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
	S0375	A. BUILDING: _____ B. WING _____	C 10/05/2023

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

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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 impairment: 6 Number of tenants with cognitive impairment: 23 Total census: 29 The following regulatory insufficiencies were cited during the investigation of Incident #111481-I and the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000	See Attached POC 2/28/24	
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 the Program failed to follow policies and procedures related to door alarm response, missing tenant and head injuries. This pertained to 1 of 1 tenant reviewed that eloped (Tenant #1) and 2 of 2 tenants reviewed that fell and hit their head (Tenant #2 and Tenant #6). Findings follow: The Program was a dedicated dementia specific program comprised of two memory care units, one on first floor and one on second floor, both required to have operating door alarms. Tenant #1 resided on the first floor memory care unit. The memory care units were attached by	A 150		

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

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A 150	Continued From page 1 structure to a general population assisted living program, which was not required to have door alarms. 1. Record review on 9/26/23 of Tenant #1's file revealed an 3/5/23 at 3:26 p.m. Tenant #1 eloped. The incident report indicated staff heard the door alarm, completed a head count, and called the front desk to see if she had seen Tenant #1. The front desk staff had not seen him. The front desk staff called back and said Tenant #1 was outside. Activity staff assisted him back into the building and took him for a walk inside. The incident report indicated the on-call nurse was notified on 3/5/23 at 3:30 p.m. Tenant #1's family was notified 3/6/23 at 5:00 p.m. the primary care provider (PCP) on 3/6/23 at 5:28 p.m. There were no vital signs recorded on the incident report and it indicated there were no injuries. The incident report also indicated there were no witnesses. Record review of the Program's investigation materials indicated the Assistant Director of Health and Wellness (ADOHW) reviewed an incident report on 3/6/23 and became aware Tenant #1 had eloped on 3/5/23. The ADOHW interviewed Staff H and Staff I who worked at the time of the elopement. They reported they were helping other tenants when the door alarm went off. They ensured safety of the tenants they worked with and checked the door alarm. They did not see anyone at the door and completed a head count. It was noted Tenant #1 was missing. Staff called the front desk staff and she had not seen him. Less than 10 minutes later the front desk staff called back and said Tenant #1 was outside. Staff on duty brought him back to the unit. The staff on duty did not contact the Executive Director or the on-call nurse.	A 150		

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A 150	Continued From page 2 The Executive Director and an interim staff, interviewed Staff J related to the elopement. Staff J took Tenant #1 and another tenant to an activity outside of the memory care unit on 3/5/23. After the activity Staff J returned to the unit with Tenant #1 and the other tenant. She "dropped him off", once Tenant #1 was inside and the door was locked, Staff J left with to take the other tenant back to the second floor memory care unit. She returned the other tenant to the unit and took the elevator back downstairs. The receptionist asked Staff J if she had seen Tenant #1 and Staff J said she just returned him to the unit. The receptionist told her he was missing and at that time Tenant #1 walked into the front main entrance (of the general population section of the building). Staff J reported Tenant #1 wore his hat and coat and he did not wear them when she left him five minutes prior. Review of the Program's investigation revealed the final summary indicated from the time from when the door alarm sounded until Tenant #1 was brought back was 10 minutes. It was clarified Staff J returned Tenant #1 to the unit and not Staff H and Staff I. Tenant #1 went outside as he was seen walking into the front entrance of the building. The temperature was approximately 32 degrees and he was wearing a coat and hat. It was determined Tenant #1 put on his coat and hat and left shortly after retuning from the activity. Staff did not report the elopement to the ADOHW or the Executive Director or nurse-on call. Tenant #1 did not sustain any injuries. Continued record review revealed verbal re-education was provided to Staff H and Staff I regarding thoroughly checking inside and outside the door as they had only checked inside the door	A 150		

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and then started the head count. Staff J was provided verbal re-education to inform staff when she was taking a tenant to an activity and returning a tenant from an activity.

When interviewed on 9/27/23 at 1:55 p.m. Staff H said she worked second shift and heard the door alarm for memory care entrance door. She was in another tenant's apartment assisting a tenant. After a short period, she responded, checked the doors, did a head count and determined Tenant #1 was unaccounted for. Another staff also came to assist. The front desk staff was called and within a few minutes they called and he was located. She said he did not have a coat, but was happy and had no injuries. He said he was going for a walk. The nurse on-call (from a different building) was notified. Staff H said she completed an incident report. She had last seen Tenant #1 about 2:30 p.m. at shift change when a head count was completed.

When interviewed on 10/4/23 at 2:30 p.m. the Executive Director said the ADOHW notified her of Tenant #1's elopement on 3/6/23. The ADOHW reported staff heard the door alarm, secured the tenants they worked with and responded, but did not check outside of the door. They started a head count and noted he was missing. Staff called the receptionist, who then called back later and said Tenant #1 was outside. The Executive Director and an interim staff interviewed Staff H, Staff I and Staff J. Staff J reported she had Tenant #1 at at activity with another tenant and took him back to the unit and then took the other tenant back. She took the elevator downstairs and the receptionist asked if she had seen Tenant #1 and he came walking back in the door. Staff J did not tell the staff Tenant #1 was back when she dropped him off.

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Staff H and Staff I told the Executive Director they did not check the outside of the door that alarmed. Both staff were in other apartments when it occurred and they were not sure if he was still with Staff J. She said she found out later staff called the nurse on-call (nurse from another building).

When interviewed on 10/4/23 at 3:14 p.m. the ADOHW said she could not remember how she found out but it was written documentation regarding Tenant #1's elopement on 3/5/23. She found out on Monday (3/6/23). She said staff heard the door alarms go off and called the front desk. The front desk staff had not seen Tenant #1 and then called back and said he was back in the building. Staff H and Staff I called the nurse on-call (nurse from a different building). The ADOHW was not notified at that time of the incident. Tenant #1 did not sustain any injuries. She said Staff H and Staff I did not look out the door that alarmed. The ADOHW followed up and notified Tenant #1's family and the PCP.

