STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD375 HFD	A. BUILDING _____ B. WING _____	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT BRIDGEWATER ALP/D	3 RUSSELL SLADE BLVD CORALVILLE, IA 52241

(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. Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 25 TOTAL Census of Assisted Living Program for People with Dementia: 25 A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. An onsite infection control survey, Incident #92688-I and Complaints 93380-C and 94081-C were also completed. The following regulatory insufficiencies were cited.	A 000	See Attached POC 12/5/21	
A 270	481-67.5(2)f(1) 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: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be	A 270		

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A 270	Continued From Page 1 administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This Requirement is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure medications were administered by staff who successfully completed a department-approved medication aide/manager course. This potentially affected 25 of 25 tenants who resided at the Program and pertained to 6 of 6 staff reviewed. Finding follows: Record review on 8/10/21 revealed documentation of staff's medication training revealed Staff A - F had not completed a department-approved medication aide/manager course. Further review revealed the Program's Policy entitled Medication Needs of Residents. According to the policy, if the Program administered or stored medications or provided medication setup - all medications would be administered by a RN (Registered Nurse), LPN (Licensed Practical Nurse), ARNP (Advanced Registered Nurse Practitioner) licensed in Iowa or by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination. When interviewed the Director confirmed staff had not completed the requirements to administer medications.	A 270		

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A 285	Continued From Page 2	A 285		
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 observations, interview and record review the Program failed to consistently ensure tenants received medications as prescribed. This affected 1 of 4 tenants (Tenant #1) reviewed. Finding follows: Record Record review on 8/10/21 revealed an medication incident report (MIR), dated 5/27/21, for Tenant #1 documented around 8:00 a.m. staff took Tenant #1's blood sugar levels, which were high. Staff had to give insulin. When preparing staff prepared more than ordered, and the tenant was given 12 additional units. The tenant should have received 18 units and four units, for a total of 22 units due to her increased blood sugars. Staff gave her 26 units and an additional four units, for a total of 30 units. Additional review of the MIR revealed no adverse outcome occurred to the tenant. The MIR further documented an investigation into the incident, which indicated the nurse spoke to the staff and the staff indicated she "guessed" how much insulin to give because she could not find how much to give, so she gave the last dose of insulin she could remember listed. The nurse reviewed	A 285		

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A 285	Continued From Page 3 the medication administration record (MAR) with staff and showed her where to find the correct amount to give. Staff was also educated on potential side effects of misdosing insulin. Staff was informed to call the nurse on call when she was unsure or had questions about medication administration. The Program's medication policy, updated 5/18/20, indicated when medications were administered traditionally by the Program, medications and treatments shall be administered as prescribed. During the exit interview the Director and Registered nurse acknowledged staff failed to administer Tenant #1's medications as ordered.	A 285		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure staff received training as required in identification and reporting of dependent adult abuse. This affected 1 of 3 staff reviewed (Staff B). Finding follows: Record review on 8/10/21 revealed the Program could not provide documentation of Staff B's dependent adult abuse training. When interviewed on 8/11/21 the Executive Director confirmed she had provided all documentation of Staff B's training.	A 380		

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A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to consistently perform criminal history and child/dependent adult abuse record checks prior to employment. This affected 1 of 3 staff reviewed (Staff A). Finding follows: Record review on 8/10/21 revealed the Program hired Staff A on 1/3/20. Further review revealed the SING (Single Contact License and Background Check) for Staff A, dated 2/4/20. When interviewed on 8/11/21 the Executive Director reported the Program could not locate a SING completed prior to Staff A's employment date. /	A 400		
A 555	481-69.30(3)a Dementia Specific Education for Personnel 69.30(3)a Except as otherwise provided in this subrule, all personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually.	A 555		

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A 555	Continued From Page 5 This Requirement is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received a minimum of eight hours of dementia-specific continuing education annually. This affected 1 of 3 staff reviewed (Staff A). Finding follows: Record review on 8/10/21 revealed Staff A did not complete eight hours of dementia- specific training. Records showed Staff A completed one hour of training on 1/21/20. When interviewed on 8/11/21 the Executive Director confirmed Staff A had not completed the required eight hours of training. She added the Program had a new tracking system to hopefully prevent this in the future.	A 555		

ok

Plan of Correction
Grand Living at Bridgewater
ALP/D

A270 -Medications

Regulatory Insufficiency
The program failed to consistently ensure medications were administered by staff who successfully completed a department-approved medication aide/manager course.

