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
	S0163	A. BUILDING: _____ B. WING _____	C 01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDENS	15 SILVERCREST PLACE IOWA CITY, IA 52240

(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: 3 Number of tenants with cognitive disorder: 28 TOTAL Census of Assisted Living Program for People with Dementia: 31 An onsite infection control survey was completed and no regulatory inefficacies were identified. A comment was made to the program regarding the recommendation of eye protection for staff. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program and the investigation of Complaint #97066-C, #98157-C, #98768-C and #100905-C and the investigation of Incident #100978-I. ********** ********** 235B.3 Dependent adult abuse reports. 3. a. If a staff member or employee is required to report pursuant to this section, the person shall immediately notify the department and shall also immediately notify the person in charge or the person's designated agent. This Requirement is not met as evidenced by:	A 000	POC attached 3/1/22	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Based on interview and record review the Program failed to report an allegation of abuse. This pertained to 1 of 2 tenants reviewed related to an allegation of abuse (Tenant #2). Findings follow:

1. Record review of an incident report dated 11-7-21 at 1:15 p.m. indicated Tenant #2 attempted to go out the utility hall door and an agency staff member "grabbed the back of the residents coat." Tenant #2 fell to the floor, hit her head and left elbow on the floor. The report indicated Tenant #2 had pain and hit her head. The Assistant Director of Nursing (ADON) was notified at 1:45 p.m. There were no vital signs recorded on the incident report form. It was reported by Staff B.

2. When interviewed on 12-21-21 at approximately 9:50 a.m. Staff B said the incident with Tenant #2 happened around lunch. She was on the west side of the building and heard Tenant #2 yell to leave her alone, to Agency Staff #1. She told Agency Staff #1 to let her be so it would not be worse and Tenant #2 was not trying to leave the building. Tenant #2 pressed the door and Agency Staff #1 grabbed Tenant #2 by the coat, both went backwards and she almost went 280 degrees. Tenant #2 fell and landed on her left hip, elbow and hit her head on the ground. Agency Staff #1 said she did not mean to do it that hard. She went to get Staff K and said Tenant #2 was shaken up at first. Staff B called the nurse on-call and her legal representative. She started the 48 hour sheet and waited for further direction. Tenant #2 had some pain in her left hip. She said she immediately made a report. When asked to describe the force used, if any, to pull Tenant #2's coat, Staff B said it was a six or seven out of ten. She said she could tell Agency

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Staff #1 was agitated, it was very visible and she huffing and puffing. She told Agency Staff #1 after the incident that she needed to be more careful and it was not how they did things. Agency Staff #1 had not been back to the Program since the incident with Tenant #2.

When interviewed on 12-16-21 at approximately 3:55 p.m. Staff K said she was working on the east side of the building and the door alarm went off she went to the service door and it was Tenant #2 and she took her back. She heard Tenant #2 scream after she walked her back. Staff B said she needed to come over and that Agency Staff #1 pulled Tenant #2 from the back and she hit her head. Staff K went to the lobby and she saw Agency Staff #1, who said she pulled Tenant #2 a little too hard and she fell. Tenant #2 was in the television area; which was not where she fell. Agency Staff #1 had gotten her up. Tenant #2 was holding her hip and head. Staff B called the nurse on-call and was told to complete an incident report. Staff K stayed into second shift to administer medications and the ADON called back, two to three hours after the fall, and told her to call 911. It had to be discussed with the Executive Director as it involved agency staff. The ambulance, fire department and police all arrived and asked questions about why there was a delay in calling. The ADON explained to the fire department and they were still confused. Agency Staff #1 was "rough" and very "vocal" towards tenants previously and nursing staff was made aware. She thought Staff B wrote a statement regarding the incident.

When interviewed on 12-21-21 at 12:19 p.m. the ADON said she got a telephone call from staff (Staff B) and said Tenant #2 was on the floor, she had hit her head and had left elbow pain. She

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said an agency staff had a hold of her coat or shirt, Tenant #2 turned and was on the ground. Regarding the delay in sending Tenant #2 out, she said Staff B said she seemed fine and the more the ADON thought about it and her level of confusion she decided it was better to have her evaluated. She notified the Executive Director of the fall. Tenant #2 returned with no injuries. Agency staff received a half hour orientation and tour of the building.

When interviewed on 12-21-21 at 1:24 p.m. and 1-6-22 at 11:02 a.m. the Executive Director said she was on paid time off and the ADON called her about a fall with Tenant #2 and said possibly an agency staff pulled her back and she fell. She told her to take statements from everyone who witnessed it. She notified her that Tenant #2 was sent out for evaluation to make sure everything was fine. Regarding the delay in sending Tenant #2 out, she said the ADON said her vitals were checked and it was thought to send her out to be safe. There were no other staff statements. The scheduler at that time was made aware to not let that agency staff return and she had not worked at the Program since. Regarding redirection for Tenant #2, she said staff should not put their hands on tenants. The Program did not complete an investigation and did not report it to the Department. She said she was off at the time and had limited information, it sounded like Tenant #2 was exit seeking and staff tried to stop her and legs got crossed and she fell. She did not know the extent until she read the staff statement when the onsite was occurring. It sounded more involved and that she pulled her.

Agency Staff #1 could not be interviewed related to the above allegation as the only information provided at the time of the investigation was her

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first name. Per the Executive Director the agency was not able to find any additional information for Agency Staff #1, including last name or contact information.

3. Continued record review of an Emergency Department Chart document from the hospital indicated Tenant #2 arrived at the hospital via ambulance at 4:25 p.m. (fall occurred at 1:15 p.m.) on 11-7-21. The document indicated Tenant #2 had tried to leave the unit and staff attempted to stop her by grabbing her vest. Tenant #2 fell backwards and hit her head. It was unknown how far Tenant #2 fell. The report indicated a computed tomography of the head indicated no intracranial hemorrhage, mass effect or midline shift. Tenant #2 was stable and returned to the program.

Further record review on 12-14-21 and 12-15-21 of Tenant #2's file revealed Tenant #4 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #2's service plan dated 7-1-21 reflected Tenant #2 had a history of wandering and looked for her spouse. Staff to reassure her that her spouse will be back and redirect to an activity. Tenant #2 also had a history of falls. Tenant #2 would often times fall when agitated and looking for her spouse.

In summary, Tenant #2 who had moderate cognitive decline attempted to go through a service hall door (not leaving the building) and Agency Staff #1 pulled her by her clothing, she fell and hit her head, hip and elbow. Staff B wrote a written statement that indicated the Agency Staff #1 pulled Tenant #2's clothing very hard when trying to get her to turn around from a door and she she hit her head very hard on the floor.

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A 000	Continued From page 5 Staff B reported Agency Staff #1 was agitated. Staff K reported staff had reported prior concerns with Agency Staff #1. Staff reported the incident to the on-call nurse and leadership staff was notified of the incident. An internal investigation was not completed and the incident was not reported to the Department.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policies and procedures. This pertained to 4 of 9 tenants reviewed (Tenants #1, #2, #6, #9). Findings follow: 1. Record review on 12-13-21 and 12-14-21 of Tenant #1's file revealed Progress Notes indicated the following: - On 4-1-21 it Tenant #1 was assessed at the hospital and noted to have increased confusion. An assessment was completed for Tenant #1's move to the Program on 4-1-21. - On 4-6-21 it a nurse was notified Tenant #1 became agitated and attempted to climb the courtyard fence on 4-3-21. Staff were not able to redirect Tenant #1 and were unable to administer as needed medication due to agitation. Staff called 911 and Tenant #1 was transported to the emergency room for evaluation. Continued record review revealed an incident	A 150		

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report was not completed related to the incident with Tenant #1 on 4-3-21.

When interviewed on 12-15-21 at approximately 11:10 a.m. and 1-6-22 at 11:02 a.m. the Executive Director confirmed an incident report was not found for Tenant #1 related to the incident on 4-3-21.

2. Record review of an incident report dated 11-7-21 at 1:15 p.m. indicated Tenant #2 attempted to go out the utility hall door and an agency staff member "grabbed the back of the residents coat." Tenant #2 fell to the floor, hit her head and left elbow on the floor. The report indicated Tenant #2 had pain, hit her head. The Assistant Director of Nursing (ADON) was notified at 1:45 p.m. There were no vital signs recorded on the incident report form. It was reported by Staff B and included a statement.

A Fall/Head Injury 48 Hour Follow-up document indicated a fall occurred at 1:20 p.m. on 11-7-21 and reflected vitals that were as follows: blood pressure was 120/80, pulse was 76, respiration rate was 13, temperature was 97.7 and oxygen saturation was 95%. The form indicated vitals and cognitive questions were to be completed every shift for 48 hours. On 11-7-21 second shift vitals and questions were completed with the exception of blood pressure which was refused. Vitals and questions were not completed on third shift on 11-7-21. Vitals and questions were completed on first shift on 11-8-21, with the exception of blood pressure which was refused. On third shift on 11-8-21 questions were completed and vitals were completed with the exception of blood pressure which was refused and the oxygen saturation which was not charted.

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A 150	Continued From page 7 When interviewed on 12-21-21 at approximately 9:50 a.m. Staff B said the incident with Tenant #2 happened around lunch. She was on the west side of the building and heard Tenant #2 yell to leave her alone, to Agency Staff A. She told Agency Staff A to let her be so it would not be worse and Tenant #2 was not trying to leave the building. Tenant #2 pressed the door and Agency Staff A grabbed Tenant #2 by the coat, both went backwards and she almost went 280 degrees. Tenant #2 fell and landed on her left hip, elbow and hit her head on the ground. Agency Staff #1 said she did not mean to do it that hard. She went to get Staff K and said Tenant #2 was shaken up at first. Staff B called the nurse on-call and her legal representative. She started the 48 hour sheet and waited for further direction. Tenant #2 had some pain in her left hip. She said she immediately made a report. When asked to describe the force used, if any, to pull Tenant #2's coat, Staff B said it was a six or seven out of ten. She said she could tell Agency Staff A was agitated, it was very visible and she huffing and puffing. She told Agency Staff A after the incident she needed to be more careful and it was not how they did things. Agency Staff A had not been back to the Program since the incident with Tenant #2. When interviewed on 12-16-21 at approximately 3:55 p.m. Staff K said she was working on the east side of the building and the door alarm went off she went to the service door and it was Tenant #2 and she took her back. She heard Tenant #2 scream after she walked her back. Staff B said she needed to come over and that Agency Staff #1 pulled Tenant #2 from the back and she hit her head. Staff K went to the lobby and she saw Agency Staff #1, who said she pulled Tenant #2 a	A 150		

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little too hard and she fell. Tenant #2 was in the television area; which was not where she fell. Agency Staff #1 had gotten her up. Tenant #2 was holding her hip and head. Staff B called the nurse on-call and was told to complete an incident report. Staff K stayed into second shift to administer medications and the ADON called back, two to three hours after the fall, and told her to call 911. It had to be discussed with the Executive Director as it involved agency staff. The ambulance, fire department and police all arrived and asked questions about why there was a delay in calling. The ADON explained to the fire department and they were still confused. Agency Staff #1 was "rough" and very "vocal" towards tenants previously and nursing staff was made aware. She thought Staff B wrote a statement regarding the incident.

When interviewed on 12-21-21 at 12:19 p.m. the ADON said she got a telephone call from staff (Staff B) and said Tenant #2 was on the floor, she had hit her head and had left elbow pain. She said an agency staff had a hold of her coat or shirt, Tenant #2 turned and was on the ground. Regarding the delay in sending Tenant #2 out, she said Staff B said she seemed fine and the more the ADON thought about it and her level of confusion she decided it was better to have her evaluated. She notified the Executive Director of the fall. Tenant #2 returned with no injuries. Agency staff received a half hour orientation and tour of the building.

When interviewed on 12-21-21 at 1:24 p.m. and 1-6-22 at 11:02 a.m. the Executive Director said she was on paid time off and the ADON called her about a fall with Tenant #2 and said possibly an agency staff pulled her back and she fell. She told her to take statements from everyone who

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witnessed it. She notified her that Tenant #2 was sent out for evaluation to make sure everything was fine. Regarding the delay in sending Tenant #2 out, she said the ADON said her vitals were checked and it was thought to send her out to be safe. There were no other staff statements. The scheduler at that time was made aware to not let that agency staff return and she had not worked at the Program since. Regarding redirection for Tenant #2, she said staff should not put their hands on tenants. The Program did not complete an investigation and did not report it to the Department. She said she was off at the time and had limited information, it sounded like Tenant #2 was exit seeking and staff tried to stop her and legs got crossed and she fell. She did not know the extent until she read the staff statement when the onsite was occurring. It sounded more involved and that she pulled her.