Record review of door alarm records indicated the Staff J opened the memory care first floor door at 3:13 p.m. Door alarm records indicated the memory care first floor door was "door forced" at 3:21 p.m.

The State Climatologist provided the following weather conditions at 4:00 p.m. at the Iowa City Municipal Airport: temperature was 50 degrees, relative humidity was 56%, winds were from the east at 16 miles per hour (mph), with gusts to 24 mph. It was overcast with no precipitation.

There were no witnesses to Tenant #1's elopement. The video footage at the time of elopement was not available at the time of

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investigation. The video footage was not reviewed by Program staff at the time of the elopement. It could not be determined the path or Tenant #1's whereabouts during the elopement. It was determined he left the unit via the memory care door and he was observed outside the building returning via the main front entrance (general population section of the building). The path and terrain Tenant #1 traveled could not be observed at the time of the investigation.

Record review of Tenant #1's file revealed he was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The Master Assessments dated 1/20/23 and 4/20/23 indicated under the Elopement Risk Evaluation, Tenant #1 wandered and had unsafe wandering out of the building with staff on 1/7/23. It indicated he exhibited exit seeking behavior and was ambulatory. After Tenant #1's elopement on 3/5/23 there was no documented evaluation (see 69.22 (3) for more information). The service plan in place at the time of the elopement indicated elopement interventions, wellness checks and wandering.

Record review of the Program's Dementia Specific Exit Doors policy and procedure indicated when a door alarm sounded staff would promptly check the door. The area inside and outside the door would be "thoroughly" checked. All tenants would be accounted for and if a tenant was not accounted for the Missing Resident policy and procedure would be initiated.

The Program's Missing Resident policy and procedure indicated staff would check the sign out sheet to determine if the tenant had left the building. If the tenant was not signed out, staff

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would then notify the nurse or designee. A search would be completed of the tenant's apartment and surrounding common areas. The nurse or designee would notify the Executive Director or designee, who would notify the family and determine if the tenant was with family. After a search of the grounds was completed law enforcement would be notified. When the tenant was located all staff would immediately be notified and the nurse or designee would complete an evaluation of the tenant. The tenant would be examined for any injuries, the family would be notified and provided a report of what had occurred, the incident report would be completed and placed in the file, the PCP would be notified and the Department would be notified.

In summary, Tenant #1, who had left the building previously with staff on 1/7/23 and who had known exit seeking and wandering behavior, eloped on 3/5/23. Staff responded to the door alarm to the memory care entrance door but staff failed to check the outside of the door that alarmed as required by the policy and procedure. Tenant #1 returned into the building and it was not determined how he exited the building or the path traveled to return to the building. Staff notified the nurse on-call (nurse from another building); however, the Executive Director was not notified of elopement until 3/6/23. An evaluation of Tenant #1 was not completed post elopement as required by policy and procedure and the incident report lacked documented vital signs, despite Tenant #1 being observed outside. Tenant #1's family and PCP were also not notified until 3/6/23 at 5:00 p.m. and 5:28 p.m., respectively. Staff did not follow the door alarm and missing tenant policies and procedures related to Tenant #1's elopement.

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A 150	Continued From page 7 2. Record review on 9/27/23 of Tenant #2's file revealed an incident report dated 9/15/23 at 3:45 p.m. reflected staff heard Tenant #2 scream and went to her apartment she was observed on her left side with her face on the floor. Tenant #2 sustained a laceration above her left eye. Tenant #2 was sent out for medical care by her family. Tenant #2's blood pressure was 180/120. Staff called the front desk and they contacted the nurse for staff. Continued record review revealed no entries in Progress Notes related to Tenant #2's fall, the medical care received, when Tenant #2 returned or the nurse's instructions for neurological checks upon Tenant #2's return. A nurse review was also not completed related to the fall. Record review on 9/28/23 of Tenant #6's file revealed and incident report dated 9/2/23 at 2:45 a.m. reflected staff found Tenant #6 on the floor when checks were completed. Tenant #6 had a bruise and bleeding over her right eye and a bruise on her wrist and knee. The September 2023 medication administration record also reflected Tenant #6 was prescribed Plavix, and anticoagulant medication. Continued record review revealed an entry in Progress Notes dated 9/19/23 (late entry for 9/5/23) indicated Tenant #6 fell on 9/2/23 and a follow up was completed on 9/4/23. Tenant #6 sustained a laceration and bruise above her right eye. Bruising was also noted to her right wrist. There was no documentation regarding Tenant #6 being encouraged to be sent out for evaluation or if Tenant #6 or her legal representative refused to go to the hospital for evaluation. There were also no documented neurological checks per the	A 150		

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A 150	Continued From page 8 nurse's direction. A nurse review was not completed related to fall when the fall occurred. A late entry was completed dated 9/19/23 for the fall that occurred on 9/2/23. Record review of the Program's policy and procedure related to head injuries indicated if a tenant had a fall or incident that involved striking their head on a solid surface the nurse would be notified immediately. The nurse would direct the tenant be transported to the emergency room for evaluation. IF the tenant or tenant's family refused, the nurse would provide further education regarding the importance of being evaluated. If they refused, the refusal would be documented and the PCP would be notified. As applicable the tenant or family would be notified. If the tenant refused care, the nurse would complete neurological checks, as intervals determined by the nurse. The nurse would complete a nurse review, review the service plan and add interventions to the service plan as needed. IF the tenant was transported to the hospital for evaluation, the nurse would be notified of their return and neurological checks would be instructed at intervals as determined by the nurse. The nurse would completed a nurse review and review the service plan and add interventions as necessary. 3. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed the above finding related to Tenant #2 and Tenant #6.	A 150		
A 270	481-67.5(2)f(1) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following:	A 270		