Plan of Correction: The insufficiency will be corrected as follows
An audit was completed to identify if any staff who are passing medications did have proof of completion of the Medication Manager course. Caregivers will not be allowed to administer medications until successful completion of the department-approved medication aide/manager course.

The following measures will be taken to ensure the problem does not recur
Caregiver on-boarding has been updated to include registration for an approved medication manager course or provide proof of completion. If the new hire is not currently certified, they will not administer any medications until they have completed an approved medication manger course with a delegating nurse.

The program will monitor performance to ensure compliance as follows
Program nurse or designee will monitor each onboarding schedule to ensure staff are not passing medications until completion of the department-approved medication aide/manager course. Caregiver files will be audited quarterly by the Director of Health and Wellness or designee to ensure that any caregiver passing medications have the proper paperwork proof in their personnel files.

Date insufficiencies corrected by December 5, 2021.

A285 -Medications

Regulatory Insufficiency
The program failed to consistently ensure tenants received medications as prescribed.

Plan of Correction: The insufficiency will be corrected as follows
The Program has a new Director of Nursing which requires all caregivers to be re-delegated under her license. All caregivers will be delegated with revised, competency-based delegations. The delegations have been implemented which include visualizing competency of tasks, by the delegating Registered Nurse, for preparing insulin pens per the electronic medication record, and how to give insulin injections appropriately.

The following measures will be taken to ensure the problem does not recur
After initial competency has been established, all caregivers will demonstrate competency at least annually by the delegating nurse.

The program will monitor performance to ensure compliance as follows
Program Director of Nursing or designee will audit care staff delegations to ensure compliance with insulin administration competencies periodically.

Date insufficiencies corrected by December 5, 2021

A380 -Staffing

Regulatory Insufficiency
The program failed to consistently ensure staff received training as required in identification and reporting of dependent adult abuse.

Plan of Correction: The insufficiency will be corrected as follows
All staff will receive training as required in identification and reporting of dependent adult abuse.

The following measures will be taken to ensure the problem does not recur
An audit was completed to identify staff who had not completed the mandatory reporting education and discrepancies addressed immediately. The onboarding process has been updated to include completion of dependent adult abuse training within one week of new hire day.

The program will monitor performance to ensure compliance as follows
The Program Director or designee will monitor to ensure compliance. Employee files will be audited quarterly to ensure staff have completed dependent adult abuse training as required.

Date insufficiencies corrected by December 5, 2021

A400 -Record Checks

Regulatory Insufficiency
The program failed to consistently perform criminal history and child/dependent adult abuse record checks prior to employment.

Plan of Correction: The insufficiency will be corrected as follows
The Program Director or designee will monitor to ensure compliance. All new employees will have a completed criminal history and child/dependent adult abuse record checks prior to employment.

The following measures will be taken to ensure the problem does not recur
An audit was completed to identify staff who have not had a completed criminal history and child/dependent adult abuse record checks prior to employment and discrepancies addressed immediately. The onboarding process has been updated to include completion of a criminal history and child/dependent adult abuse record check prior to new hire day.

The program will monitor performance to ensure compliance as follows
New hire personnel files will be reviewed quarterly for completed criminal history and child/dependent adult abuse record checks prior to employment by the Program Director or designee.

Date insufficiencies corrected by December 5, 2021

A555 -Dementia Specific Education for Personnel

Regulatory Insufficiency
Program failed to ensure staff received a minimum of eight hours of dementia-specific continuing education annually.

Plan of Correction
All staff that work on the dementia units will receive a minimum of eight hours of dementia-specific continuing education annually.

The following measures will be taken to ensure the problem does not recur
The Program Director of designee will work in conjunction with Department Heads to ensure that all staff that works on the Dementia Units will receive a minimum of eight hours of Dementia continuing education annually. The Human Resources department will track continuing education dates and will inform necessary department heads who and when staff should be educated.

The program will monitor performance to ensure compliance as follows
Program director or designee will monitor and audit dementia-specific continuing education completion to ensure staff received a minimum of eight hours of dementia-specific education quarterly.

Date insufficiencies corrected by December 5, 2021