Agency Staff A could not be interviewed related to the above allegation as the only information provided at the time of the investigation was her first name. Per the Executive Director the agency was not able to find any additional information for Agency Staff A, including last name or contact information.

Continued record review of an Emergency Department Chart document from the hospital indicated Tenant #2 arrived at the hospital via ambulance at 4:25 p.m. (fall occurred at 1:15 p.m.) on 11-7-21. The document indicated Tenant #2 had tried to leave the unit and staff attempted to stop her by grabbing her vest. Tenant #2 fell backwards and hit her head. It was unknown how far Tenant #2 fell. The report indicated a CT of the head indicated no intracranial hemorrhage, mass effect or midline shift. Tenant #2 was stable and returned to the program.

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A 150	Continued From page 10 In summary, Agency Staff #1 pulled Tenant #2 by her clothing as she tried to go through a service hall door, she fell and hit her head, hip and elbow. Staff notified the nurse on-call; however, Tenant #2 was not sent out to the hospital until three hours post fall. The incident report did not reflect any vital signs for Tenant #2. Staff B provided a witness statement; however, no other staff involved with the incident provided witness statements, including Agency Staff #1. The 48 hour form utilized post fall when a tenant hit their head, reflected incomplete documentation on third shift after Tenant #2's return from the hospital. 3. Record review on 12-15-21 and 12-16-21 of Tenant #6's file revealed Tenant #6 had a diagnoses of advanced Parkinson's disease. Review of incident reports and Progress Notes indicated Tenant #6 had over 30 falls or incidents from 5-29-21 to 12-10-21. Review of Fall/Head Injury 48 Hour Follow-up forms indicated the following: - A fall occurred on 10-5-21 at 7:50 a.m.. The 48 hour sheet reflected incomplete documentation of cognitive questions on 10-6-21 on second shift. - A fall occurred on 11-7-21 at 8:30 a.m. The 48 hour sheet reflected incomplete documentation on second shift on 11-7-21, first shift on 11-8-21, second shift on 11-8-21 and first shift on 11-9-21. All of the required fields were empty with the exception of the shift. - A fall occurred on 11-12-21 at 4:30 p.m. The 48	A 150		

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hour sheet reflected incomplete documentation on 11-13-21 on two shifts on 11-13-21 and 11-14-21. All of the required fields were empty with the exception of the shift.

- A fall occurred on 11-20-21 at 3:30 p.m. The 48 hour sheet reflected incomplete documentation on 11-22-21 on second shift. The only information recorded was the date, shift and staff's name.

- A fall occurred on 12-9-21 at 11:50 p.m. The 48 hour sheet reflected incomplete documentation on two shifts on 12-12-21. All of the required fields were empty with the exception of the shift.

Further record review revealed faxes to a physician indicated the following:

- On 12-10-21 (x 2) it was noted on 12-9-21 that Tenant #6 had fallen and hit his head on a table and had a laceration to the back of his head. Tenant #6 was sent out to the hospital for evaluation. The 48 hour sheet upon Tenant #6's return from the hospital with a laceration to the back of his was incomplete, as noted above.

4. Continued record review revealed the Program's policy and procedure for the completion of incident reports indicated all accidents and incidents would be reported as an incident. The staff member who was in charge, or witnessed the incident or was first informed of the incident, would complete the incident report form. All fields were to be completed and witness statements included.

The Program's and procedure regarding falls indicated the guidance applied if a fall was

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witnessed or observed on the ground, "presumably fallen." It indicated to identify if a tenant had hit their head. If it was witnessed that the tenant hit their head, or the tenant reported they hit their head, or if it was unwitnessed or there was an injury was noted above the neck staff, were to asked cognitive questions, obtain a full set of vital signs, notify the nurse of the findings and recommend the tenant be evaluated (physician or equivalent).

A Fall/Head Injury 48 Hour Follow-up document indicated the form reflected vitals and cognitive questions were to be completed every shift for 48 hours.

When interviewed on 1-6-22 at 11:02 a.m. the Executive Director confirmed all incident reports and 48 hour reports (at the time of the onsite) were provided.

5. Record review of an incident report dated 10-9-21 at 7:52 p.m. indicated at approximately 7:52 p.m. Tenant #9 set off the front door alarm. The pager went off and a staff member was with another tenant. At 7:56 p.m. another staff member answered the front door alarm, called for assistance and went outside and found Tenant #9 walking towards the independent living building. Tenant #9 did not have any visible injuries. The report indicated vital signs were taken but were not entered. The other staff indicated on the incident report was Agency Staff #2. The report indicated a nurse on-call was notified and Tenant #9 had a history of exit seeking.

Continued record review revealed additional Incident Reports indicated the following:

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(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 150	Continued From page 13 - On 6-21-21 Tenant #9 was found by kitchen staff walking up the sidewalk. Tenant #9 walked out of gate as it was unlocked. - On 8-8-21 Tenant #9 exited the building through the rear exit. Staff searched the outside of the parameter and completed a head count inside the building. Staff called the nurse on-call, who called 911 for assistance in finding Tenant #9. Police located Tenant #9 a distance from the Program. Upon return to the building, it was noted Tenant #9 had a skin tear. He was sent was sent to the hospital for evaluation. - On 9-26-21 Tenant #9 went out of the lobby entrance, the pagers went off and staff responded. Tenant #9 was in the parking lot. Staff called for assistance to get Tenant #9 back to the building as he was aggressive. When back in the building it was noted Tenant #9 was very upset as he was not able to leave. Continued record review revealed the service plan dated 8-10-21 Tenant #9 had a history of wandering and exit seeking at his current community per Tenant #9's family. The service plan reflected Tenant #9 would frequently exit seek and 30 minute checks were in place. Record review of the Program's policy and procedure related to alarmed doors indicated if a door alarms staff was to immediately complete a check of the area outside of the door that alarmed to ensure that none of the tenants were outside of the building and then complete a check of each tenant in the building to ensure none of the tenants had exited the building. If assistance was required for completing a check of all tenants, staff would request (via radio) for additional assistance accounting for all of the	A 150		

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A 150	Continued From page 14 tenants. When interviewed on 1-6-22 at 11:02 a.m. the Executive Director said the expectation was that if staff were with a tenant and the door alarm went off, staff would ensure the tenant's safety and respond to the door alarms as soon as possible. In summary, Tenant #9 who had a history of exit seeking left the building and there was a four minute delay in staff responding to the door alarms, despite the policy and procedure indicating an immediate response to the door alarms.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure a tenant was treated with consideration, respect and dignity. This pertained to 1 of 1 tenant reviewed related to the Program's self report (Tenant #1). Findings follow: 1. Record review of a statement dated 6-11-21 from the Executive Director indicated at approximately 4:45 p.m. on 6-11-21 Tenant #1's legal representative came to the Program to	A 155		

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discuss an incident with Tenant #1. The legal representative was "visibly upset" and had a voicemail recording from 6-10-21. In the voicemail recording a Program staff was heard "taunting and engaging in inappropriate conversation" with Tenant #1. Another staff member could "vaguely be heard laughing." The voicemail was forwarded to the Executive Director. She contacted regional staff and informed them of the incident. The Assistant Director of Nursing (ADON) was called and returned to the building. The ADON arrived at approximately 5:15 p.m., listened to the voicemail and identified the voice on the voicemail as Staff I. At 5:30 p.m. the Executive Director and ADON called Staff I and she did not answer. At 6:51 p.m. Staff I returned the call and she was informed she was suspended pending investigation.

Continued record review revealed a Incident Investigation Report dated 6-11-21 indicated the date of the incident was 6-10-21 and the date the investigation was started was 6-11-21. It indicated Tenant #1's legal representative met with the Executive Director on 6-11-21. A voicemail recording from 6-10-21 at 2:26 p.m. was provided and Program staff were heard taunting and engaging in inappropriate communication with Tenant #1. The persons involved in the incident were identified as Tenant #1, Staff I and Staff J. The Executive Director and ADON started an investigation and the ADON identified the voice on the recording as Staff I. At 5:30 p.m. on 6-11-21 they attempted to call Staff I. She called back and she confirmed she was caring for Tenant #1 at the time of the voicemail. She asked if there were any other staff present in the room and she said Staff J was present. The investigative conclusion indicated Staff I and Staff

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J were identified. Staff I was terminated on 6-14-21 and Staff J was given a final written warning on 6-15-21. All nursing staff would be provided a re-education on tenant abuse and reporting procedures by 7-14-21.

When interviewed on 12-20-21 at 2:42 p.m. Tenant #1's legal representative said her family member had received a voicemail and shared it with her. She listened to it and met the Executive Director and played it for her. She said they took it seriously and told them the conversation was not appropriate. The Program followed up and the person was terminated. It sounded like two people were with Tenant #1, they had tried to call a family member and had not hung up. The voicemail talked about who had the money, where one of his family member's worked, who else had the money and needing to find out who had the money and he was going to be locked in the attic or basement.

When interviewed on 12-15-21 at 9:56 a.m. the ADON reported she had left for the day and received a telephone call from the Executive Director regarding a voicemail left on Tenant #1's family's phone. The ADON came back to the building and the voicemail was played again and she was asked if she recognized the voice and she said it was Staff I and the laughing the in the background she could not say confidently. The voicemail was garbled a bit but it was something about who had the money, something to do with money and something about in the basement. The Executive Director and the ADON called Staff I and left a voicemail as there was no answer. Staff I called back and the Executive Director told her she would be suspended pending an investigation. The ADON understood that Tenant #1 wanted to call family because he wanted

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money and Staff I helped him call. The ADON listened to the voicemail recording at the time of the interview and confirmed it was Staff I's voice and said she had a distinctive voice. She confirmed it was Tenant #1's voice on the voicemail and said she was not 100% sure who was laughing.

When interviewed on 12-16-21 at 11:59 a.m. the Executive Director said it was her first day. Tenant #1's family was there, were upset about an incident and wanted to play a voicemail. The day before staff had assisted Tenant #1 with calling a family member and did not hang up and left a voicemail. She asked if they were willing to share the voicemail and family sent the voicemail to the Executive Director. She called the ADON and asked her to come back and listen to the voicemail. She also notified regional staff. They went to the ADON's office and the ADON was able to identify Staff I as the main employee on the voicemail. Tenant #1 was identified as the tenant and the person laughing was not identified. They called Staff I that evening and she did not answer. The ADON and Executive Director were looking at the schedule when Staff I called back. Staff I said she was putting away laundry at shift change in Tenant #1's apartment and Staff J was also there. Staff I was informed she was suspended pending investigation and she could not share details. The information was brought to the regional staff and the decision was made to proceed with termination. The Former Director of Nursing (DON) and the Executive Director were on the call when Staff I was terminated. The Former DON had the conversation with her as the Executive Director did not know her. Staff I was told there was a voicemail with an inappropriate conservation with a tenant. Staff I was identified as the staff and it would be reported to the

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Department. The Executive Director said Tenant #1 was proud to talk about his family. She said regarding hearing the voicemail, there was a line or comment about putting him in the basement or attic. She said Tenant #1's family confirmed he had no access to funds and no money was missing.

An attempt on 12-20-21 at 1:48 p.m. to interview Staff I was not successful. A woman answered the phone at the number provided by the Program for Staff I. The monitor asked if it was Staff I and the woman and asked who was calling. When the monitor identified herself and the purpose of the call the person on the phone denied that it was Staff I.

The voicemail recording was played for the monitor during the investigation. The voicemail was was left on 6-10-21 at 2:26 p.m. The voices on the recording could not be identified by the monitor; however, there was a woman's voice and a man's voice audible on the recording. There was laugher that could be heard at times as well. The recording revealed a conversation where staff (identified by the Program as Staff I) engaged in a conversation with a tenant (identified by the Program as Tenant #1) about who had the money, where Tenant #1's family members worked, who else had the money, and a comment about putting Tenant #1 in the basement or attic.

Continued record review revealed Staff I and Staff J were both on the list of staff working first shift on 6-10-21.

In summary, Tenant #1 who resided in a dementia specific program, had moderate cognitive decline, had staff attempt to call his

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A 155	Continued From page 19 family without success. The phone did not get hung up and an inadvertent voicemail was left on Tenant #1's family member's phone. The message left revealed a conservation with Staff I (voice identified by the ADON) engaging in an inappropriate conversation with Tenant #1. A voice could be heard laughing in the background; and Staff I confirmed Staff J was in the apartment at that time. The voicemail recording mentioned comments regarding who had the money, where Tenant #1's family worked, who else had the money, and a comment regarding putting Tenant #1 in the attic or basement. Staff I confirmed to Program staff she was in Tenant #1's apartment at that time and Staff J was also present. Tenant #1 was not treated with respect, consideration and dignity.	A 155		
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 provide care, treatments and services that were adequate and appropriate. This pertained to 9 of 9 of tenants reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9). Findings follow: 1. When interviewed on 12-14-21 at 10:30 a.m. Staff L said some tenants were in the same	A 160		

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clothing as the day prior. It happened pretty often in the summer. It had been improving.