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A 270	Continued From page 9 f. When medications are administered traditionally by the program: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure staff administering medications completed a state-approved medication manager course prior. This pertained to 1 of 1 staff observed on a medication pass (Staff F). Findings follow: 1. Observation on 9/26/23 during the time of the lunch medication pass Staff F administered medications to four tenants, including Tenants #2, #4 and #5. Staff F assisted Tenant #4 with a blood glucose check and insulin administration (pen). He used hand sanitizer (the pump did not work) he removed the top to apply to his hand and donned gloves. There was no barrier observed on the table where Tenant #4 and Staff F were seated and the supplies were located (small table with activity supplies on other the other side of a partial wall from dining room	A 270		

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tables). He wiped her finger with alcohol and then attempted to check her blood glucose several times, different fingers before getting a reading for the glucometer. The finger stick occurred in the middle of the finger tip and not off center. He reported a reading of 277 (279 was recorded on the MAR). After the blood glucose reading he touched Tenant #4's walker, locked the medication cart and touched the tablet with the gloves that were used during the blood glucose check. No glove change was observed after the blood glucose testing or after touching contaminated surfaces. Staff F then wiped Tenant #4's abdomen with alcohol and administered 8 units of insulin (5 units scheduled insulin and 3 units sliding scale insulin). The insulin pen was not primed prior to administration and was removed from Tenant #4's abdomen after injection without a wait period observed. He disposed on the materials from the blood glucose check and insulin administration in the sharps container on the medication cart, initially with one gloved hand and one bare hand and then eventually two bare hands.

Continued observation revealed Staff F administered an eye drop (s) to Tenant #2 (only one eye drop was observed as the process was started before the surveyor was made aware it was being administered) at the dining room table with three other tenants seated at the table at that time. Staff F wore gloves with the eye drop administration and then touched the tablet with the gloved hands.

Further observation revealed Staff F administered an oral medication to Tenant #5. He used attempted to use hand sanitizer prior to the administration of the medication; however, the pump did not work. He removed the top and

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touched the plastic wand of the container directly to his hand and then donned gloves. He administered Tenant #5's lorazepam 0.5 milligram (mg), 1/2 tablet take 0.25 mg, after a meal and signed it out in the narcotic book.

2. When interviewed on 9/27/23 at approximately 11:00 a.m. the Director of Health and Wellness indicated Tenant #5's lorazepam 0.25 mg after lunch was discontinued on 9/25/23. Record review of Tenant #5's MARs indicated the lorazepam 0.25 mg take 1/2 tablet after lunch reflected an X on the date of 9/26/23, when Staff F administered the medication. Staff F administered the medication despite it being discontinued on 9/25/23.

3. Record review on 9/27/23 of Staff F's training documents revealed a hire date of 7/6/22. A medication manager certificate was provided dated 9/28/23. A Medication Administration Clinical Skills Checklist was dated 1/31/23 signed by the Former Director of Health and Wellness.

Continued record review revealed an email dated 10/2/23 from the Executive Director indicated the Former Director of Health and Wellness completed the checklist but failed to submit it. The current Director of Health and Wellness called to follow up on Staff F's certificate and found out that was why the certificate was not issued. Staff F's medication manager certificate was dated 9/28/23 (despite being completed on 1/31/23).

4. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed when trying to find Staff F's medication manager certificate it was determined it was 90% complete with Former Director of Health and Wellness;

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A 270	Continued From page 12 however, the checklist was not submitted. She submitted the needed information and a medication manager certificate was issued dated 9/28/23. She confirmed the expectations for gloves would be that gloves would be applied before cares and in between tenants. Blood glucose testing would occur on inner most or outer most part of the finger and a paper towel would be placed (barrier) on the surface. She confirmed with insulin administration after injected and the plunger pushed down, to wait a few seconds. Blood glucose testing and eye drops could be administered (common areas) as long no one else was at the table. Disposals of sharps needed to occur with gloved hands.	A 270		
A 280	481-67.5(2)f(3) 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: (3) The program shall maintain a list of each tenant's medications and document the medications administered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to document medications administered. This pertained to 1 of 1 reviewed that received sliding scale insulin (Tenant #4). Findings follow: 1. When observed on 9/26/23 at the lunch medication pass Staff F took Tenant #4's blood	A 280		

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A 280	Continued From page 13	A 280		

glucose reading and administered her scheduled and sliding scale insulin. Staff F administered 5 units of scheduled insulin and 3 units (sliding scale) for a total of 8 units. Staff F administered the insulin into her abdomen by insulin pen.

2. Record review on 9/27/23 of Tenant #4's file revealed the September medication administration record (MAR) reflected a blood glucose reading of 279 on 9/26/23 at 12:00 p.m. The MAR also reflected the order for insulin ASPA injection flexpen inject 7-5-5 units prior to meals, breakfast was 7 units (scheduled) and lunch and supper were each 5 units (scheduled). Additionally, a sliding scale of 1 unit for every 50>150. The sliding scale indicated to administer 3 units for blood glucose readings between 251 and 300. The MAR indicated a place for staff to initial/sign off for the administration of the scheduled insulin administration and for the blood glucose reading. The number of sliding scale units administered was not documented on the MAR for the time observed on 9/26/23 at 12:00 p.m. or for the entire month of September.

Continued record review revealed the September 2023 MAR also reflected omissions for the insulin administration and blood glucose monitoring on 9/7/23, 9/13/23, 9/20/23 and 9/23/23.

