergarment. In June Staff B started changing the tenant in bed as she was not able to get her off the toilet. The tenant needed two staff and a gait belt to transfer. It took both staff to get her to stand up and pivot. The tenant was transferred to a wheelchair for meals but generally ate in her apartment. Tenant #1 had lost weight and her strength had decreased. She often just picked at her supper. The tenant had a hard time taking her medications. When interviewed on 1-14-21 at 10:06 a.m. and 1-21-21 at 11:18 a.m. Staff C said Tenant #1 had a slow decline in the last couple of months before being transferred. When she was first admitted she pretty much did everything on her own. She began needing more assistance with showering and then dressing. It was a struggle to get her up to the bathroom in the last couple of months. Staff spent a significant amount of time in the morning doing her cares. Near the end the only thing the tenant could do was help wash her face. The tenant declined regarding transfers in the last several weeks before being transferred. She was incontinent of urine and the last couple of months had a cream applied on her buttocks as she was not as mobile. Towards the end she pretty much stayed in her room and rarely went to the dining room. Staff had to cut her food and she would eat approximately half of it if she liked the meal.	A 350		

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A 350	Continued From page 8 When interviewed on 1-19-21 at 11:50 a.m. the AL Manager said Tenant #1 was ill in March with bronchitis and went downhill during the May timeframe. Staff brought concerns regarding Tenant #1 needing more help with her cares. By the June timeframe Tenant #1 noticeably needed more cares. The Nurse was in her room helping a lot more. She often came early to help get the tenant up. At least three to four out of five days the Nurse completed Tenant #1's morning cares. The Manager stated Tenant #1 was a one person transfer with a gait belt. She used a walker and occasionally the wheelchair. Staff helped Tenant #1 with dressing, medications, toileting, hygiene, transfers and walking. 3. Review of the Staff Communication Reports indicated the following: - The report dated 11-28-19 reflected a change incontinence for Tenant #1. The report indicated Tenant #1 was not getting up on her own to go to the bathroom, was helped off the couch and was "soaking wet." She was given a shower and placed into bed. - The report dated 11-29-19 reflected a change in urinary frequency. The report indicated staff checked on Tenant #1 during the day and asked her if she needed help to use the restroom. She said she had been to bathroom. At 1:30 p.m. she paged and staff found her "completely wet." She had not gone to the bathroom that day like she had said. She had wet through her protective undergarment, pants and on the couch. Staff got her to her bathroom, changed her and gave her a sponge bath. At 1:30 p.m. the staff assumed she was done with her lunch and realized she was not able to stand up by herself. Two staff helped her get up and go to the restroom. After Tenant #1 was changed she ate the lunch at her table.	A 350		

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A 350	Continued From page 9 - The report dated 12-1-19 reflected a change in urinary frequency. At 11:20 a.m. staff checked on her to see if she was coming for lunch and a strong urine odor was noted. Tenant #1 was lying in bed, said she was "soaked" and could not get out of bed. She was assisted out of bed, her clothes were changed and she was washed up with disposable wipes. - The report dated 1-5-20 reflected several changes including frequency in incontinence, decreased appetite, increased disorientation and agitation, refusal of dressing and increased bathing services. The report indicated Tenant #1 was intermittently confused, easily agitated, refused shower and bathroom assistance. - The report dated 5-17-20 reflected changes regarding increased fatigue (leaning towards the right), more disorientation, not responding to questions and refusal of medications/treatments. At 5:00 p.m. staff went in to help her get ready for supper. She kept pushing the staff away, did not respond and had no facial expressions. The AL Manager came in and they were able to help her sit up as she could not do so on her own. They asked if she hurt but did not receive a response. They offered her a sandwich and received no response. At 5:30 p.m. staff attempted to give her the 6:00 p.m. medications. The medications dropped out of her mouth. A nurse was called and her temperature was 98.5 and her blood glucose was 121. She was still not responding and was put back bed at 6:50 p.m. 4. On 2-22-21 review of Tenant #1's service plan signed on 4-8-20 (updated on 4-17-20 and 5-1-20) reflected staff assisted with bathing twice per week and if she refused, staff gave a bed bath/sponge bath on the toilet. Tenant #1 needed set up with grooming/hygiene and assistance as needed. Tenant #1 needed assistance with	A 350		

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A 350	Continued From page 10 dressing/undressing. Staff was to set up for upper body dressing/undressing and allow extra time and allow her to complete as much as she could do herself. Staff assisted her with what she was unable to do. The service plan reflected Tenant #1 transferred and ambulated with one person assist with a front wheeled walker (FWW). The service plan reflected Tenant #1 ate independently and requested to eat in her room at times. She needed assist of one person and FWW (with gait belt) to ambulate to the dining room. She sometimes used a wheelchair for transport if she was tired. Staff assisted Tenant #1 with bedtime cares and ensured she was in bed for the night. She needed assist of one person and FWW (with gait belt) for routine toileting. Tenant #1 wore incontinence pull ups and needed assistance when soiled to change them. Staff performed routine toileting and incontinent cares as needed at night. Tenant #1's service plan was not updated as needed and did not reflect changes in specific service needs including two person transfers and increased dependence for ADLs including eating, toileting, dressing, grooming, bathing and mobility. 5. On 3-22-21 at 2:28 p.m. the AL Manager confirmed the 4-8-20 service plan was the most recent service plan for Tenant #1.	A 350		

Solon Assisted Living Village Plan of Correction for site visit on 5/12/2020

6/16/21

A195 481-69-.23(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:

i. Requires maximal assistance with activities of daily living.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #1 no longer resides at this facility and the Nurse Coordinator at the time is no longer employed here. All tenants residing at the facility currently have been reviewed and are appropriate for the assisted living facility. The new Nurse Coordinator and Program Manager have been educated on admission/retention guidelines through the Assisted Living Manager Certification Course and the Nurse Regulation Course.

The following Measures will be taken to ensure the problem dose not recur:

- Nurse Coordinator and Program Manager have weekly checks in and go over any concerns brought up to Nurse Coordinator about cares for tenants from staff or families. Also, since this situation occurred, and former nurse coordinator is no longer employed staff have felt more comfortable bring concerns to program manager as well as the new nurse coordinator.

- New Nurse Coordinator and Program Manager have been educated on admission/retention guidelines through the Assisted Living Manager Certification Course and the Nurse Regulation Course. Nurse Coordinator and Program Manager will reeducate staff on admission and retention guidelines as well by 5/30/2021.

The Program will monitor performance to ensure compliance as follows:

- The Program Manager and Nurse Coordinator will encourage staff to come forward with any changes in condition for all tenants and have them write out those changes on a communication sheet for the Nurse Coordinator to follow up on, the Nurse Coordinator will also share these with the Program Manager to help in determining if tenants still meet the retention standards.

A089: 481-69.26 (4) Service Plans

481-69.26(1) Service Plans.

69.26(1) The service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

6/16/21

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #1 is no longer resides at this facility, and Nurse Coordinator that was here at the time is no longer employed here. After a review of all tenants currently residing here services plan have been created based on evaluations by the nurse are up to date and reflecting the needs and preferences of our tenants.

The following measures will be taken to ensure the problem dose not recur:

- The Program Manager and Assisted Living Nurse Coordinator will monitor Incident/accident reports, communication book, progress notes and observe residents for significant changes that trigger the initiation of evaluation and service plan updates in order to meet the residents changing needs/preference for care.

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator will monitor services plans over the next six months with documentation of random audits of service plans to ensure that all tenants needs and preference for assistance are identified correctly along with service plans updated at least annually and whenever changes are needed.

Date deficiencies corrected by: 5/30/2020