One family interview indicated a tenant had a doctor's appointment and at the appointment it was noticed that he had pants on backwards, the pants were not his and he was not wearing underwear. Two to three weeks ago the tenant was missing socks and underwear. At one point there was a conversation as it appeared he needed to shower more frequently.

Another family interview indicated a tenant's clean clothes were left in the basket and were not put away.

2. Record review on 12-13-21 and 12-14-21 of Tenant #1's file revealed the Monthly Task Log documents reflected "Action" tasks for Tenant #1, including grooming/personal hygiene (minimal assistance), dressing (minimal assistance) and bathing (moderate assistance).

September 2021 Monthly Task Log reflected the following: grooming/personal hygiene, 15 entries charted as task not completed (TNC); dressing, 13 entries charted as TNC; bathing,5 entries charted as refusals and 1 charted as TNC. The task log reflected 3 baths given for September.

October 2021 Monthly Task Log reflected the following: grooming/personal hygiene, 20 entries charted as TNC; dressing, 20 entries charted as TNC; bathing, 3 entries charted as refusals and 3 entries charted as TNC. The task log reflected 2 baths given for October.

November 2021 Monthly Task Log reflected the following: grooming/personal hygiene, over 20

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entries charted as TNC; dressing. over 20 entries charted as TNC; bathing, 3 entries charted as TNC. There were 5 baths charted as given for November.

December 2021 (12-1-21 to 12-13-21) Monthly Task Log reflected the following: grooming/personal hygiene, 9 entries charted as TNC; dressing, 9 entries charted as TNC; bathing, 2 entries charted as TNC. The task log reflected 2 baths given for December.

3. Record review on 12-14-21 of Tenant #2's file revealed the Monthly Task Log documents reflected "Action" tasks for Tenant #2, including dressing (extensive assistance), toileting (moderate assistance) and bathing (moderate assistance).

September 2021 Monthly Task Log reflected the following: dressing, 14 entries charted as TNC; toileting, 14 entries on first and second shifts charted as TNC; bathing, 1 entry charted as a refusal and 3 charted as TNC. The task log reflected 4 baths given for September.

October 2021 Monthly Task Log reflected the following: dressing 19 entries charted as TNC; toileting, 20 entries on first and second shifts charted as TNC.

November 2021 Monthly Task Log reflected the following: dressing, 18 entries charted as TNC; toileting, 18 entries on first and second shifts charted as TNC; bathing, 1 entry charted as a refusal and 4 entries charted as TNC. The task log reflected 4 baths given for November.

December (12-1-21 to 12-13-21) 2021 Monthly

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Task Log reflected the following: dressing, 5 entries charted as TNC; toileting, 5 entries on first and second shifts charted as TNC; bathing, 1 entry charted as TNC. The task log reflected 3 baths given for December.

4. Record review on 12-14-21 and 12-15-21 of Tenant #3's file revealed the Monthly Task Log documents reflected "Action" tasks for Tenant #3, including grooming/personal hygiene (minimal assistance), dressing (minimal assistance), toileting (moderate assistance) and laundry (extensive assistance).

September 2021 Monthly Task Log reflected the following: grooming/personal hygiene, over 20 entries charted as TNC; dressing, 19 entries charted at TNC; toileting, 19 entries charted as TNC; laundry, 5 entries charted as TNC.

October 2021 Monthly Task Log reflected the following: grooming/personal hygiene, over 20 entries charted as TNC; dressing, over 20 entries charted at TNC; toileting, over 20 entries charted as TNC; laundry, 5 entries charted as TNC.

November 2021 Monthly Task Log reflected the following: grooming/personal hygiene, 16 entries charted as TNC; dressing, 16 entries charted at TNC; toileting, 16 entries charted as TNC; laundry, 5 entries charted as TNC.

December 2021 (12-1-21 to 12-13-21) Monthly Task Log reflected the following: grooming/personal hygiene, 8 entries charted as TNC; dressing, 8 entries charted at TNC; toileting, 8 entries charted as TNC; laundry, 2 entries charted as TNC.

5. Record review on 12-14-21 of Tenant #4's file

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revealed the Monthly Task Log documents reflected "Action" tasks for Tenant #4, including for grooming/personal hygiene (moderate assistance), dressing (extensive assistance) and toileting (moderate assistance).

September 2021 Monthly Task Log reflected the following: grooming/personal hygiene, 15 entries charted as TNC; dressing, 15 entries charted as TNC; toileting, over 50 entries charted at TNC.

October 2021 Monthly Task Log reflected the following: grooming/personal hygiene, over 20 entries charted as TNC; dressing, there were over 20 entries charted as TNC; toileting there were over 50 entries charted at TNC.

November 2021 Monthly Task Log reflected the following: grooming/personal hygiene, 19 entries charted as TNC; dressing, 16 entries charted as TNC; toileting, over 50 entries charted at TNC.

December 2021 (12-1-21 to 12-13-21) Monthly Task Log reflected the following: grooming/personal hygiene, 7 entries charted as TNC; dressing 6 entries charted as TNC; toileting, over 30 entries charted at TNC.

6. Record review on 12-15-21 and 12-16-21 of Tenant #5's file revealed the Monthly Task Log document reflected "Action" tasks for Tenant #5 including: grooming/hygiene (minimal assistance), dressing (extensive assistance), toileting (moderate assistance), personal laundry (third shift), linens laundered, and bathing (moderate assistance).

September 2021 Monthly Task Log reflected the following: grooming/hygiene, 14 entries charted as TNC; dressing 14 entries charted as TNC;

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toileting, over 50 entries charted as TNC; linens laundered, 1 entry charted as TNC; personal laundry, 6 entries charted as TNC; bathing, 1 entry charted as TNC.

October 2021 Monthly Task Log reflected the following: grooming/hygiene, 19 entries charted as TNC; dressing, over 20 entries charted as TNC; toileting, over 50 entries charted as TNC; linens laundered, 4 entries charted as TNC; personal laundry, 3 entries charted as TNC; bathing, 3 entries charted as refused and 2 entries charted as TNC. The task log reflected 4 baths given for October.

November 2021 Monthly Task Log reflected the following: grooming/hygiene there were over 20 entries charted as TNC; dressing, over 20 entries charted as TNC; toileting, over 50 entries charted as TNC; linens laundered, 5 entries charted as TNC; personal laundry, 5 entries charted as TNC; bathing, 1 entry charted as a refusal and 4 entries charted as TNC. The task log reflected 4 baths as given for November.

December 2021 (12-1-21 to 12-14-21) Monthly Task Log reflected the following: grooming/hygiene, over 9 entries charted as TNC; dressing, 8 entries charted as TNC; toileting, over 50 entries charted as TNC; linens laundered, 2 entries charted as TNC; personal laundry, 3 entries charted as TNC.

6. Record review on 12-15-21 and 12-16-21 of Tenant #6's file revealed the Monthly Task Log documented reflected "Action" tasks for Tenant #6 including dressing (extensive assistance), toileting (moderate assistance) and bathing (moderate assistance).

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A 160	Continued From page 25 September 2021 Monthly Task Log reflected the following: dressing, 10 entries charted as TNC; toileting, 12 entries charted as TNC; bathing, 1 entry charted as TNC. October 2021 Monthly Task Log reflected the following: dressing, 18 entries charted as TNC; toileting, 20 entries charted as TNC; bathing, 4 entries charted as TNC. November 2021 Monthly Task Log reflected the following: dressing, 20 entries charted as TNC; toileting, over 20 entries charted as TNC; bathing, 5 entries charted as TNC. December 2021 (12-1-21 to 12-14-21) Monthly Task Log reflected the following: dressing, 8 entries charted as TNC; toileting, 7 entries charted as TNC; bathing, 3 entries charted as TNC. 7. Record review on 12-20-21 of Tenant #7's file revealed the Monthly Task Log documents reflected "Action" tasks for Tenant #7, including dressing (extensive assistance) and toileting (moderate assistance) and bathing (moderate). October 2021 Monthly Task Log reflected the following: dressing, 15 entries charted as TNC; toileting, there were 16 entries charted as TNC on first and second shifts and 18 entries charted as TNC on third shift; bathing, 1 entry charted as refusals and 2 entries charted as TNC. The task log reflected 5 baths given for October. November 2021 Monthly Task Log reflected the following: dressing, 16 entries charted as TNC; toileting, 6 entries charted as TNC on first and second shifts and 18 entries charted as TNC on third shift; bathing, 2 entries, charted as refusals	A 160		

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A 160	Continued From page 26	A 160		

and 3 entries charted as TNC. The task log reflected 3 baths given for November.

December 2021 Monthly Task Log (12-1-21 to 12-19-21) reflected the following: dressing, 8 entries charted as TNC; toileting, 7 entries charted as TNC on first and second shifts and 5 entries charted as TNC on third shift.

8. Record review on 12-20-21 of Tenant #8's file revealed revealed the Monthly Task Log documents reflected "Action" tasks for Tenant #8, including bathing (extensive assistance), grooming/personal hygiene (moderate assistance), dressing (extensive assistance) and toileting (moderate assistance).

October 2021 Monthly Task Log reflected the following: grooming/personal hygiene, 18 entries charted as TNC; dressing there were 17 entries charted as TNC; bathing, 1 entry charted as a refusal and 5 entries charted as TNC. The task log reflected 3 baths given for October; toileting, 18 entries charted as TNC on first and second shifts and over 20 entries charted as TNC on third shift. The schedule indicated two hours during the day and twice in the evening (three times daily, day, evening and night shift).

November 2021 Monthly Task Log reflected the following: grooming/personal hygiene there were over 20 entries charted as TNC; dressing, over 20 entries charted as TNC; bathing, 2 entries charted as TNC; toileting, over 20 entries charted as TNC on first and second shifts and over 20 entries charted as TNC on third shift. The schedule indicated two hours during the day and twice in the evening (three times daily, day, evening and night shift).

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December (12-1-21 to 12-19-21) 2021 Monthly Task Log reflected the following: grooming/personal hygiene, 9 entries charted as TNC; dressing, 10 entries charted as TNC; bathing, 1 entry charted as TNC; toileting, 10 entries charted as TNC on first and second shifts. There were 13 entries charted as TNC on third shift. The schedule indicated two hours during the day and twice in the evening (three times daily, day, evening and night shift).

9. Record review on 12-20-21 of Tenant #9's file revealed the Monthly Task Log documents reflected "Action" tasks for Tenant #9, including bathing (moderate assistance) and laundry (bed linens) and laundry (personal laundry).

October 2021 Monthly Task Log reflected the following: bed linens laundered, 2 entries charted as TNC and 1 refusal; personal items laundered (third shift) there were 5 entries charted as TNC; bathing there were 3 entries charted as TNC and 3 refusals. The task log reflected 2 baths given for October;

November 2021 Monthly Task Log reflected the following: bed linens laundered, 4 entries charted as TNC; personal items laundered (third shift) there were 5 entries charted as TNC; bathing, 4 entries charted as TNC and 4 refusals. The task log reflected 1 bath given for November.

December 2021 (12-1-21 to 12-19-21) Monthly Task Log reflected the following: personal items laundered, 6 entries charted as TNC; bathing, 1 entries charted as TNC and 1 refusals. The task log reflected 1 bath given for December.