Further record review revealed the July and August 2023 MARs reflected the order for insulin ASPA injection flexpen inject 7-5-5 prior to meals, breakfast was 7 units (scheduled) and lunch and supper were each 5 units (scheduled). Additionally, a sliding scale of 1 unit for every 50>150. The MAR indicated the orders for number of units per sliding scale, 151 to 200 was 1 unit, 201 to 250 was 2 units, 251 to 300 was 3 units, 301 to 350 was 4 units, 351 to 400 was 5

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A 280	Continued From page 14 units. The primary care provider was to be notified of blood glucose readings greater than 400. Staff initialed/signed off for the administration of the insulin and the blood glucose monitoring; however, the units of sliding scale insulin were not documented for July and August. 3. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed the sliding scale insulin for Tenant #4 was not documented.	A 280		
A 340	481-67.9(4)a 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: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide staff nurse delegation training within 60 days of the nurse's employment. This pertained to 4 of 4 staff reviewed that administered medications (Staff A, B, D and F). Findings follow:	A 340		

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A 340	Continued From page 15 1. Observation on 9/26/23 at the lunch medication pass Staff F administered insulin (pen) to Tenant #4. 2. Record review of a staff list reflected the Director of Health and Wellness' date of employment was 3/20/23. 3. Record review on 9/26/23 of Staff A's training documents revealed a hire date of 2/10/23. Staff A had nurse delegation training for medication administration dated 6/4/23, which was greater than 60 days from the Director of Health and Wellness' date of employment. The nurse delegation training completed on 6/4/23 lacked nurse delegation training for administration of insulin (pen). 4. Record review on 9/26/23 of Staff B's training documents revealed a hire date of 1/31/23. Staff B had nurse delegation training for medication administration and activities of daily living (ADLs) dated 6/6/23, which was greater than 60 days from the Director of Health and Wellness' date of employment. The nurse delegation training completed on 6/6/23 lacked nurse delegation training for administration of insulin (pen). 5. Record review on 9/26/23 of Staff D's training documents revealed a hire date of 8/18/22. Staff D had nurse delegation training for medication administration dated 6/1/23, which was greater than 60 days from the Director of Health and Wellness' date of employment. The nurse delegation training completed on 6/1/23 lacked nurse delegation training for administration of insulin (pen). 6. Record review on 9/26/23 of Staff F's training documents revealed a hire date of 7/6/22. Staff F	A 340		

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A 340	Continued From page 16 had nurse delegation training for medication administration dated 6/6/23, which was greater than 60 days from the Director of Health and Wellness' date of employment. The nurse delegation training completed on 6/6/23 lacked nurse delegation training for administration of insulin (pen). 7. When interviewed on 10/5/23 at 2:00 p.m. the confirmed all delegations for the staff listed above were provided. She also confirmed the program did not have a delegation for insulin administration (pen).	A 340		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed dependent adult abuse training within six months of employment. This pertained to 2 of 6 staff reviewed (Staff B and Staff E). Findings follow: 1. Record review on 9/26/23 of Staff B's training documents revealed a hire date of 1/31/23. Staff B did not complete dependent adult abuse training within six months of employment or at the time of the review. 2. Record review on 9/26/23 of Staff E's training documents revealed a hire date of 6/14/22. Staff E did not complete dependent adult abuse	A 380		

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A 380	Continued From page 17 training within six months of employment or at that time of the review. 3. When interviewed on 10/5/23 at 2:30 p.m. the Executive Director confirmed no dependent adult abuse training was located for the staff listed above.	A 380		
A 415	481-67.19(3)c Record Checks 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to request the department of human services (DHS) perform an evaluation prior to employment of a staff. This pertained to 1 of 1 staff reviewed with a criminal history record (Staff A). Findings follow: 1. Record review on 9/26/23 of Staff A's training documents revealed a hire date of 2/10/23. A background check was completed dated 1/26/23 and indicated further research was needed on the criminal history background check. The child abuse and dependent adult abuse registries did not indicated a record was found. An Iowa Record Check Form S was completed dated 1/27/23 and indicated a CCH record was found.	A 415		

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A 415	Continued From page 18 An evaluation determination was not completed prior to Staff A's employment. Continued record review of time card records revealed Staff A first worked on 2/10/23. Further record review revealed a new background check was completed dated 9/28/23, which again indicated further research for the criminal history background check was required and a CCH record was found. An evaluation determination was received dated 10/4/23, which indicated an approval for Staff A to work at the Program. 2. When interviewed on 10/5/23 at 2:30 p.m. the Executive Director said she the last page of Staff A's background check (evaluation determination) could not be found. She said she thought it was done previously, but was potentially misfiled.	A 415		
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.	A 145		

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A 145	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 3 of 6 tenants reviewed (Tenants #2, #3 and #5). Findings follow: 1. Record review on 9/27/23 of Tenant #2's file revealed Tenant #2 was admitted on 9/11/23. Hospital documentation prior to admission to the Program reflected Tenant #2 was admitted for altered mental state and passive suicidal ideations on 8/27/23. The history and physical note indicated Tenant #2's family reported at her prior assisted living placement Tenant #2 had kept three to four butter knifes to herself and had been caught up with her oxygen tubing around her neck and wrists. When interviewed on 9/16/23 at 4:14 p.m. Staff G said Tenant #2 made comments about pushing off of a bridge, she had found her with oxygen tubing around her neck and she assisted her and that Tenant #2 was ready to leave here. Staff G said the Director of Health and Wellness was informed. When interviewed on 9/26/23 at 4:34 p.m. Staff A said he had heard she was a little bit unstable where she was before. She had made comments to him asking if he believed in God and thought he if was real. Tenant #2 had made other comments to co-workers. Staff A said the Director of Health and Wellness was aware. Continued record review revealed Progress Notes indicated the following: a. On 9/16/23 it was noted Tenant #2 was	A 145		

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A 145	Continued From page 20 repeatedly saying help and that someone was trying to harm her or kill her. b. On 9/19/23 it was noted Tenant #2 said she was feeling better, said she was having delusions but could differentiate between reality and delusions at that time. Further record review revealed evaluations were completed on 9/8/23 and were not completed with significant change related to Tenant #2's behavior as noted above. 2. Record review on 9/27/23 of Tenant #3 file revealed evaluations were completed on 7/27/23 related to an increase in assistance with transfers, bathing and toileting. When interviewed on 926/23 at 4:14 p.m. Staff G said all the female staff used two staff for transfers for Tenant #3. Staff G said Tenant #3 had trouble moving. When interviewed on 9/26/23 at 4:34 p.m. Staff A said Tenant #3 had declined physically and was not as strong as before. Staff A said some staff use to caregivers for her transfers. Staff A transferred her with one. Staff A said Tenant #3 took two staff for transfer a little over 50% of the time. Continued record review indicated Progress Notes indicated the following: a. On 7/30/23 it was noted Tenant #3 was "dead weight", leaned to the left and was in a lot of pain. b. On 8/5/23 it was noted staff transferred her and she did not help at all, could not get up and did not move her legs.	A 145		

