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
	S0428	A. BUILDING: _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OSKALOOSA	2107 SOUTH MARKET STREET OSKALOOSA, IA 52577

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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: 62 Number of tenants with cognitive disorder: 3 TOTAL census of Assisted Living Program: 65 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program. The following regulatory insufficiencies were cited during the investigation into Incident #112197-I.	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 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 properly supervise 1 of 1 discharged tenants (Tenant C1). Finding follows: Record review on 7/13/23 of Tenant C1's service plan, dated 2/22/23, revealed he was noted to have episodes of forgetfulness. He had short-term and long-term recall issues. He scored 4 out of 10 on the Short Portable Mental Status Questionnaire (SPMSQ) indicating	A 160		

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moderate cognitive impairment.

A review of progress notes found on 3/29/23, the Resident Care Coordinator (RCC) noted Tenant C1 did not tolerate a treatment he received for an infection very well (Gentamicin flushes of his suprapubic catheter) and his confusion increased. He was placed on hourly supervision checks until his infection was over and his blood sugar values were within normal parameters.

On 4/9/23 at 2:10 a.m., the RCC was contacted when Tenant C1 was found outside banging on another tenant's window. Staff went outside and found Tenant C1 without pants, socks or shoes. Tenant C1 was using his walker and informed staff he worked at the program and was locked out. A physical assessment was completed and Tenant C1 had no injuries, but was very confused.

A review of hourly checks from 4/8/23 and 4/9/23 revealed one staff made four entries at 17:22 (5:22 p.m.) over four hours noting her hourly checks of Tenant C1. Another staff then noted checking on Tenant C1 over the next four hours four times at 21:57 (9:57 p.m.). Staff G made two entries at :40 (12:40 a.m.) and a third entry at 2:20 a.m.. Tenant C1 eloped at 2:10 a.m.

Notes from the program investigation identified the Executive Director called Staff G on 4/9/23. Staff G stated she was in Tenant C1's room when she did her last hourly check but could not recall when it was. She stated she did not know Tenant C1 was outside until the pendant went off saying someone was beating on the window. The Executive Director reviewed camera footage of the elopement on 4/10/23. The Executive Director was unable to determine what door

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Tenant C1 exited through or when he left the building. Staff G was seen cleaning the north hallway and then going to the cafe. She saw Tenant C1 outside without pants trying to get inside at 2:01 a.m., but the exterior door was locked. Tenant C1 wandered outside on the sidewalk, went to an outside tenant window and knocked. The Exuecitive Director then saw Staff H outside walking to Tenant C1 at 2:13 a.m. The video was not available for review at the time of the investigation.

When interviewed on 7/17/23 at 11:10 a.m., Staff G reported she checked on Tenant C1 at 2:00 a.m. and then gave the worker in the memory care unit a break. She could not explain why her documentation noted she last saw Tenant C1 at 12:40 a.m. She described Tenant C1 as a little restless but did not seem to be awake. Staff G recieved a call from Staff H who informed her about the situation outside of another tenant's apartment.

One of the other residents, Tenant C1's next door neighbor, said she heard a noise. By then Staff H already found Tenant C1. He was in his normal sleepwear. She was not sure if he had his walker. Tenant C1 wore a shirt. It was normal for him not to wear bottoms at night time. He did not like to wear them with his catheter. He seemed fine (no injuries) just confused.

The next day Tenant C1 moved to Memory Care. The Program increased his supervision to 30 minute checks after the elopement. The nurse came in and sat with him after it occurred until a family member came.

When interviewed on 7/13/23 at 1:40 p.m. Staff H stated on 4/9/23, one of the residents paged and

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A 160	Continued From page 3 said there was a drunk outside banging on her window. Staff H looked outside and saw Tenant C1. Staff H paged for the backup and called the nurse. Tenant C1 met her halfway to the door. He was on hourly checks at that point. He had nothing on below the waist but a gripper sock. His catheter bag was below his foot. The catheter did not come out. It was chilly. He had on a flannel, quilted t-shirt. They asked if he fell and he denied this. He had no apparent injuries. She could not say how long he was outside. She's not sure if he was checked within an hour. Staff G was covering the assisted living part of the building where Tenant C1 lived and when the elopement occurred, she was on break. She had not known Tenant C1 to exit-seek. According to Wunderground.com, the temperature in Oskaloosa, Iowa on 4/9/23 at 2:00 a.m was approximately 50 degrees with 0 precipitation. The Director, RN and RCC confirmed Tenant C1 did not receive hourly supervision on 7/19/23 at 1:30 p.m.	A 160		
A 420	481-67.19(3)d Record Checks 67.19(3)d If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the	A 420		