10. When interviewed on 1-6-22 at 11:02 a.m. the Executive Director confirmed all task sheets

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A 160	Continued From page 28 (at the time of the onsite) were provided for tenants listed above. The expectation was that staff charted at the end of their shift.	A 160		
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 interview and record review the Program failed to administer medications and complete treatments as ordered. This pertained to 9 of 9 of tenants reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9). Findings follow: 1. Record review on 12-13-21 and 12-14-21 of Tenant #1's file revealed a Physician Visit Form document, dated 7-9-21, indicated Tenant #1 did not wear his continuous positive airway pressure (CPAP) machine. New orders were received to help Tenant #1 apply the CPAP mask nightly, perform routine CPAP maintenance and contact the Veterans Affairs (VA) for CPAP supplies. The orders were noted on 7-9-21. Review of the November 2021 and December 2021 medication administration records (MARs) failed to reflect orders for the CPAP, assistance to	A 285		

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A 285	Continued From page 29 apply nightly or the routine CPAP maintenance as ordered. Continued record review revealed an order for COVID vitals (temperature) one time per day at 4:00 p.m. The November MARs reflected over 15 times the COVID vitals were not documented as completed. The December MARs (12-1-21 to 12-13-21) reflected 8 times the COVID vitals were not documented as completed. 2. Record review on 12-14-21 and 12-15-21 of Tenant #2's file revealed an order for COVID vitals (temperature) one time per day at 10:00 a.m. The November MARs (11-1-21 to 11-23-21) revealed 12 entries where the COVID vitals were not documented as completed. The December MARs (12-1-21 to 12-14-21) revealed 5 entries where the COVID vitals were not documented as completed. 3. Record review on 12-14-21 and 12-15-21 of Tenant #3's file revealed an order for COVID vitals (temperature) one time per day at 8:00 a.m. The November MARs (11-1-21 to 11-24-21) revealed 14 entries where the COVID vitals were not documented as completed. The December MARs (12-1-21 to 12-13-21) revealed 5 entries where the COVID vitals were not documented as completed. The MAR reflected an order for monthly vitals and weight one time per day on the 1st at 8:00 a.m. The November and December 2021 MARs did not reflect a documented weight for Tenant #3 as ordered. Tenant #3's weights were requested and the most current weight provided was from 8-1-21, which indicated 170.9 pounds.	A 285		

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A 285	Continued From page 30 Continued record review revealed an After Visit Summary document indicated Tenant #3 was seen by his PCP on 7-1-21 and his weight was 183 pounds. An After Visit Summary document revealed Tenant #3 was seen by his PCP on 12-9-21. He was seen for items including weight loss. His weight was 167 pounds. Tenant #3 had lost 16 pounds from 7-1-21 (admitted on 7-12-21) to 12-9-21. 4. Record review on 12-14-21 of Tenant #4's file revealed an order for Tubi grips, apply to both lower extremities daily and remove at bedtime and COVID vitals (temperature) one time per day at 10:00 a.m. The November MARs (11-1-21 to 11-24-21) and December MARs (12-1-21 to 12-13-21) indicated Tubi grips, apply to both lower extremities daily and remove at bedtime with one entry at 7:00 p.m. for removal of the Tubi grips. The MARs did not reflect an entry for the application of the Tubi grips daily. The November MARs (11-1-21 to 11-24-21) revealed COVID vitals daily at 10:00 a.m. was not documented as completed 12 times. The December MARs (12-1-21 to 12-13-21) revealed COVID vitals daily at 10:00 a.m. was not documented as completed 4 times. 5. Record review on 12-15-21 and 12-16-21 of Tenant #5's file revealed the file revealed the November MAR reflected an order for COVID vitals (temperature) daily at 4:00 p.m. It was not documented as completed 14 times. The December MARs (12-1-21 to 12-14-21) reflected 8 times the COVID vitals were not documented as completed.	A 285		

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A 285	Continued From page 31 6. Record review on 12-15-21 and 12-16-21 of Tenant #6's file revealed the November MAR reflected an order for COVID vitals (temperature) daily at 4:00 p.m. It was not documented as completed 14 times. The December MARs (12-1-21 to 12-14-21) reflected 8 times the COVID vitals were not documented as completed. 7. Record review on 12-20-21 of Tenant #7's file revealed the November 2021 MARs reflected an order for COVID vitals (temperature) daily at 10:00 a.m. It was not documented as completed 14 times. The December MARs (12-1-21 to 12-20-21) reflected 5 times the COVID vitals were not documented as completed. 8. Record review on 12-20-21 of Tenant #8's file revealed a diagnoses included type 2 diabetes mellitus. Review of the November 2021 medication administration records (MARs) revealed the following orders: Novolog FlexPen 100 unit/milliter (ml), inject 5 units subcantaneously (SQ) three times daily before meals and inject additional units per sliding scale three times daily before meals. An order was on the MAR for blood glucose monitoring four times per day, prior to meals and prior to bed. The order on the MAR indicated blood glucose monitoring four times per day and had one two entries recorded on 11-25-21 at 8:00 a.m. and 12:00 p.m. Another section of the MARs under Vitals listed blood sugars. It reflected blood sugar checks and reflected 12:00 p.m. 5:00 p.m. and 8:00 a.m. checks. The blood glucose monitoring under Vitals did not reflect the 8:00 p.m. blood glucose check. In the Vitals sections there were	A 285		

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A 285	Continued From page 32 11 times the 8:00 a.m. blood glucose check was not documented as completed, there were 19 times the 12:00 p.m. blood glucose check was documented as completed and there were 22 times the 5:00 p.m. blood glucose check was not documented as completed. As indicated above the 8:00 p.m. check was not reflected in the Vitals section. The sliding scale insulin reflected on the MARs at 8:00 a.m., 12:00 p.m. and 5:00 p.m. reflected initials and at times blood glucose readings; however, did not reflect the units administered in the entry related to the order. In the Notes section there were entries that reflected no sliding scale insulin given or the number of units; however, it was not consistently documented on the MAR with the order. The December 2021 MARs (12-1-21 to 12-20-21) reflected Novolog FlexPen 100 unit/ml, inject 5 units SQ three times daily before meals and inject additional units per sliding scale three times daily before meals. An order was on the MAR for blood glucose monitoring four times per day, prior to meals and prior to bed. The order on the MAR for blood glucose monitoring four times per day had three entries, two on 12-13-21 and one on 12-15-21. Another section of the MARs under Vitals listed of blood glucose readings. It reflected the 12:00 p.m., 5:00 p.m., 8:00 a.m. and 8:00 p.m. checks. There were 11 times the 8:00 a.m. blood glucose check was not documented as completed, there were 10 times the 12:00 p.m. blood glucose check was not documented as completed, there were 18 times the 5:00 p.m. blood glucose check was not documented as completed and there were 19 times the 8:00 p.m. the blood glucose check was not documented as completed.	A 285		

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A 285	Continued From page 33 The sliding scale insulin reflected on the MARs at 8:00 a.m., 12:00 p.m. and 5:00 p.m. reflected initials and at times blood glucose readings; however, did not reflect the units administered in the entry related to the order. In the Notes section there were entries that reflected no sliding scale insulin given or the number of units; however, it was not consistently documented on the MAR with the order. The November 2021 MAR reflected an order for COVID vitals (temperature) daily at 4:00 p.m. and it was not documented as completed 15 times. The December 2021 MAR (12-1-21 to 12-19-21) reflected an order for COVID vitals (temperature) daily at 4:00 p.m. and it was not documented as completed 11 times. When interviewed on 1-6-22 at the time of the exit meeting the Assistant Director of Nursing said the blood glucose monitoring and insulin tasks for Tenant #8 were entered into the electronic MAR system as a task for a caregiver and not a medication passer. 9. Record review on 12-20-21 of Tenant #9's file revealed the November 2021 MAR reflected an order for COVID vitals (temperature) daily at 4:00 p.m. It was not documented as completed 15 times. The December MAR (12-1-21 to 12-19-21) reflected it was not documented as completed 11 times. 11. When interviewed on 1-6-22 at 11:02 a.m. the Executive Director confirmed all MARs (at the time of the onsite) were provided for the tenants	A 285		

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A 285	Continued From page 34 listed above.	A 285		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse delegated training within 30 days of staffs' employment. This pertained to 6 of 7 current staff reviewed (Staff A, B, C, D, E and G). Findings follow: 1. Record review on 12-9-21 and 12-13-21 of Staff A's training documents revealed a hire dated 8-13-21. Nurse delegations were not completed at the time of the review. 2. Record review on 12-9-21 and 12-13-21 of Staff B's training documents revealed a hire dated 10-14-21. Nurse delegations were not completed at the time of the review. 3. Record review on 12-9-21 and 12-13-21 of Staff C's training documents revealed a hire dated 5-10-21. Nurse delegations were dated 7-14-21; which was greater than 30 days from Staff C's employment. 4. Record review on 12-9-21 and 12-13-21 of	A 345		

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A 345	Continued From page 35 Staff D's training documents revealed a hire dated 8-19-21. Nurse delegations were dated 11-4-21 and 11-10-21 for medications and treatments and training on activities of daily living was not completed. 5. Record review on 12-9-21 and 12-13-21 of Staff E's training documents revealed a hire dated 5-1-21. Nurse delegations were dated 6-23-21; which was greater than 30 days from Staff E's employment. 6. Record review on 12-9-21 and 12-13-21 of Staff G's training documents revealed a hire dated 10-30-21. Nurse delegations were not completed within 30 days of employment and were not completed at the time of the review. 7. When interviewed on 1-6-22 at 11:02 a.m. the Executive Director confirmed all nurse delegation documents for the staff listed above were provided.	A 345		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on observation, interview and record review the Program failed to have staff provide services in accordance with training provided.	A 361		

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This pertained to one of one staff observed that completed blood glucose monitoring and administered insulin (Staff H). Findings follow:

1. When observed on 12-13-21 at approximately 11:20 to 11:30 a.m. Staff H administered medications to four tenants including Tenant #8. Staff H took Tenant #8's blood glucose reading and administered insulin during the observation. Prior to administration she gathered the supplies and propelled Tenant #8's in his wheelchair from the dining room table to a sitting area. The medication cart and computer with the electronic medication administration record (MAR) were located in an activity area. She took Tenant #8's blood glucose without wiping his finger with an alcohol swab and Tenant #8's blood glucose reading was 236. She went to the medication cart and computer with the electronic MAR, which was in the activity area. She returned to the sitting area to administer Tenant #8's insulin (scheduled and sliding scale). Staff H said she had put the information in her phone (regarding Tenant #8's insulin). She wiped his abdomen with an alcohol swab prior to the administration of the insulin and injected the insulin into his abdomen. After the administration of the insulin,she started to take Tenant #8 back to the dining room table in his wheelchair, when Staff M assisted and took Tenant #8 to the dining room table. Staff H had not doffed her gloves after the insulin administration prior to assisting Tenant #8 in the wheelchair. Staff H returned to the medication cart and computer located in the activity area and doffed her gloves.

2. Record review on 12-20-21 of Tenant #8's file revealed the December 2021 MAR revealed the following orders: Novolog FlexPen 100 unit/milliter (ml), inject 5 units subcantaneously

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(SQ), three times daily before meals and inject additional units per sliding scale three times daily before meals. An order was found for blood glucose monitoring four times per day, prior to meals and prior to bed. The MARs reflected two recorded blood glucose reading one of 236 and one of 243 for 12-13-21 at 12:00 p.m. (blood glucose readings were recorded in several locations on the MAR). Staff H signed off for the scheduled and sliding scale insulin at 12:00 p.m. on 12-13-21. The sliding scale insulin did not reflect the units given. Per the sliding scale provided on the MAR, a blood glucose reading between 201-300 was 4 units.

Continued record review revealed the Program's procedure for using a glucometer indicated to wipe the side of the finger with an alcohol pad and allow to dry. The Program's procedure for insulin medication management indicated to compare the medication label against the MAR (first safety check), dial the insulin pen to the correct number of units as ordered, re-check the medication label with the MAR and units (second safety check), have another medication manager verify the correct medication and units were dialed up on the insulin pen and MAR (third safety check), minimize the MAR on the computer screen, wipe the area of administration with an alcohol wipe, wash and dry hands and don gloves. After the insulin was administered to remove gloves and wash and dry hands.

3. Continued record review revealed Staff H's hire date was 4-13-21. Training documents revealed Staff H had training on insulin administration and blood glucose monitoring dated 12-3-21.

4. When interviewed on 1-6-22 at 11:51 a.m. the

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A 361	Continued From page 38 ADON said the expectation was that staff should wipe the finger with an alcohol wipe and let air dry, prior to the taking a blood glucose reading. The ADON confirmed Staff H had taken the medication manager course.	A 361		
A 365	481-67.9(4)g Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have in a place a system for staff to communicate in writing occurrences that differed from the tenants' normal health, functional and cognitive status. This pertained to 9 of 9 tenants reviewed (Tenants #1, #2, #3,#4, #5, #6, #7, #8 and #9) and potentially affected all	A 365		

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tenants (census of 31). Findings follow:

1. Record review of Tenant #1, #2, #3, #4, #5, #6, #7, #8 and #9's files revealed there were were no staff to nurse communication report documents completed in the last six months for the any of tenants noted above, despite changes that occurred in their cognitive, functional and health status.

See 69.22(3) and 69.26(1) regarding occurrences that differed from the normal health, functional and cognitive status for tenants as indicated in interviews and record review.