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A 145	Continued From page 21 c. On 8/5/23 it was noted Tenant #3 was "pure dead wait (sic)" and she refused to try. d. On 8/19/23 it was noted Tenant #3 had a lot of pain in her hip and back. Tenant #3 could not move her right leg or foot. Tenant #3 would not let go of the bar by the toilet and froze for 10 minutes. e. On 8/23/23 it was noted Tenant #3 had a lot of pain, there were several attempts to stand her and more assistance was needed. f. On 8/25/23 it was noted Tenant #3's spouse was contacted regarding getting therapy notes from the doctor due to increased weakness. g. On 9/20/23 it was noted Tenant #3 was a two person assist was needed today. Further record review revealed evaluations were last completed on 7/27/23 and did not reflect the current transfer status for Tenant #3. Evaluations were not completed as needed with Tenant #3's increased transfer assistance and pain. 3. Record review on 9/28/23 of Tenant #5's file revealed Tenant #5 was admitted on 8/28/23. Progress Notes indicated the following: a. On 9/2/23 it was noted Tenant #5 urinated in the corners of his apartment b. On 9/2/23 it was noted Tenant #5 refused redirection and continued to be agitated and aggressive. Tenant #5 went into other tenants' apartments and created a "hostile environment."	A 145		

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A 145	Continued From page 22 c. On 9/4/23 it was noted Tenant #5 continued to go into other tenants' apartments and was involved in a few altercations with another tenant. d. On 9/5/23 it was noted Tenant #5 refused to leave two tenant apartments. e. On 9/7/23 it was noted Tenant #5 was seen for back pain and received new orders including for a Lidocaine patch. f. On 9/8/23 (late entry for 9/6/23) it was noted Tenant #5 complained of lower back, thighs and leg pain. As needed Tylenol was administered without effect. g. On 9/15/23 it was noted staff reported Tenant #5 was paranoid. He did not recognize them and was afraid of everyone. h. On 9/27/23 it was noted Tenant #5 did not sleep from 12:00 a.m. to 1:00 p.m. and refused to relax i. On 9/29/23 it was noted Tenant #5 went to the emergency room and returned with no new orders. It was noted Tenant #5 had physical aggression towards private caregivers and had insomnia. Continued record review revealed evaluations were completed on 8/28/23 and were not completed with significant change related to Tenant #5's behaviors, pain and new order for Lidocaine patch. 4. When interview on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed all evaluations were provided for tenant listed above.	A 145		

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A 290	Continued From page 23	A 290		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 3 of 6 tenants reviewed (Tenants #1, #2 and #6). Findings follow: 1. Record review on 9/27/23 of Tenant #1's file indicated Progress Notes indicated the following: a. On 5/22/23 it was noted Tenant #1 was congested, had a cough and tested positive for COVID-19. Tenant #1's spouse wanted him to have Paxlovid for his symptoms. A fax was sent to the primary care provider. b. On 5/26/23 it was noted a new order was received Mucinex 600 milligrams twice daily. Continued record review revealed a nurse's note was not completed by exception when Tenant #1 was no longer infectious, symptoms had resolved and he was no longer COVID-19 positive. 2. When interviewed on 9/16/23 at 4:14 p.m.	A 290		

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A 290	Continued From page 24 Staff G said Tenant #2 made comments about pushing off of a bridge, she had found her with oxygen tubing around her neck and she assisted her and that Tenant #2 was ready to leave here. Staff G said the Director of Health and Wellness was informed. When interviewed on 9/26/23 at 4:34 p.m. Staff A said he had heard she was a little bit unstable where she was before. She had made comments to him asking if he believed in God and thought he if was real. Tenant #2 had made other comments to co-workers. Staff A said the Director of Health and Wellness was aware. Record review on 9/27/23 of Tenant #2's file revealed there were no entries in nurse's notes related to the comments or behavior noted in Staff G and Staff A's interviews. Nurse's notes were not documented by exception. 3. Record review on 9/28/23 of Tenant #6's file revealed an entry in Progress Notes dated 9/19/23 (late entry for 9/5/23) indicated Tenant #6 fell on 9/2/23 and a follow up was completed on 9/4/23. Tenant #6 sustained a laceration and bruise above her right eye. Bruising was also noted to her right wrist. A nurse's note was completed; however, it was not completed by exception when Tenant #6's fall occurred on 9/2/23. The follow up nurse's note was not completed until 9/19/23. 4. When interviewed on 10/5/23 at 2:00 p.m. the Director of Health and Wellness confirmed all nurse's notes for the tenants listed above were provided.	A 290		

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A 350	Continued From page 25	A 350		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed to develop service plans to reflect the service needs of the tenants. This pertained to 6 of 6 tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6). Findings follow: 1. Record review on 9/27/23 of Tenant #1's file revealed an incident report indicated on 3/5/23 at 3:26 p.m. Tenant #1 eloped. Staff heard the door alarm and did a head count. It was noted Tenant #1 was missing. Staff called the receptionist and was told he had not been seen. The receptionist called back and said Tenant #1 was outside. Activity staff brought him back into the building and then took him for a walk inside the building. Continued record review revealed Progress Notes indicated the following: a. On 5/9/23 it was noted Tenant #1 raised his voice, yelled and refused to move from the front door. b. On 6/9/23 it was noted Tenant #1 raised his	A 350		

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	S0375	A. BUILDING: _____ B. WING _____	C 10/05/2023

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voice, walked towards staff in an aggressive manner and refused to move from the door.

c. On 7/30/23 it was noted Tenant #1 yelled and had several attempts to elope. Tenant #1 raised his voice after redirection.

d. On 8/19/23 it was noted Tenant #1 eloped after an activity and was found outside.