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A 420	Continued From page 4 founded child or dependent adult abuse warrants prohibition of employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to have the Department of Human Services (DHS) perform an evaluation on an employee's child abuse history to determine whether the abuse warranted prohibition from employment for 1 of 7 staff reviewed with an abuse history (Staff F). Finding follows: Record review on 7/17/23 revealed a background check was completed for Staff F on 4/23/21. The program was notified Staff F had a history of child abuse. The program failed request an evaluation from the Department of Health and Human Services to determine if Staff F was eligible to work at the facility. The Executive Director confirmed this finding on 7/17/23 at 3:45 p.m.	A 420		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	A 360		

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program failed to update 1 of 1 discharged tenant's service plans to meet his needs (Tenant C1). Finding follows:

Record review on 7/13/23 of Tenant C1's service plan, dated 2/22/23, revealed he was independent with toileting. Tenant C1 had a catheter which increased the probability of urinary tract infections (UTIs). Staff were to remind Tenant C1 to keep the catheter tubing and drainage bag below his bladder so the urine did not leak back up into his bladder. He had a history of wrapping the catheter tubing around his waist. Tenant C1 was also an insulin dependent diabetic. Staff performed accu-checks per his primary care provider's (PCP's) orders and gave him insulin as needed. Tenant C1 was noted to have episodes of forgetfulness. He had short-term and long-term recall issues.

On 3/6/23, Tenant C1 received an order for a Gentamicin 480 mg-L sterile normal saline solution irrigation to his bladder. Tenant C1 tolerated the treatment well. The program nurses administered the irrigations according to a review of the medication administration records.

On 3/13/23, Tenant C1's doctor reviewed a urinalysis and gave new orders for a Gentamicin irrigation daily for ten days, then every other day. Staff were to encourage Tenant C1 to leave the Gentamicin in for 6 hours with a plug or valve, or drain earlier if he experienced discomfort.

On 3/15/23, the staff contacted the RN (Registered Nurse) at 3:08 a.m. because Tenant C1 was in the bathroom with his catheter tubing pulled out. Tenant C1's Power of Attorney (POA) was called and he agreed to take the tenant to a walk-in clinic when it opened. At 3:57 a.m.,

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Tenant C1 was not responding to questions and appeared to be fidgety. His blood sugar reading was 576. Tenant C1's POA was contacted again and took him to the hospital. Tenant C1 was admitted to the hospital and diagnosed with a urinary tract infection (UTI), Diabetes Mellitus II, Hypertension and Sepsis. Tenant C1 also had surgery for a suprapubic catheter.

A note on 3/23/23 indicated the program received orders for Tenant C1 to begin physical therapy, occupational therapy and speech therapy (for dysphagia).

On 3/26/23, a communication report noted Tenant C1 tried to get into the locked room of another tenant. Tenant C1 moved apartments earlier that morning.

Tenant C1 had a blood sugar reading of 443 on 3/27/23. Also on that date, the RN went to assess the bladder irrigation of Gentamicin solution at 3:45 p.m., which started at 1:30 p.m.. Tenant C1 disconnected the catheter clamp and the tubing was open without a bag attached. The RN assisted Tenant C1 with changing his pants as they were wet.

The RN was called to assess Tenant C1 during his therapy session on 3/28/23. Tenant C1 was asleep during the attempted program. When they got him up, he was shaky and his legs were buckling. Tenant C1's blood sugar reading was 466. Tenant C1's PCP was notified.

On 3/29/23, the Resident Care Coordinator (RCC) noted Tenant C1 did not tolerate the Gentamicin treatment well and his confusion increased. He was placed on hourly supervision checks until his infection and blood sugar values

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were within normal parameters.

Tenant C1 was found in another tenant's apartment on 3/30/23. This was near the apartment he recently moved from. Tenant C1 was placed on half hour checks. His daughter asked for the Gentamicin flushes to end to see if they were the cause of the confusion.

On 4/1/23, during checks staff found Tenant C1 pulled his catheter out of his penis. Tenant C1 was sent to the emergency room by ambulance. Tenant C1 remained at the hospital until 4/4/23. There was significant tissue trauma when Tenant C1 removed the catheter.

Tenant C1 cut the tubing to his suprapubic catheter on 4/8/23 at 8:35 a.m.. The catheter remained in tact. There was no trauma to the skin or sutures. His son took him to the Emergency Room. The catheter was plugged and clamped. The tubing was not replaced at the time. The family removed all scissors from his apartment. Tenant C1 continued on hourly checks.

On 4/9/23 at 2:10 a.m., the RCC was contacted when Tenant C1 was found outside banging on another tenant's window. Staff went outside and found Tenant C1 without pants, socks, or shoes. Tenant C1 was using his walker and informed staff he worked at the program and was locked out. A physical assessment was completed and Tenant C1 had no injuries, but was very confused.

Tenant C1's service plan was not updated to reflect the addition of the Gentamicin flushes, the suprapubic catheter, his increased blood sugars or the addition of the hourly checks.

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A 360	Continued From page 8 The Director, RN and RCC confirmed these findings on 7/19/23 at 1:30 p.m.	A 360		