2. Record review of the Program's Staff to Nurse Communication Policy and Procedure indicated a "Staff Communication Report" or "Report a Change" forms would be used as written communication to communicate tenant information to the nurse. The forms would be used by non-licensed staff when the nurse was in or out of the building. Unlicensed staff would indicated occurrences that differed from tenant's normal status. Staff would complete the staff communication report by circling or indicated the information on the form or making a notation about the concern at the bottom on the form. The communication would be maintained by the Program for 5 years.

3. When interviewed on 1-6-22 at 11:51 a.m. the Assistant Director of Nursing (ADON) confirmed there were no staff to nurse communication forms found for the tenants listed above for the past six months. She said the Former Director of Nursing (DON) made a comment that the form no longer needed to be used. She did not know the timeframe it occurred.

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A 365	Continued From page 40 4. When interviewed on 1-6-22 at 11:02 a.m. the Executive Director said the ADON had reported to her that at some point in 2021, the ADON was told by the Former DON, the staff to nurse communications forms no longer needed to be used. She confirmed no staff to nurse communications forms were found for the past six months for the tenants listed above. .	A 365		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 6 of 9 tenants reviewed (Tenants #1, #3, #4, #5, #6, and #8). Findings follow: 1. Record review on 12-13-21 and 12-14-21 of Tenant #1's file revealed a Physician Visit Form	A 145		

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document dated 7-9-21 indicated Tenant #1 did not wear his continuous positive airway pressure (CPAP). New orders were received to help Tenant #1 apply the CPAP mask nightly, perform routine CPAP maintenance and contact the Veterans Affairs (VA) for CPAP supplies. The orders were noted on 7-9-21.

Continued record review revealed Progress Notes indicated the following:

-On 11-17-21 it was noted Tenant #1 had increased agitation. He had aggressive and confrontational behavior with other tenants and accused them of "imagined offences." Staff could redirect Tenant #1 with "much effort." The above was faxed to the primary care provider (PCP).

-On 11-17-21 it was noted an addendum was made to the prior fax sent to the PCP. Tenant #1 "was again engaging in an unprovoked and aggressive manner." Tenant #1 was not easily redirected. Staff thought Tenant #1 seemed more pale.

-On 12-7-21 it was noted a telephone call was received and indicated the VA offered "Behavioral Recovery." A person's name and number was provided to get assistance with addressing Tenant #1's behavior.

Further record review revealed Monthly Task Log documents from September to November 2021 reflected eight entries regarding bathing refusals.

Continued record review revealed the current evaluations were dated 6-25-21 and evaluations were not completed as needed with significant change including staff assistance with the CPAP, bathing refusals or the increased behaviors noted

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above that were sent to the PCP.

2. Record review on 12-14-21 and 12-15-21 of Tenant #3's file revealed Tenant #3 was admitted on 7-12-21 and diagnoses included Alzheimer's disease and functional urinary incontinence. Tenant #3 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline.

Progress Notes indicated the following:

-On 7-22-21 it was noted that on 7-21-21 Tenant #3 grabbed a tenant's wrist and would not let go. Tenant #3 said he was trying to help the tenant to her room to lay down. A nurse tried to redirect Tenant #3 away for the other tenant. Tenant #3 was agitated and yelled at staff. Tenant #3 attempted to leave the building and when staff redirected, he grabbed a staff by the neck and pushed him against the wall. A nurse called 911 and Tenant #3 was transported to the hospital for evaluation.

-On 7-26-21 it was noted on 7-25-21 Tenant #3's spouse took him to urgent care related to complaints of hip pain. Tenant #3 returned with a new order for naproxen, 500 milligram (mg), take one tablet, orally twice per day with meals.

-On 11-16-21 it was noted Tenant #3's spouse was concerned Tenant #3 had increased pain with ambulation.

-On 12-1-21 it was noted a order was received to discontinue use of the CPAP.

-On 12-9-21 it was noted Tenant #3 returned from a visit with the PCP and a new was received for acetaminophen 500 mg, take two tablets, orally,

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twice daily.

Continued record review of After Visit Summary documents revealed on 7-1-21 Tenant #3 was seen by his PCP for a follow up, Alzheimer's disease, neck pain and urinary incontinence. His weight was 183 pounds. An After Visit Summary document revealed Tenant #3 was seen by his PCP on 12-9-21. He was seen for a follow up, pain, hip pain, neck pain and weight loss. His weight was 167 pounds. Tenant #3 had lost 16 pounds from 7-1-21 (admitted on 7-12-21) to 12-9-21 and was seen for weight loss at the 12-9-21 appointment.

When interviewed on 12-16-21 at 3:55 p.m. Staff K said Tenant #3's apartment had a urine odor. When staff tried to assist Tenant #3 with toileting he was aggressive. Tenant #3 urinated other places than his toilet. When Tenant #3 had a bowel movement (BM) he used the toilet.

When interviewed on 12-16-21 at 10:30 a.m. Staff A said Tenant #3 would not let a female staff assist him. She said Tenant #3 liked to go on his own and would urinate in his apartment, hallway and trash can. Regarding behavior, she said he was very aggressive. Tenant #3 tried to tell Tenant #2 what to do and tried to take care of her.

When interviewed on 12-21-21 at 2:51 p.m. Staff H said Tenant #3 had urinated in a cup, dining room, garden room and hallway. Tenant #3 had a toileting schedule; but refused.

Continued record review revealed Monthly Task Logs from September to December 2021 indicated 15 documented refusals for hygiene and grooming, 24 documented refusals for dressing and 23 documented refusals for

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toileting. The logs at times indicated Tenant #3 was very aggressive or was very upset with staff.

Further record review revealed evaluations were most recently completed on 8-11-21 and were not completed as needed with significant change including Tenant #3's weight loss, urination in places other than the toilet, the extent of the care refusals and at times aggressive behavior related to care refusals and hip pain with ambulation.

3. Record review on 12-14-21 and 12-15-21 of Tenant #4's file revealed Tenant #4's service plan dated 3-2-21 reflected Tenant #4 ambulated independently and used a walker for ambulation.

When observed on 12-14-21 at approximately 4:35 p.m. Tenant #4 was seated in a wheelchair at the dining room table.

Continued record review revealed an incident reports indicated the following:

-On 7-1-21 it was noted Tenant #4 tried to get out of her wheelchair when the breaks were locked, tipped over the foot pedal and fell back.

-On 8-3-21 it was noted Tenant #4 was found by an aide in bed with a skin tear, the staff did not know how she got it and thought she hit her arm on the railing on her bed.

-On 10-9-21 it was noted Tenant #4 got up from her wheelchair, lost her balance and fell. There was a lot of blood present, 911 was called and Tenant #4 was sent out for evaluation.

Further record review revealed the most current evaluations were dated 3-2-21 and evaluations

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were not completed as needed with a significant change including a change in mobility, the use of the wheelchair or railing on Tenant #4's bed.

4. Record review on 12-15-21 and 12-16-21 of Tenant #5's file revealed diagnosis included type 2 diabetes mellitus. Tenant #5 was staged at a four on the GDS, which indicated moderate cognitive decline.

When interviewed on 1-5-22 at 11:41 a.m. Tenant #5's legal representative indicated she had requested the Program not allow Tenant #5 to leave the building with a friend.

When interviewed on 12-14-21 at 10:30 a.m. Staff L said Tenant #5's apartment had an odor. Tenant #5 had been been incontinent of BM between the bathroom and living room. Staff cleaned his apartment and at times there was BM on the walls.

When interviewed on 12-16-21 at approximately 3:55 p.m. Staff K said Tenant #5's apartment had an BM odor. She said Tenant #5 pulled down his pants and attempted to stand by the toilet. He was incontinent at least once per shift and at times would go in bed. At times Tenant #5 went to the bathroom independently and then laid in bed without after toileting care. Staff removed the sheets if soiled. Tenant #5 got himself dressed and if soiled would take a shower. Staff did not assist Tenant #5 with with a hearing aide.

When interviewed on 12-16-21 at 10:30 a.m. Staff A said Tenant #5's apartment had an odor. She said he was constantly incontinent on the floor. That morning Tenant #5 had a BM in the brief and got him to the bathroom and he sat on

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the chair and leaked on the floor. He was incontinent of bladder and bowel on the floor. She said staff tried to keep it cleaned up as best they could. Tenant #5 did not have a hearing aide.

When interviewed on 12-21-21 at 2:51 p.m. Staff H said Tenant #5 was toileted every one to two hours and he refused a lot. When Tenant #5 was incontinent it got all over the bed and floor. It happened a couple times per week.

When interviewed on 12-21-21 at approximately 9:50 a.m. Staff B said Tenant #5 was very hard to get to sit down for toileting. Tenant #5 would get up and go on the floor. She thought he was maybe on too many laxatives. She said he was incontinent at least twice per day. There had been BM in the closet.

When interviewed on 12-21-21 Nurse #1 said Tenant #5 occasionally had explosive diarrhea. Tenant #5 had BM on his mattress and recently had the mattress was replaced. The mattress had a vinyl cover that indicated not to remove.

When interviewed on 12-21-21 at 12:19 p.m. the Assistant Director of Nursing (ADON) said at times Tenant #5's apartment had an odor and they were trying to ensure the bathroom was cleaned daily. Staff did not assist Tenant #5 with hearing aides.

Continued record review indicated a podiatry office document indicated Tenant #5 was seen on 10-8-21. He needed diabetic foot care and reported pain on the bottom of his foot. The impression indicated hammer toe(s) on the right and left foot. It was recommended for periodic debridement and to only wear "prescribed

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diabetic footwear." Tenant #5 had "severe Equinus" and physical therapy (PT) was recommended for stretching and mobility.

Physician Visit Forms indicated the following:

-On 4-5-21 it was noted Tenant #5 was concerned about this teeth and said they hurt and were not working correctly. Tenant #5 had moderate gum inflammation. New orders indicated to monitor Tenant #5's oral hygiene. Tenant #5 "was not brushed for today's appt-teeth were full of food and debris."

-On 12-21-21 it was noted Tenant #5 had "moderate-heavy deposit and food on teeth." Tenant #5 was not able to care for his teeth and had a very dry mouth. It was noted to have water at bedside. A new order was received to brush Tenant #5's teeth twice daily (a.m. and p.m.).

Further record review revealed the most current evaluations were dated 4-9-21 and were not completed as needed with significant change including with staff assistance needed with oral cares, Tenant #5's incontinence related to the bed and floor, the recommendation for the diabetic footwear and foot pain.

5. Record review on 12-15-21 and 12-16-21 of Tenant #6's file revealed Tenant #6 had a diagnoses of Parkinson's disease.

When observed on 12-13-21 at lunch Tenant #6 was assisted by his family member to eat and was seated in a wheelchair.

Review of incident reports and Progress Notes indicated Tenant #6 had over 30 falls or incidents

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from 5-29-21 to 12-10-21.

When interviewed on 12-14-21 at 10:30 a.m. Staff L said staff needed more training related to Tenant #6 and his Parkinson's could get out of control.

When interviewed on 12-14-21 at 11:09 a.m. Staff M identified Tenant #6 required a significant amount of cares and time. She said he was very strong. He was working with PT.

When interviewed on 12-16-21 at approximately 3:55 p.m. Staff K said it depended on the day regarding transfers, regarding if one or two people were used with Tenant #6. At times he was resistive and leaned back. If he was not cooperative, it took two people. She said when he slipped out of bed on third shift, they put a pillow and a blanket on the floor and it seemed to relax him when he was on the floor. She said when fell he hit his head really hard and previously had staples.

When interviewed on 12-16-21 at 10:30 a.m. Staff A said Tenant #6 had "spasms." She said was dependent for toileting, dressing and bathing. She said he constantly fell and usually took two people for transfers 100% of the time. Sometimes staff assisted with eating.

When interviewed on 12-21-21 at 2:51 p.m. Staff H said Tenant #6 took two to three staff to transfer. She said he had seizure type episodes. Tenant #6's family member helped with feeding Tenant #6. Tenant #6 had falls and injuries where he hit his head.

When interviewed on 12-21-21 the Nurse #1 said Tenant #6 had severe Parkinson's disease and

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sometimes took two to transfer. Tenant #6 walked around the building with PT.

When interviewed on 12-21-21 at 12:19 p.m. the ADON said at times took two people for transfers. PT was working with him. Tenant #6's family member visited daily and assisted with cares. She said it depended on the day but approximately 30 to 40 % of the time Tenant #6 took two people for transfers. She recently spoke with PT and they said he would be safer at a higher level of care.

When interviewed on 12-21-21 at 1:24 p.m. the Executive Director said there was a discussion last week regarding Tenant #6's and his level of care.

Continued record review revealed Physician Visit Forms indicated the following:

-On 11-4-21 it was noted Tenant #6 mentioned some depressed thoughts and to monitor for increased tearfulness and a depressed mood.