Further record review revealed Tenant #1's service plans were dated 1/20/23, 4/20/23 and 7/16/23 and were updated related to the 90 day nurse reviews. The service plans reflected a category of elopement interventions and wandering behaviors. The service plan was not updated after the elopement on 3/5/23 or 8/19/23 to reflect that Tenant #1 had eloped from the building and additional interventions related to safety. The service plan also did not reflect the behavior documented in nurse's notes.

2. Record review on 9/27/23 of Tenant #2's file revealed Tenant #2 was admitted on 9/11/23. Hospital documentation prior to admission to the Program reflected Tenant #2 was admitted for altered mental state and passive suicidal ideations on 8/27/23. The history and physical note indicated Tenant #2's family reported at her prior assisted living placement Tenant #2 had kept three to four butter knifes to herself and had been caught up with her oxygen tubing around her neck and wrists.

When interviewed on 9/16/23 at 4:14 p.m. Staff G said Tenant #2 made comments about pushing off of a bridge, she had found her with oxygen tubing around her neck and she assisted her and that Tenant #2 was ready to leave here. Staff G said the Director of Health and Wellness was

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informed.

When interviewed on 9/26/23 at 4:34 p.m. Staff A said he had heard she was a little bit unstable where she was before. She had made comments to him asking if he believed in God and thought he if was real. Tenant #2 had made other comments to co-workers. Staff A said the Director of Health and Wellness was aware.

Continued record review revealed Progress Notes indicated the following:

a. On 9/16/23 it was noted Tenant #2 was repeatedly saying help and that someone was trying to harm her or kill her.

b. On 9/19/23 it was noted Tenant #2 said she was feeling better, said she was having delusions but could differentiate between reality and delusions at that time.

Further record review revealed the service plan dated 9/11/23 reflected safety and wellness checks. The service plan was not updated as needed and did not reflect Tenant #2's behavior and interventions related to her safety.

3. Record review on 9/27/23 of Tenant #3 file revealed the service plan was last updated on 7/27/23 and reflected Tenant #3 was a physical assist of one for transfers.

When interviewed on 926/23 at 4:14 p.m. Staff G said all the female staff used two staff for transfers for Tenant #3. Staff G said Tenant #3 had trouble moving.

When interviewed on 9/26/23 at 4:34 p.m. Staff A said Tenant #3 had declined physically and was

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not as strong as before. Staff A said some staff use to caregivers for her transfers. Staff A transferred her with one. Staff A said Tenant #3 took two staff for transfer a little over 50% of the time.

Continued record review indicated Progress Notes indicated the following:

a. On 7/30/23 it was noted Tenant #3 was "dead weight", leaned to the left and was in a lot of pain.

b. On 8/5/23 it was noted staff transferred her and she did not help at all, could not get up and did not move her legs.

c. On 8/5/23 it was noted Tenant #3 was "pure dead wait (sic)" and she refused to try.

d. On 8/19/23 it was noted Tenant #3 had a lot of pain in her hip and back. Tenant #3 could not move her right leg or foot. Tenant #3 would not let go of the bar by the toilet and froze for 10 minutes.

e. On 8/23/23 it was noted Tenant #3 had a lot of pain, there were several attempts to stand her and more assistance was needed.

f. On 8/25/23 it was noted Tenant #3's spouse was contacted regarding getting therapy notes from the doctor due to increased weakness.

g. On 9/20/23 it was noted Tenant #3 was a two person assist was needed today.

Further record review revealed Tenant #3's service plan was not updated as needed and did not reflect Tenant #3's needs related to transfers and pain.

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A 350	Continued From page 29 4. Record review on 9/27/23 of Tenant #4's file revealed Progress Notes indicated the following: a. 8/6/23 it as noted Tenant #4 had frequent "accidents", when going to the bathroom on her own. She refused to let staff take her. She did not make it no matter how close. It had been happening daily. b. On 8/8/23 it was noted Tenant #4 was upset and wandering. She attempted to get other tenants to leave with her. c. On 8/17/23 it was noted Tenant #4 had been refusing some of her creams and topical medications. d. On 9/13/23 it was noted staff reported Tenant #4 had been more confused and exit seeking today. She had trouble finding the toilet, which was right next to her. e. On 9/13/23 it was noted Tenant #4 made several attempts to elope. f. On 9/17/23 it was noted Tenant #4 refused to move from the back exit door. g. On 9/20/23 it was noted Tenant #4 was started on an antibiotic for a urinary tract infection (UTI) on 9/16/23. Continued record review revealed the service plan dated 7/16/23 did not reflect Tenant #4 behaviors as noted above. The service plan was not updated as needed and did not reflect Tenant #4's elopement attempts, exit seeking, toileting issues and history of UTIs.	A 350		

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A 350	Continued From page 30 5. Record review on 9/28/23 of Tenant #5's file revealed Tenant #5 was admitted on 8/28/23. Progress Notes indicated the following: a. On 9/2/23 it was noted Tenant #5 urinated in the corners of his apartment b. On 9/2/23 it was noted Tenant #5 refused redirection and continued to be agitated and aggressive. Tenant #5 went into other tenants' apartments and created a "hostile environment." c. On 9/4/23 it was noted Tenant #5 continued to go into other tenants' apartments and was involved in a few altercations with another tenant. d. On 9/5/23 it was noted Tenant #5 refused to leave two tenant apartments. e. On 9/7/23 it was noted Tenant #5 was seen for back pain and received new orders including for a Lidocaine patch. f. On 9/8/23 (late entry for 9/6/23) it was noted Tenant #5 complained of lower back, thighs and leg pain. As needed Tylenol was administered without effect. g. On 9/15/23 it was noted staff reported Tenant #5 was paranoid. He did not recognize them and was afraid of everyone. h. On 9/27/23 it was noted Tenant #5 did not sleep from 12:00 a.m. to 1:00 p.m. and refused to relax i. On 9/29/23 it was noted Tenant #5 went to the emergency room and returned with no new orders. It was noted Tenant #5 had physical aggression towards private caregivers and had	A 350		

