

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALPD413 HFD</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2022</b>
NAME OF PROVIDER OR SUPPLIER <b>COURTYARD ESTATES AT WALCOTT - BETTY'S GARDEN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 NORTH MAIN STREET WALCOTT, IA 52773</b>		
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A 000	Initial Comments  Assisted living Programs for People with Dementia 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: 0 Number of tenants with cognitive disorder: 5  TOTAL census of Assisted Living Program: 5  The following regulatory insufficiencies were cited during the investigation into Complaint #102871-C and #106604-C.	A 000		
A 130	481-67.2(1)e Program Policies and Procedures  67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:  e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents.  This Requirement is not met as evidenced by: Based on interview and record review, the program failed to document incidents for 1 of 1 discharged tenants reviewed. Finding follows:  Record review on 10/4/22 revealed Tenant C1 moved into the program on 12/21/22. According to a Global Deterioration Scale assessment conducted on 12/12/21, Tenant C1 scored 6 on the scale, indicating severe cognitive decline.  On 10/5/22 at 11:45 AM, Former Staff C reported she worked alone in the building covering the	A 130		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 130	Continued From Page 1  assisted living program and the memory care unit one night Tenant C1 eloped (a tenant who left the memory care unit without knowledge of staff would have eloped). Tenant C1 was confused and seemed lost. Staff C took the tenant to the assisted living portion of the building with her as he refused to return to his apartment. Tenant C1 continued to attempt to leave through the assisted living exit doors. Another tenant tried to redirect Tenant C1. Staff C did report this to the former nurse.  On 10/4/22 at 8:50 AM, Staff A recalled another situation in which Tenant C1 was found in the hallway of the assisted living program at 5:30 AM. Staff A was unsure of the circumstances. Staff A stated Tenant C1 was upset and it took quite some time to convince him to return to the memory care unit.  On 10/4/22 at 9:10 AM, Staff B remembered there were times Tenant C1, who lived on the memory care unit, was found in the common area of the assisted living program during the overnight shift. She was unsure of the dates of these events.  Documentation of these events could not be located in Tenant C1's record.  The Administrator confirmed these findings on 10/4/22 at 3:15 PM.	A 130			
A 150	481-69.23(1)a 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:  a. Is bed-bound	A 150			

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A 150	Continued From Page 2  This Requirement is not met as evidenced by: Based on observation, interview and record review, the program retained 1 of 2 tenants reviewed who exceed level of care (Tenant #2). Findings follow:  During observations of Tenant #2 on 10/4/22 at 11:45 AM, 10/5/22 at 8:25 AM and 10/5/22 at 11:25 AM, she was found to be in her room, in bed.  Record review on 10/4/22 revealed Tenant #2's service plan, dated 8/15/22, documented Tenant #2 did not transfer out of her bed as she did not bare weight on her lower extremities. Tenant #2 was repositioned by two staff throughout the day in her bed. She received meals in her bed as well as bed baths.  A Hospice Plan of Care Update Report for the period 6/27/22 - 9/24/22 noted Tenant #2 was bed bound.  On 10/4/22 at 3:00 PM, a nurse at Tenant #2's hospice provider expressed concern Tenant #2 was unable to leave her bed. She felt Tenant #2 would be better served in a facility with a lift which would allow Tenant #2 to leave her bedroom and interact with others.  On 10/4/22 at 3:15 PM, the Administrator confirmed Tenant #2 was bed bound.	A 150			
A 160	481-67.3(2) Tenant Rights  481-67.3 Tenant rights. All tenants have the following rights:	A 160			

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A 160	Continued From Page 3  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 consistently provide adequate services. The Program failed to respond to orders from outside providers within a timely manner. This affected 1 of 2 tenants reviewed (Tenant #2). Findings follow:  Record review on 10/4/22 revealed the program received a verbal order on 7/5/22 from Tenant #2's hospice provider for a portable right shoulder x-ray, frontal and Y views, for assessment of shoulder injury, possible dislocation.  Additional record review revealed a Nurse's Note dated 9/13/22 revealed a second order was received on that date for a shoulder x-ray with a diagnosis of right shoulder pain. The x-ray was completed on 9/14/22 with a determination there was no acute fracture.  On 10/5/22 at 10:20 AM the Director reported Tenant #2's daughter reported to them at the meeting on 9/9/22, her mother's shoulder was injured when she was brought into the building upon returning to the program from a stay at a skilled nursing facility on 6/10/22. It took four staff to bring her into the building and the daughter said Tenant #2's shoulder was injured, hanging at a strange angle.  On 10/5/22 at 10:35 AM, the Memory Care Coordinatord stated she could not recall Tenant #2 reporting pain during the process of transferring her into the building on 6/10/22. However, Tenant #2 did later point to her shoulder and indicate it hurt. An order was obtained for Tenant #2 to have	A 160			

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A 160	Continued From Page 4  an x-ray and the issue was dropped by the former nurse. The x-ray was performed in September.  The LPN confirmed these findings on 10/5/22 at 10:25 AM.	A 160			
A 530	481-69.29(4) 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 interviews the program failed to ensure a staff person on-site in the dementia-specific assisted living program 24 hours a day potentially affecting 5 of 5 tenants. Findings follow:  When interviewed on 10/4/22 at 8:50 AM with the Memory Care Coordinator revealed in the past there were a handful of times when there was only one staff member working in the building which provided a dementia-specific assisted living program and a non-dementia-specific assisted living program. When staff responded to a page from a tenant on the assisted living portion of the building, it left tenants on the memory care unit	A 530			

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A 530	Continued From Page 5  unattended.  When interviewed on 10/4/22 at 9:10 AM, Staff B stated there were quite a few times there was only one person working in the building covering both the assisted living program and the memory care unit. Staff B reported this happened when employees did not come in to work.  When interviewed on 10/5/22 at 11:45, former Staff C recalled one time when she worked alone in the building covering both the assisted living program and the memory care unit.  The Administrator, who was not employed when these events occurred, confirmed these findings on 10/4/22 at 3:15 PM.	A 530			

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