-On 11-17-21 it was noted food being trapped was causing gingivitis and Tenant #6 needed regular cleanings. There was "Severe gum inflammation noted with upper right and left side of the jaws." New orders included to dip Tenant #6's toothbrush in chore and "brush for patient" twice per day.

Further record review faxes to a physician indicated the following:

-On 11-19-21 it was noted on 11-18-21 Tenant #6 was found on the floor in his apartment. Staff thought they observed "seizure activity." On 11-19-21 Tenant #6 was on the floor and

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"presenting with dyskinesia."

-On 12-10-21 (x 2) it was noted on 12-9-21 that Tenant #6 had fallen and hit his head on a table and had a laceration to the back of his head. Tenant #6 had a "recent history of exacerbation of his Parkinson's symptoms. Staff reported more seizure like activity and is "adamant that resident symptoms are worsening." Tenant #6 was sent out to the hospital for evaluation.

Continued record review revealed indicated Progress Notes indicated the following

-On 6-18-21 it was noted Tenant #6 had debridement procedure on the left pointer finger and had cast that was to be left on until the follow up. The cast was to be kept dry.

-On 6-29-21 it was noted Tenant #6 returned from a follow up appointment and a splint was to remain on the left index finger except for hygiene cares and a wrist brace was off for "wrist, hand, finger ROM 2-3 times daily."

- On 12-14-21 it was noted Tenant #6 was seen by PT and a PT note indicated "Resident has episodes of Severe Dykensenia (sic) that makes it hard for staff to assist with with (sic) mobility and ADL's. He falls very frequently, because of his PD there aren't any solutions to his frequent falls. He is sometimes able to get up on his ow2n (sic), but is unable to maintain his balance and falls immediately. I agree with Legacy Gardens staff that he would be safer and better supported in a SNF setting." Regional and local leadership staff were made aware.

Further record review evaluations were most recently completed on 10-22-21. Evaluations

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were was not completed as needed with significant change including with orders for oral care, increased assistance with transfers and eating and increased falls, including those with injury and discharge due to needing a higher level of care.

6. Record review on 12-20-21 of Tenant #8's file revealed a diagnoses of type 2 diabetes mellitus. The service plan dated 8-6-21 reflected Tenant #8 required assistance of one person for transfers. The service plan also reflects to assist with toileting every two hours during the day and twice at night.

When interviewed on 12-16-21 at approximately 3:55 p.m. Staff K said Tenant #8 was incontinent of urine from his knees to his shirt when she arrived for first shift. She said Tenant #8 was soaked when agency staff worked on third shift.

When interviewed on 12-21-21 at 2:51 p.m. Staff H said two staff were used for transfers all the time for Tenant #8. He was soaked head to toe when she arrived on first shift. She said third shift was supposed to toilet Tenant #8.

When interviewed on 12-14-21 at 11:09 a.m. Staff M said Tenant #8 sometimes took two people to transfer.

Continued record review revealed Progress Notes indicated the following:

-On 10-13-21 it was noted Tenant #8 complained of dysuria.

-On 10-13-21 it was noted an order was received to collect a urinalysis with culture and sensitivity.

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A 145	Continued From page 52 -On 10-15-21 it was noted staff attempted to collect a sample; however, it was difficult due to Tenant #8's incontinence. -On 10-18-21 it was noted a urine sample was collected and send to the lab on 10-15-21. The results were received on 10-18-21 and indicated abnormal findings including a white blood cell count of more than 100. -On 10-20-21 it was noted a new order was received for amoxcillion 500 mg, take orally three times per day for a urinary tract infection (UTI). Further record review revealed evaluations were dated 8-6-21 were not completed as needed with significant change related to Tenant #8's incontinence, his transfer status and a UTI. 7. When interviewed on 1-6-22 at 11:02 a.m. the Executive Director confirmed the most current evaluations (at the time of the onsite) were provided for the tenants listed above.	A 145		
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:	A 350		

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A 350	Continued From page 53 Based on observation, interview and record review the Program failed to update service plans as needed and failed ensure service plans reflected the service needs of the tenants. This pertained to 9 of 9 tenants reviewed (Tenants #1, #2, #3, #4, #5, #6 #7, #8, #9). Findings follow: 1. Record review on 12-13-21 and 12-14-21 of Tenant #1's file revealed a Physician Visit Form document dated 7-9-21 indicated Tenant #1 did not wear his continuous positive airway pressure (CPAP). New orders were received to help Tenant #1 apply the CPAP mask nightly, perform routine CPAP maintenance and contact the Veterans Affairs (VA) for CPAP supplies. The orders were noted on 7-9-21. Continued record review revealed Progress Notes indicated the following: -On 11-17-21 it was noted Tenant #1 had increased agitation. He had aggressive and confrontational behavior with other tenants and accused them of "imagined offences." Staff could redirect Tenant #1 with "much effort." The above was faxed to the primary care provider (PCP). -On 11-17-21 it was noted an addendum was made to the prior fax sent to the PCP. Tenant #1 "was again engaging in an unprovoked and aggressive manner" Tenant #1 was not easily redirected. Staff thought Tenant #1 seemed more pale. -On 12-7-21 it was noted a telephone call was received and indicated the VA offered "Behavioral Recovery." A person's name and number was provided to get assistance with addressing Tenant #1's behavior.	A 350		

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A 350	Continued From page 54 Further record review revealed Monthly Task Log documents from September to November 2021 reflected eight entries regarding bathing refusals. Continued record review revealed the current service plan was dated 6-25-21. The service plan did not reflect the CPAP and cares to be provided by staff, bathing refusals or the increased behaviors noted above that were sent to the PCP. 2. a. Record review on 12-14-21 and 12-15-21 of Tenant #2's file revealed the service plan dated 7-1-21 reflected Tenant #2 received occupational therapy (OT) and physical therapy (PT). When interviewed on 12-15-21 the Executive Director confirmed Tenant #2 no longer received therapy services. The service plan was not updated to reflect the discontinuation of therapy services. b. When interviewed on 12-14-21 at 10:30 a.m. Staff L identified Tenant #2 had exit seeking behavior. When interviewed on 12-14-21 at 11:09 a.m. Staff M identified Tenant #2 had exit seeking behavior. Continued record review revealed the service plan dated 7-1-21 reflected Tenant #2 had a history of wandering and would wander and tried to find her spouse. The service plan did not reflect Tenant #2's exit seeking behavior and interventions. 3. Record review on 12-14-21 and 12-15-21 of Tenant #3's file revealed Tenant #3 was admitted	A 350		

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on 7-12-21 and diagnoses included Alzheimer's disease and functional urinary incontinence. Tenant #3 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline.

Progress Notes indicated the following:

-On 7-22-21 it was noted that on 7-21-21 Tenant #3 grabbed a tenant's wrist and would not let go. Tenant #3 said he was trying to help the tenant to her room to lay down. A nurse tried to redirect Tenant #3 away for the other tenant. Tenant #3 was agitated and yelled at staff. Tenant #3 attempted to leave the building and when staff redirected, he grabbed a staff by the neck and pushed him against the wall. A nurse called 911 and Tenant #3 was transported to the hospital for evaluation.

-On 7-26-21 it was noted on 7-25-21 Tenant #3's spouse took him to urgent care related to complaints of hip pain. Tenant #3 returned with a new order for naproxen, 500 milligram (mg), take one tablet, orally twice per day with meals.

-On 11-16-21 it was noted Tenant #3's spouse was concerned Tenant #3 had increased pain with ambulation.

-On 12-1-21 it was noted a order was received to discontinue use of the CPAP.

-On 12-9-21 it was noted Tenant #3 returned from a visit with the PCP and a new was received for acetaminophen 500 mg, take two tablets, orally, twice daily.

Continued record review of After Visit Summary documents revealed on 7-1-21 Tenant #3 was

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seen by his PCP for a follow up, Alzheimer's disease, neck pain and urinary incontinence. His weight was 183 pounds. An After Visit Summary document revealed Tenant #3 was seen by his PCP on 12-9-21. He was seen for a follow up, pain, hip pain, neck pain and weight loss. His weight was 167 pounds. Tenant #3 had lost 16 pounds from 7-1-21 (admitted on 7-12-21) to 12-9-21 and was seen for weight loss at the 12-9-21 appointment.

When interviewed on 12-16-21 at 3:55 p.m. Staff K said Tenant #3's apartment had a urine odor. When staff tried to assist Tenant #3 with toileting he was aggressive. Tenant #3 urinated other places than his toilet. When Tenant #3 had a bowel movement he used the toilet.

When interviewed on 12-16-21 at 10:30 a.m. Staff A said Tenant #3 would not let a female staff assist him. She said Tenant #3 liked to go on his own and would urinate in his apartment, hallway and trash can. Regarding behavior, she said he was very aggressive. Tenant #3 tried to tell Tenant #2 what to do and tried to take care of her.

When interviewed on 12-21-21 at 2:51 p.m. Staff H said Tenant #3 had urinated in a cup, dining room, garden room and hallway. Tenant #3 had a toileting schedule; but refused.

Continued record review revealed Monthly Task Logs from September to December 2021 indicated 15 documented refusals for hygiene and grooming, 24 documented refusals for dressing and 23 documented refusals for toileting. The logs at times indicated Tenant #3 was very aggressive or was very upset with staff.

Further record review revealed the service plan

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dated 8-11-21 reflected staff assisted to wear the CPAP each night. The service plan also reflected Tenant #3 had a current or history of occasional "disruptive, aggressive, or socially in appropriate behavior, either verbally or physically improper." The service plan reflected staff assisted Tenant #3 to the bathroom every four hours while awake and that he took himself to the bathroom throughout the day and was incontinent. It reflected staff encouraged Tenant #3 to wear protective undergarments during the day and assist with changing it. If Tenant #3 had "continued refusals to notify the nurse for further assessment." The service plan was not updated as needed and did not reflect Tenant #3's weight loss, urination in places other than the toilet and possible interventions related to the behavior, the extent of the care refusals and at times aggressive behavior related to care refusals, hip pain with ambulation and the discontinuation of the CPAP.

4. Record review on 12-14-21 and 12-15-21 of Tenant #4's file revealed Tenant #4's service plan dated 3-2-21 reflected Tenant #4 ambulated independently and used a walker for ambulation.

When observed on 12-14-21 at approximately 4:35 p.m. Tenant #4 was seated in a wheelchair at the dining room table.

Continued record review revealed an incident reports indicated the following:

-On 7-1-21 it was noted Tenant #4 tried to get out of her wheelchair when the breaks were locked, tipped over the foot pedal and fell back.

-On 8-3-21 it was noted Tenant #4 was found by

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an aide in bed with a skin tear, the staff did not know how she got it and thought she hit her arm on the railing on her bed.

-On 10-9-21 it was noted Tenant #4 got up from her wheelchair, lost her balance and fell. There was a lot of blood present, 911 was called and Tenant #4 was sent out for evaluation.

Further record review revealed the service plan dated 3-2-21 did not reflect the use of the wheelchair or railing on Tenant #4's bed.

5. Record review on 12-15-21 and 12-16-21 of Tenant #5's file revealed diagnosis included type 2 diabetes mellitus. Tenant #5 was staged at a four on the GDS, which indicated moderate cognitive decline.

When interviewed on 1-5-22 at 11:41 a.m. Tenant #5's legal representative indicated she had requested the Program not allow Tenant #5 to leave the building with a friend.

When interviewed on 12-14-21 at 10:30 a.m. Staff L said Tenant #5's apartment had an odor. Tenant #5 had been been incontinent of BM between the bathroom and living room. Staff cleaned his apartment and at times there was BM on the walls.

When interviewed on 12-16-21 at approximately 3:55 p.m. Staff K said Tenant #5's apartment had an BM odor. She said Tenant #5 pulled down his pants and attempted to stand by the toilet. He was incontinent at least once per shift and at times would go in bed. At times Tenant #5 went to the bathroom independently and then laid in bed without after toileting care. Staff removed the

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sheets if soiled. Tenant #5 got himself dressed and if soiled would take a shower. Staff did not assist Tenant #5 with with a hearing aide.

When interviewed on 12-16-21 at 10:30 a.m. Staff A said Tenant #5's apartment had an odor. She said he was constantly incontinent on the floor. That morning Tenant #5 had a BM in the brief and got him to the bathroom and he sat on the chair and leaked on the floor. He was incontinent of bladder and bowel on the floor. She said staff tried to keep it cleaned up as best they could. Tenant #5 did not have a hearing aide.

When interviewed on 12-21-21 at 2:51 p.m. Staff H said Tenant #5 was toileted every one to two hours and he refused a lot. When Tenant #5 was incontinent it got all over the bed and floor. It happened a couple times per week.