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A 350	Continued From page 31 insomnia. Continued record review revealed the service plan was not updated as needed and did reflect the behaviors and changes as noted above, including going into other tenants' apartments and altercations, urination in his apartment, pain and order for the lidocaine patch, paranoia, agitation and private duty caregivers. 6. Record review on 9/28/23 of Tenant #6's file revealed Tenant #6 received hospice services. A Services Received document indicated on 9/23/23 bathing was not completed and the reason was because there was no hospice. Continued record review revealed the service plan dated 7/16/23 reflected hospice services; however, did not reflected hospice assisted with bathing. The service plan indicated staff assisted Tenant #6 with bathing. 7. When interviewed on 10/5/23 at the Director of Health and Wellness confirmed all service plans for tenants listed above were provided.	A 350		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 465		

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A 465	Continued From page 32 Program failed to provide an orientation on sanitation and safe food handling and an annual in-service training on food protection. This pertained to 2 of 6 staff reviewed (Staff B and Staff D). Findings follow: 1. Record review on 9/26/23 of Staff B's training documents revealed a hire date of 1/31/23. Staff B did not have any documented food safety training completed prior to handling food or at the time of the review. 2. Record review on 9/26/23 of Staff D's training documents revealed a hire date of 8/18/22. Staff D had a certificate dated 8/25/22 for safe food handling; however, Staff D did not have an annual in-service training on food protection. 3. When interviewed on 10/5/23 at 2:30 p.m. the Executive Director confirmed Staff B and Staff D would have served food and no additional food safety training was located for the staff listed above.	A 465		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide staff eight hours of	A 545		

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A 545	Continued From page 33 dementia specific education within 30 days of employment. This pertained to 2 of 5 direct care staff reviewed (Staff B and Staff C). Findings follow: 1. Record review on 9/26/23 of Staff B's training documents revealed a hire date of 1/31/23. Staff B did not have eight hours of dementia training completed within 30 days of employment or at that time of the review. 2. Record review on 9/26/23 of Staff C's training documents revealed a hire date of 8/15/23. Staff C had a Certificate of Achievement for seven hours of dementia training dated 9/26/23, which was greater than 30 days from her date of hire. Staff C had certificate for completion of general orientation which included hands on dementia training dated 8/25/23; however, it was not eight hours of dementia training. 3. When interviewed on 10/5/23 at 2:30 p.m. the Executive Director confirmed all dementia training for the listed above was provided.	A 545		

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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. • Alarm response 1. Staff H & I have been retrained on program's door alarm policy, specifically the need to also look outside the door when an alarm goes off to determine who set off alarm. 2. All staff have/will receive training/retraining on current Door Alarm policy by 2/28/2024. 3. All new hires will receive training on Door Alarm policy prior to working on the floor and retrained as necessary. This will be monitored by the BOM/designee on an ongoing basis. • Missing Tenant 1. Staff H & I have been retrained on program's Missing Resident policy, specifically the need to also look outside the door when an alarm goes off to determine who set off alarm and need for completed documentation on the Incident Report including vital signs; and Staff J is no longer employed by the program. 2. Program's nurses have been trained on the Missing tenant policy, specifically notification of the Executive Director, evaluation of the resident post elopement and need for immediate notification of family and PCP. 2/12/2024 3. All elopements/missing resident incidents will be reviewed by DOHW/designee for completeness/adherence to program's policies. • Head Injury 1. All program nurses have been educated on Head Injury policy, specifically need for timely progress notes that includes, but is not limited to: Nurse review of incident, instructions given to staff for neuro checks and documentation of the nurse educating the resident/family of importance of being evaluated for head injury if they are resistant to transfer to ER. 2/12/2024 2. All head injury incidents will be reviewed by the DOHW/designee for completeness/adherence to program's policies.	2/28/2024

A 270	481-67.5(2) f(1) Medications 67.5(2) Each program will follow it's own written medication policy which shall include the following: f. When medications are administered traditionally by the program: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department -approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination or by a physician assistant… 1. Staff F completed the state approved medication manager course including the clinical skills checklist on 1/31/2023. The completed skills checklist was submitted late and the Medication Manager Certificate was issued on 9/28/2023. Staff F was removed from the role of passing medications to residents until he was retrained and once again delegated by current Director of Health and Wellness on all aspects of medication administration including: A. Use of barrier when performing blood glucose checks; B. Proper location for finger sticks; C. Proper use of gloves including when to change; D. Proper use of insulin pen including priming pen prior to insulin administration and waiting period after administration of insulin before the needle is removed; E. Privacy of residents during medication administration 2. Files for all current staff responsible for passing medications will be audited by DOHW/Designee to ensure that a certificate for completing a state-approved Medication Manager course is available. 2/28/2024 3. DOHW/Designee will ensure that any new staff to pass medications will have a certificate for completing a state-approved medication manager course available in their file prior to administering medications.	2/28/2024
A 280	Each program shall follow its own written medication policy, which shall include the following: F. When programs are traditionally administered by the program: (3) The program shall maintain a list of each tenant's medications and document the medications administered. 1. Staff F was retrained and once again delegated by current DOHW on all aspects of medication administration including but not limited to proper documentation. The e-mar has been updated and the sliding scale insulin is now a separate order with a dedicated space for documenting the number of units administered.	2/28/2024