When interviewed on 12-21-21 at approximately 9:50 a.m. Staff B said Tenant #5 was very hard to get to sit down for toileting. Tenant #5 would get up and go on the floor. She thought he was maybe on too many laxatives. She said he was incontinent at least twice per day. There had been BM in the closet.

When interviewed on 12-21-21 Nurse #1 said Tenant #5 occasionally had explosive diarrhea. Tenant #5 had BM on his mattress and recently had the mattress was replaced. The mattress had a vinyl cover that indicated not to remove.

When interviewed on 12-21-21 at 12:19 p.m. the Assistant Director of Nursing (ADON) said at times Tenant #5's apartment had an odor and they were trying to ensure the bathroom was cleaned daily. Staff did not assist Tenant #5 with

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hearing aides.

Continued record review indicated a podiatry office document indicated Tenant #5 was seen on 10-8-21. He needed diabetic foot care and reported pain on the bottom of his foot. The impression indicated hammer toe(s) on the right and left foot. It was recommended for periodic debridement and to only wear "prescribed diabetic footwear." Tenant #5 had "severe Equinus" and PT was recommended for stretching and mobility.

Physician Visit Forms indicated the following:

-On 4-5-21 it was noted Tenant #5 was concerned about this teeth and said they hurt and were not working correctly. Tenant #5 had moderate gum inflammation. New orders indicated to monitor Tenant #5's oral hygiene. Tenant #5 "was not brushed for today's appt-teeth were full of food and debris."

-On 12-21-21 it was noted Tenant #5 had "moderate-heavy deposit and food on teeth." Tenant #5 was not able to care for his teeth and had a very dry mouth. It was noted to have water at bedside. A new order was received to brush Tenant #5's teeth twice daily (a.m. and p.m.).

Further record review revealed the service plan dated 4-9-21 reflected Tenant #5 was able to brush his own teeth. The service plan indicated Tenant #5 was at times incontinent of bowel and consistently incontinent of urine. Tenant #5 had a history of touching the BM and placing it inappropriate areas. Staff assisted to the bathroom every two hours during the day and twice in the evening. It also reflected Tenant #5 had a riser on the toilet and took it off. The

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service plan also reflected assistance with a hearing aide. The service plan was not updated as needed to reflect assistance needed with oral cares, Tenant #5's incontinence related to the bed and floor, housekeeping and linen laundry related to the incontinence and to keep the mattress cover on the bed. The service plan also did not reflect the recommendation for the diabetic footwear and foot pain or the legal representative's request for Tenant #5's not to leave the building with a friend. The service plan did not reflect the current status with Tenant #5's hearing and if a hearing device was available and if so, if staff assisted.

6. Record review on 12-15-21 and 12-16-21 of Tenant #6's file revealed Tenant #6 had a diagnoses of Parkinson's disease.

When observed on 12-13-21 at lunch Tenant #6 was assisted by his family member to eat and was seated in a wheelchair.

Review of incident reports and Progress Notes indicated Tenant #6 had over falls or incidents from 5-29-21 to 12-10-21.

When interviewed on 12-14-21 at 10:30 a.m. Staff L said staff needed more training related to Tenant #6 and his Parkinson's could get out of control.

When interviewed on 12-14-21 at 11:09 a.m. Staff M identified Tenant #6 required a significant amount of cares and time. She said he was very strong. He was working with PT.

When interviewed on 12-16-21 at approximately 3:55 p.m. Staff K said it depended on the day

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regarding transfers, regarding if one or two people were used with Tenant #6. At times he was resistive and leaned back. If he was not cooperative, it took two people. She said when he slipped out of bed on third shift, they put a pillow and a blanket on the floor and it seemed to relax him when he was on the floor. She said when fell he hit his head really hard and previously had staples.

When interviewed on 12-16-21 at 10:30 a.m. Staff A said Tenant #6 had "spasms." She said was dependent for toileting, dressing and bathing. She said he constantly fell and usually took two people for transfers 100% of the time. Sometimes staff assisted with eating.

When interviewed on 12-21-21 at 2:51 p.m. Staff H said Tenant #6 took two to three staff to transfer. She said he had seizure type episodes. Tenant #6's family member helped with feeding Tenant #6. Tenant #6 had falls and injuries where he hit his head.

When interviewed on 12-21-21 the Nurse #1 said Tenant #6 had severe Parkinson's disease and sometimes took two to transfer. Tenant #6 walked around the building with PT.

When interviewed on 12-21-21 at 12:19 p.m. the ADON said at times took two people for transfers. PT was working with him. Tenant #6's family member visited daily and assisted with cares. She said it depended on the day but approximately 30 to 40 % of the time Tenant #6 took two people for transfers. She recently spoke with PT and they said he would be safer at a higher level of care.

When interviewed on 12-21-21 at 1:24 p.m. the

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Executive Director said there was a discussion last week regarding Tenant #6's and his level of care.

Continued record review revealed Physician Visit Forms indicated the following:

-On 11-4-21 it was noted Tenant #6 mentioned some depressed thoughts and to monitor for increased tearfulness and a depressed mood.

-On 11-17-21 it was noted food being trapped was causing gingivitis and Tenant #6 needed regular cleanings. There was "Severe gum inflammation noted with upper right and left side of the jaws." New orders included to dip Tenant #6's toothbrush in chlorhexidine and "brush for patient" twice per day.

Further record review faxes to a physician indicated the following:

-On 11-19-21 it was noted on 11-18-21 Tenant #6 was found on the floor in his apartment. Staff thought they observed "seizure activity." On 11-19-21 Tenant #6 was on the floor and "presenting with dyskinesia."

-On 12-10-21 (x 2) it was noted on 12-9-21 that Tenant #6 had fallen and hit his head on a table and had a laceration to the back of his head. Tenant #6 had a "recent history of exacerbation of his Parkinson's symptoms. Staff reported more seizure like activity and is "adamant that resident symptoms are worsening." Tenant #6 was sent out to the hospital for evaluation.

Continued record review revealed indicated Progress Notes indicated the following

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(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 350	Continued From page 64 -On 6-18-21 it was noted Tenant #6 had debridement procedure on the left pointer finger and had cast that was to be left on until the follow up. The cast was to be kept dry. -On 6-29-21 it was noted Tenant #6 returned from a follow up appointment and a splint was to remain on the left index finger except for hygiene cares and a wrist brace was off for "wrist, hand, finger ROM 2-3 time daily." - On 12-14-21 it was noted Tenant #6 was seen by PT and a PT note indicated "Resident has episodes of Severe Dykensenia (sic) that makes it hard for staff to assist with with (sic) mobility and ADL's. He falls very frequently, because of his PD there aren't any solutions to his frequent falls. He is sometimes able to get up on his ow2n (sic), but is unable to maintain his balance and falls immediately. I agree with Legacy Gardens staff that he would be safer and better supported in a SNF setting." Regional and local leadership staff were made aware. Further record review revealed Tenant #6's service plan was updated on 10-22-21. The service plan reflected Tenant #6 ate independently. Staff cut items on his plate prior to serving and if tremors were observed to offer hand over hand assistance. The service plan indicated Tenant #6 assistance of one with transfers. The service plan reflected Tenant #6 was a fall risk and provided some interventions. The service plan reflected Tenant #6 had a cast on his left hand and to cover while bathing. The service plan was not updated with the removal of the cast, with orders for oral care, increased assistance with transfers, increased assistance with eating, increased falls, including those with injury and possible discharge due to needing a	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0163	A. BUILDING: _____ B. WING _____	C 01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDENS	15 SILVERCREST PLACE IOWA CITY, IA 52240

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A 350	Continued From page 65 higher level of care. 7. Record review on 12-20-21 of Tenant #7's file revealed the service plan dated 3-17-21 reflected Tenant #7 reflected cueing and or observation during bathing. Staff was to remain with Tenant #7 for the entire process and assisted with hard to reach areas. Continued record review revealed Monthly Task Log documents from October 2021 to December 2021 reflected four refusals of bathing, including one entry on 11-3-21, when staff charted Tenant #7 became agitated. The service plan did not reflect Tenant #7 as times refused bathing. 8. Record review on 12-20-21 of Tenant #8's file revealed a diagnoses of type 2 diabetes mellitus. The service plan dated 8-6-21 reflected Tenant #8 required assistance of one person for transfers. The service plan also reflected to assist with toileting every two hours during the day and twice at night. When interviewed on 12-16-21 at approximately 3:55 p.m. Staff K said Tenant #8 was incontinent of urine from his knees to his shirt when she arrived for first shift. She said Tenant #8 was soaked when agency staff worked on third shift. When interviewed on 12-21-21 at 2:51 p.m. Staff H said two staff were used for transfers all the time for Tenant #8. He was soaked head to toe when she arrived on first shift. She said third shift was supposed to toilet Tenant #8. When interviewed on 12-14-21 at 11:09 a.m. Staff M said Tenant #8 sometimes took two people to	A 350		

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A 350	Continued From page 66	A 350		

transfer.

Continued record review revealed Progress Notes indicated the following:

-On 10-13-21 it was noted Tenant #8 complained of dysuria.

-On 10-13-21 it was noted an order was received to collect a urinalysis with culture and sensitivity.

-On 10-15-21 it was noted staff attempted to collect a sample; however, it was difficult due to Tenant #8's incontinence.

-On 10-18-21 it was noted a urine sample was collected and send to the lab on 10-15-21. The results were received on 10-18-21 and indicated abnormal findings including a white blood cell count of more than 100.

-On 10-20-21 it was noted a new order was received for amoxcillion 500 milligram, take orally three times per day for a urinary tract infection (UTI).

Further record review indicated the service plan reflected PT and OT services.

On 1-6-22 the Executive Director confirmed therapy services were discontinued for Tenant #8.

Continued record review revealed the service plan dated 8-6-21 was not updated to reflect the level of Tenant #8's incontinence and other interventions, his transfer status, a UTI and discontinuation of therapy services.

9. Record review on 12-20-21 of Tenant #9's file

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A 350	Continued From page 67	A 350		

revealed diagnoses included: dementia without behavioral disturbance. Tenant #9 was staged at a four on the GDS, which indicated moderate cognitive decline.

Monthly Task Log documents from October 2021 to December 2021 reflected eight refusals of bathing. The service plan did not reflect Tenant #9 as times refused bathing.

Continued record review revealed Incident Reports indicated the following:

-On 6-21-21 it was noted Tenant #9 was found by kitchen staff walking up the sidewalk. Tenant #9 walked out of gate as it was unlocked.

-On 8-8-21 it was noted Tenant #9 exited the building through the rear exit. Staff searched the outside of the parameter and completed a head count inside the building. Staff called the nurse on-call, who called 911 for assistance in finding Tenant #9. Police located Tenant #9 a distance from the Program. Upon return to the building, it was noted Tenant #9 had a skin tear. He was sent was sent to the hospital for evaluation.

-On 9-26-21 it was noted Tenant #9 went out of the lobby entrance, the pagers went off and staff responded. Tenant #9 was in the parking lot. Staff called for assistance to get Tenant #9 back to the building as he was aggressive. When back in the building it was noted Tenant #9 was very upset as he was not able to leave.