	2. All staff that are responsible for medication administration have been educated about the changes in the system and the need for proper documentation. 3. E-mars will be audited by DOHW/designee at a minimum of weekly for incomplete documentation. Audits will be documented in State survey audit manual.	
A 340	481-67.9(4)a 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: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. 1. Staff A, B, D and F have been delegated by the program's registered nurse on all aspects of medication administration including but not limited to, administration of insulin (pen). All current staff responsible for administration of medications will be delegated by the program's current registered nurse on all aspects of medication administration including but not limited to, administration of insulin (pen) by 2/28/2024. 2. A delegation for administration of insulin (pen) has been added to our Medication Administration delegation packet. All current staff responsible for administering medications will be delegated on administration of insulin (pen). With any change in the program's registered nurse, the ED/Designee will educate the new registered nurse of the need to document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. 3. The program's registered nurse will use the Nurse Delegation Flow Sheet, which includes the delegation for administration of insulin (pen), to sign off when delegating all staff responsible for administering medications in the future. With any change in the program's registered nurse, the ED/designee will audit all staff's files within 59 days or sooner of the nurse's beginning employment date to ensure that all needed delegations are completed.	2/28/2024
A 380	481-67.9(6) Staffing 67.9(6) Dependent Adult Abuse Training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. 1. Staff B has completed Dependent Adult Abuse training. Staff E has completed Dependent Adult Abuse training. All current employees' files have been audited for the Dependent Adult Abuse training to determine which staff lacked this training. All current staff will have the needed training completed by 2/28/2024.	2/28/2024

	2. The ED/designee will audit all new hires' files for required Dependent Adult Abuse training prior to sending them on to their department manager for departmental training. 3. The ED/designee will set up a calendar to track the expiration date of the Dependent Adult Abuse certificate for all employees. They will notify the employee at least 30 days prior to expiration and provide needed information to take recertification course. Any employee not completing the training by required completion date will be removed from the schedule.	
A 415	481-67.19(3)c Record Checks 67.19(3)c If a person being considered for employment has been convicted of a crime under a law of any state, the program shall request that the department of human services perform an evaluation to determine if whether the crime warrants prohibition of the person's employment in the program. 1. A new background check for Staff A was completed on 9/28/23, CCH record was found, and an evaluation determination was received 10/4/23, which indicated an approval for Staff A to work at the program. All current employee's files will be audited by 2/28/2024 for DHS evaluation and evaluation determination if needed. 2. ED/designee will be responsible for reviewing all background checks and ensuring that DHS evaluation has been completed and evaluation determination has been received if needed. 3. ED/designee will audit the files of all new hires for the next 6 months to ensure that a DHS evaluation has been completed and evaluation determination has been received if needed. Audits will be documented in the State survey audit manual.	2/28/2024
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 a tenant has exhibited a significant change. 1. Tenant #2 has had a new evaluation for significant change completed to include behaviors noted. Tenant #3 was discharged from the program on 11/30/2023. Tenant #5 has had a new evaluation for significant change completed to include increased transfer assistance and pain. DOHW will review the current evaluation on all other AL tenants for need of change of condition evaluation by 2/28/2024.	2/28/2024

	2. The program's nurses have been educated on what constitutes a significant change and what needs to be done when a tenant has a significant change on 2/12/2024. 3. The DOHW/designee will audit all evaluations completed for the next 90 days to ensure that significant change evaluations have been completed as needed. All concerns will be corrected. Audits will be documented in the State survey audit manual.	
A 290	481-69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. 1. A late entry progress note has been entered into Tenant #1's file to indicate that he is no longer infectious, symptoms have resolved, and he is no longer COVID-19 positive. A late entry progress note has been entered into Tenant #2's file to indicate behaviors noted by staff. A late entry progress note has been entered into Tenant # 6's file regarding the fall which occurred on 9/2/23. 2. All program nurses have been reeducated on the process of documentation by exception and the expectation for this to be completed in a timely manner 0n 2/12/2024. 3. The DOHW/designee will perform weekly audits, for the next 90 days, on the nurses' notes of all tenants with a known illness, hospitalization, behavior, or incident report. Any concerns will be corrected. Audits will be documented in the State survey audit manual.	2/28/2024
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(10 and 69.22(2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall be updated at least annually and whenever changes are needed. 1. Tenant #1's service plan has been updated to reflect his elopements and behavior as documented in the nurses' notes and interventions related to his safety. Tenant #2's service plan has been updated to reflect her behaviors and interventions related to her safety. Tenant #3 has been discharged from the program. Tenant #4's service plan has been updated to reflect her elopement attempts, exit seeking, toileting issues and history of UTIs. Tenant # 5's service plan has been updated to reflect the behaviors including going into other tenant's apartments, altercations, urinating in his apartment, pain, paranoia, agitation, and private duty caregivers. Tenant #6's service plan has been updated to reflect hospice services.	2/28/2024

	2. All program nurses have been reeducated on the process of developing a service plan and updating it as needed on 2/12/2024. 3. The DOHW/designee will perform weekly audits, for the next 90 days, on all newly developed service plans as well as service plans for all tenant's with new orders, a known illness, behavior, or incident report. Any concerns will be corrected. Audits will be documented in the State survey audit manual.	
465	481-69.28(5) Food Service 69.28(5)Personnel who are employed by or contract with the program and who are responsible for food preparation or service shall have an orientation on sanitation and safe food handling prior to handling food and have annual in-service training on food protection. 1. Staff B has now been trained regarding food safety. Staff D has now had additional in-service training on food protection. 2. All current employees' files have been audited for the required initial training on sanitation and safe food handling as well as annual in-service training on food protection. All current staff will have the needed training completed by 2/28/2024. All future hires will receive an orientation on sanitation and safe food handling prior to handling any food. 3. The ED/designee will audit all new hires' files for required initial training prior to starting on the floor and will set up a training calendar to offer the required annual in-service training. The ED/designee will keep track of all employees' completion of required training on a spreadsheet. Any employee not completing the training by the required completion date will be removed from the schedule.	2/28/2024
A 545	A 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 8 hours of dementia-specific education and training within 30 days of either employment or beginning date of the contract, as applicable. 1. Staff B has now completed all 8 hours of Dementia training. Staff C is no longer employed by the program. All current staff will have completed all 8 hours of dementia-specific training by 2/28/24. 2. All staff hired in the future will complete General Orientation which includes 1 hour of dementia training and the 7 hours of computer training on Myalf site prior to starting on the floor. 3. The ED/designee will audit all new hires' files for required initial training prior to sending them on to their department manager for departmental training.	2/28/2024