-On 10-9-21 it was noted Tenant #9 set off the front door alarm at 7:52 p.m. Staff was busy with another tenant. At 7:56 p.m. another staff answered the front door alarm, called for assistance and found Tenant #9 outside walking

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A 350	Continued From page 68 towards the independent living building. Tenant #9 was redirected back to the building at 7:58 p.m. Continued record review revealed the service plan dated 8-10-21 Tenant #9 had a history of wandering and exit seeking at his current community per Tenant #9's family. The service plan reflected Tenant #9 would frequently exit seek and 30 minute checks were in place. The service plan did not reflect that Tenant #9 had left the building on multiple occasions as noted above, including one incident where he left the grounds of the campus. 10. When interviewed on 1-6-22 at 11:02 a.m. the Executive Director confirmed the most current service plans (at the time of the onsite) were provided for the tenants listed above.	A 350		
A 370	481-69.26(3)a 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. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain signed service plans when a significant change occurred. This	A 370		

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A 370	Continued From page 69 pertained to 2 of 3 tenants reviewed with a significant change service plan completed from April 2021 to current (Tenants #5 and #6). Findings follow: 1. Record review on 12-15-21 and 12-16-21 of Tenant #5's file revealed a Progress Note dated 4-9-21 indicated the nurse completed a change of condition related to increased incontinence and toileting assistance. A service plan was completed for a change of condition for Tenant #5 on 4-9-21. The service plan was signed by a nurse on 4-9-21; however, was not signed by Tenant #5 or his legal representative. 2. Record review on 12-15-21 and 12-16-21 of Tenant #6's file a Progress Note dated 10-27-21 (late entry) indicated a change of condition was completed on 10-20-21. A service plan was completed for a change of condition for Tenant #6 on 10-22-21. The service plan was signed by a nurse; however, was not signed by Tenant #6 or his legal representative. 3. When interviewed on 1-6-22 at 11:02 a.m. the Executive Director confirmed the most current service plans (at the time of the onsite) were provided for the tenants listed above.	A 370		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.	A 545		

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A 545	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete eight hours of dementia-specific education and training within 30 days of employment. This pertained to 3 of 7 current staff reviewed (Staff D, F and G). Findings follow: 1. Record review on 12-9-21 and 12-13-21 of Staff D's training documents revealed a hire date of 8-19-21. There was no dementia- specific education and training completed at the time of the review. 2. Record review on 12-9-21 and 12-13-21 of Staff F's training documents revealed a hire date of 8-23-21. A certificate for 8 hour dementia training was provided; however was dated 10-27-21, which was greater than 30 days from employment. 3. Record review on 12-9-21 and 12-13-21 of Staff G's training documents revealed a hire date of 10-30-21. There was no dementia- specific education and training completed within 30 days of employment or at the time of the review. 4. When interviewed on 1-6-21 at 11:02 a.m. the Executive Director said Staff D was no longer employed at the Program and no additional dementia education was found for the staff listed above.	A 545		

OK 2/15/22

15 Silvercrest Place Iowa City, IA 319-341-0911

Plan of Correction for Legacy Gardens
In Response to
Recertification Visit
Dated 12/8/21-1/6/2022
Complaints #97066-C, #98157-C, #98768-C, #100905-C

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared is prepared and/or executed solely because it is required by the provisions of state law.

Regulatory Insufficiency: Dependent Adult Abuse Reports: 235B.3a
If a staff member or employee is required to report pursuant to this section, the person shall immediately notify the department and shall also immediately notify the person in charge or the person's designation agent.

1. **Elements detailing how the program will correct the insufficiency.**
   a. The person in charge or designee will immediately notify the department if an allegation of abuse is reported.
2. **What measures will be taken to ensure the problem does not recur.**
   a. On February 10th, 2022 documented re-education in relation to 235B.3a was provided to Jacobi Feckers-ED, Natasha Squires, Assistant ED, Katie Deitz, DON and Julie Reynolds, ADON by Erica Ewoldt, Director of Health Care Services.
   b. An all-staff in-service is scheduled for February 16th, 2022 to review the Abuse Reporting and Investigation policy and procedure.
3. **How the program plans to monitor performance to ensure compliance.**
   a. Health Services team will provide periodic re-education to leadership team and follow up on any allegations of abuse to ensure compliance
   b. Program Director or designee will provide yearly re-education to staff on Abuse Reporting and Investigation policy and procedure.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. March 1st, 2022

Regulatory Insufficiency: Program Policies and Procedures: 481-67.2(3)
67.2(3)-The program shall follow the policies and procedures established by the program.

1. **Elements detailing how the program will correct the insufficiency.**
   a. The program will follow the polices and procedures established by the program.
2. **What measures will be taken to ensure the problem does not recur.**
   a. On February 10th, 2022 re-education related to 67.2(3) was provided to Jacobi Feckers-ED, Katie Deitz-DON, and Julie Reynolds-ADON by Erica Ewoldt, Director of Health Care Services.

b. An in-service is scheduled for February 16th, 2022 to review program policies and procedures-specifically resident fall policy and procedure and alarmed door policy and procedure for locked memory unit.

3. **How the program plans to monitor performance to ensure compliance.**
   a. Program Director or designee will periodically review response times to door alarms.
   b. Health Services Team will periodically audit incident reports and supporting documentation for completion at monthly visit.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. **March 1st, 2022**

Regulatory Insufficiency: Tenant Rights: 481-67.3(1)

481-67.3 Tenant rights. All tenants have the following rights:

67.3(1)-To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

1. **Elements detailing how the program will correct the insufficiency**
   a. Staff will treat tenants with consideration, respect, and full recognition of personal dignity and autonomy.
2. **What measures will be taken to ensure the problem does not recur.**
   a. On February 10th, 2022 documented reeducation related to 67.3(1) was provided to Jacobi Feckers-ED, Katie Deitz-DON, and Julie Reynolds-ADON by Erica Ewoldt, Director of Health Care Service.
   b. Inservice scheduled on February 16th, 2022 at 2pm with staff to review tenant rights policy and procedure.
3. **How the program plans to monitor performance to ensure compliance**
   a. Program Director or designee to provide yearly in-service related to tenant/resident rights.
   b. Health Services Team to periodically observe interactions during monthly visit.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. March 1st, 2022

Regulatory Insufficiency: Tenant Rights: 481-67.3(2)

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.

1. **Elements detailing how the program will correct the insufficiency.**
   a. Residents will receive care, treatment, and services which are adequate and appropriate
2. **What measures will be taken to ensure the problem does not recur.**
   a. On February 10th, 2022 re-education in relation to 67.3(2) was provided to Katie Deitz, DON and Julie Reynolds, ADON by Erica Ewoldt, Director of Health Care Services.
   b. In-service scheduled for February 16th, 2022 to provide training to all nursing staff on proper documentation of ADL's in Yardi.
3. **How the program plans to monitor performance to ensure compliance.**
   a. DON or ADON will perform periodic audits of ADL logs to ensure documentation is complete.
   b. Health Services team will perform audits at a minimum of yearly to ensure compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. March 1st, 2022

Regulatory Insufficiency: Medications: 481-67.5(2)f(4)

67.5(2): Each program shall follow its own written medication policy, which shall include the following:

f. When medications are administered traditional by the program:

(4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.

1. **Elements detailing how the program will correct the insufficiency.**
   a. Program will follow its own written medication policy. Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.
2. **What measures will be taken to ensure the problem does not recur.**
   a. On February 10th, 2022 documented re-education related to 67.5(2)f(4) was provided to Katie Deitz, DON and Julie Reynolds, ADON by Erica Ewoldt, Director of Health Services.
   b. Inservice scheduled for all medication managers on February 16th, 2022 to review medication administration policy.
3. **How the program plans to monitor performance to ensure compliance.**
   a. Health Services team will perform periodic audit of charts during monthly visit.
   b. Annual and as needed review of compliance by Director of Health Care Services.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. March 1st, 2022

Regulatory Insufficiency: Staffing: 481-67.9(4)b

67.9(4): Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

1. **Elements detailing how the program will correct the insufficiency.**
   a. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse.
2. **What measures will be taken to ensure the problem does not recur.**
   a. Education provided to Katie Deitz, DON during onboarding with Health Services team on December 27th, 2021.
   b. On February 10th, 2022 documented re-education related to 67.9(4)b was provided to DON, Katie Deitz by Jacobi Feckers, ED and Erica Ewoldt, Director of Health Services. Katie expressed understanding of need for all program staff to receive delegation within 30 days of beginning employment.
3. **How the program plans to monitor performance to ensure compliance.**
   a. Program Director or designee will perform monthly audits for 6 months to ensure delegations are complete within 30 days of beginning employment and periodically thereafter.
   b. Annual and as needed review of compliance by Health Services team.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. February 10th, 2022

Regulatory Insufficiency: Staffing 481-67.9(4)f

67.9(4): Nurse delegation procedures. The program's registered nurse shall ensure certified and non-certified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

f. Services shall be provided to tenants in accordance with the training provided.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Services shall be provided to tenants in accordance with the training provided.
2. **What measures will be taken to ensure the problem does not recur.**
    a. Education provided to Katie Deitz, DON during onboarding with the health services team.
    b. On February 10th, 2022 documented re-education related to 67.9(4)f was provided to Katie Deitz, DON by Jacobi Feckers, ED and Erica Ewoldt, Director of Health Services. Katie expressed understanding of expectation for services to be provided to tenant in accordance with the training provided.
    c. Inservice scheduled for all medication managers on Wednesday, February 16th, 2022 to review blood glucose monitoring and administered insulin.
3. **How the program plans to monitor performance to ensure compliance.**
    a. Katie Deitz, DON or designee will perform periodic review of competency of delegated staff.
    b. Annual and as needed review of compliance by Health Services Team.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. March 1st, 2022

<u>Regulatory Insuffciency: Staffing 481-67.9(4)g</u>

67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and non-certified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

g. The program shall have in place a system by which certified and noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years and shall be accessible to the department upon request.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Program will re-introduce system by which certified and noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee and will document occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required will be retained for three years and available to the department upon request.
2. **What measures will be taken to ensure the problem does not recur.**
    a. Education provided to Katie Deitz, DON during onboarding with Health Service team on December 27th, 2021.
    b. On February 10th, 2022 documented re-education related to 67.9(4)g was provided to Katie Deitz, DON and Julie Reynolds, ADON by Jacobi Feckers, ED and Erica Ewoldt, Director of Health Services. Katie and Julie expressed understanding of expectation to have a system in place by which certified and noncertified staff can communicate in writing occurrences that differ from the tenant's normal health, functional, and cognitive status. Also expressed understanding of expectation to obtain records for three years and

have them accessible to department upon request. Reviewed staff to nurse communication policy and procedure. Katie and Julie expressed verbal understanding.

c. Inservice scheduled for nursing staff on February 16th, 2022 to review Staff to Nurse communication policy and procedure and Staff Communication Report.

3. **How the program will correct the insufficiency.**
   a. Program Director or designee will perform periodic checks to ensure staff communication report form is being utilized.
   b. Annual and as needed reviews will be completed by Health Services team.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. March 1st, 2022

Regulatory Insuffciency: Evaluation of Tenant 481-69.22(3)

69.22(3)-Evaluation of annual and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.

1. **Elements detailing how the program will correct the insufficiency.**
   a. The program shall evaluate each tenant's functional, cognitive and health status as needed with a significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.
2. **What measures will be taken to ensure the problem does not recur.**
   a. Initial training provided to Katie Dietz, DON during onboarding with Health Services Team on December 27th, 2021.
   b. On February 10th, 2022 documented re-education related to 69.22(3) was provided to Katie Dietz, DON and Julie Reynolds, ADON by Jacobi Feckers, ED and Erica Ewoldt, Director of Health Services. Both Katie and Julie expressed understanding of regulation 69.22(3) and service plan policy and procedure.
3. **How the program will correct the insufficiency.**
   a. Health Services team will perform periodic audit of charts during monthly visit.
   b. Annual and as needed review of compliance by Director of Health Care Services.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. February 10th, 2022

Regulatory Insufficiency: Service Plans 481-69.26(1)

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.

1. **Elements detailing how the program will correct the insufficiency.**

i. 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.

2. **What measures will be taken to ensure the problem does not recur.**
    a. Initial training provided to Katie Deitz, DON during onboarding with Health Services team on December 27th, 2021.
    b. On February 10th, 2022 documented re-education related to 69.26(1) was provided to Katie Dietz, DON and Julie Reynolds, ADON by Erica Ewoldt, Director of Health Care services.
3. **How the program plans to monitor performance to ensure compliance.**
    a. Regional nurse or designee will perform periodic audit of charts during scheduled monthly visit.
    b. Annual and as needed review of compliance by Health Services team.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. February 10th, 2022

Regulatory Insufficiency: Service Plans 481-69.26(3)a

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.

a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.

1. **Elements detailing how the program will correct the insufficiency.**
    a. When a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.
2. **What measures will be taken to ensure the problem does not recur.**
    a. Initial training provided to Katie Deitz, DON by Health Services team during onboarding on December 27th, 2021.
    b. On February 10th, 2022 documented re-education related to 69.26(3) was provided to Katie Dietz, DON and Julie Reynolds, ADON by Erica Ewoldt, Director of Health Services.
3. **How the program plans to monitor performance to ensure compliance.**
    a. Regional nurse or designee will perform periodic audit of service plans during scheduled monthly visit.
    b. Annual and as needed review of compliance by Health Services team.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. February 10th, 2022

Regulatory Insufficiency: Dementia Specific Education for Personnel 481-69.30(1)

69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.

1. **Elements detailing how the program will correct the insufficiency.**
    a. All personnel employed by or contracting with the dementia specific program will receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.
2. **What measures will be taken to ensure the problem does not recur.**

a. On February 10th, 2022 documented re-education related to 69.30(1) was provided to Jessica German, Team Member Services and Katie Deitz, DON by Jacobi Feckers, Executive Director.

3. **How the program plans to monitor performance to ensure compliance.**
   a. Assistant ED or designee will do period audits of employee training records.
   b. Program Director will perform annual and as needed audits of employee training records.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. February 10th, 2022