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
	S0379	A. BUILDING: _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 22 Total census: 27 The following regulatory insufficiencies were cited during the investigation of Complaint #107449-C.	A 000		
A 155	481-69.23(1)b Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure tenants did not exceed level of care for 1 of 2 tenants reviewed who required assistance of 2 for transfers (Tenant #1). Findings follow: Record review on 12/28/22 of Tenant #1's Face Sheet documented he moved in the memory care unit on 9/28/22. Review of his Comprehensive Assessment and Service Plan dated 9/28/22 revealed he required the assistance of 2 staff and a pivot disk for	A 155	The Plan of Correction is attached.	

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A 155	Continued From page 1 transfers. Review of his Comprehensive Assessment and Service Plan dated 10/11/22 revealed he required the assistance of 2-3 staff, a pivot disk, and a gait belt for transfers. On 12/28/22 at 11:12 a.m. the Registered Nurse confirmed these findings.	A 155		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharge a tenant that displayed unmanageable verbal and physical aggression for 1 of 1 tenants reviewed with a history of aggression (Tenant #2). Findings follow: 1. Record review of Tenant #2's Progress Notes on 12/28/22 revealed the following: a. July 2022 notes documented physical and verbal aggression towards staff on 5 occasions. - On 7/15/22 the Program received new orders to administered .25 milligrams (mg) of lorazepam every 8 hours as needed (PRN) for	A 160		

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A 160	Continued From page 2	A 160		

behavior.
b. August 2022 notes revealed 5 entries related to physical and verbal aggression towards staff and tenants.
c. September 2022 notes included 6 entries of physical and verbal aggression.
d. October 2022 notes documented 7 incidents of physical and verbal aggression and included hitting staff in the face at least 3 times.
- On 10/11/22 the roommate complained she could not sleep due to Tenant #2's yelling and screaming.
e. November 2022 notes revealed 11 entries documenting physical and verbal aggression and included hitting staff at least 2 times.
- On 11/4/22 staff observed her slap her roommate multiple times and separated them.
- On 11/14/22 received new orders to increase trazadone to 100 mg at bedtime for behaviors.
f. December 2022 notes included 2 entries of combativeness and hitting staff during medication administration.
- On 12/27/22 new orders to discontinue lorazepam and start 25 mg of trazadone to be given every 8 hours PRN for behaviors.

2. Review of Medication Administration Records revealed the following:
a. August 2022 staff administered PRN medication 5 times for aggression.
b. September 2022 staff administered PRN medication 7 times for aggression.
c. October 2022 staff administered PRN medication 10 times for aggression.
d. November 2022 staff administered PRN medication 21 times for aggression.
e. December 2022 staff administered PRN medication 57 times for aggression.

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A 160	Continued From page 3 On 12/28/22 at 11:12 a.m. the Registered Nurse confirmed these findings.	A 160		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans based on the tenant's identified needs and preferences for 1 of 1 tenants reviewed with a history of aggression (Tenant #2). Findings follow: Record review on 12/28/22 of Tenant #2's file revealed the following: 1. Record review of Tenant #2's Progress Notes revealed the following: a. July 2022 notes documented physical and verbal aggression towards staff on 5 occasions. - On 7/15/22 the Program received new orders to administered .25 milligrams (mg) of lorazepam every 8 hours as needed (PRN) for behavior. b. August 2022 notes revealed 5 entries related to physical and verbal aggression towards staff and tenants. c. September 2022 notes included 6 entries of physical and verbal aggression. d. October 2022 notes documented 7 incidents of physical and verbal aggression and included hitting staff in the face at least 3 times.	A 395		

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A 395	Continued From page 4	A 395		

- On 10/11/22 the roommate complained she could not sleep due to Tenant #2's yelling and screaming.

e. November 2022 notes revealed 11 entries documenting physical and verbal aggression and included hitting staff at least 2 times.

- On 11/4/22 staff observed her slap her roommate multiple times and separated them.
- On 11/14/22 received new orders to increase trazadone to 100 mg at bedtime for behaviors.

f. December 2022 notes included 2 entries of combativeness and hitting staff during medication administration.

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e. December 2022 staff administered PRN medication 57 times for aggression.

The tenant's service plan dated 12/7/22 failed to include interventions and use of PRN (as needed) medication to manage ongoing physical and verbal aggression.

On 12/28/22 at 11:12 a.m. the Registered Nurse confirmed these findings.

The Willows of Marshalltown
To: Iowa Department of Inspections & Appeals
From: Jennifer Stanley
Cc: Deb Dixon
Date: February 17, 2023
Re: Memory Care Corrections

A 155 When a nurse is sent out for an assessment of a potential tenant, nurse will complete pre-admission assessment which includes tenant's transfers and ambulation. This will determine if more than an assist of 1 is needed. If potential tenant is determined to need an assist of more than 1 to transfer or ambulate, this will be reported to the Executive Director. A second assessment will be completed with the nurse and Executive Director/Assistant Director present. If tenant is still determined to be an assist of more than 1, tenant will not be admitted. Nurse and Executive Director will refamiliarize themselves to DIA Chapter 69. If questions arise, we will contact DIA for clarifications.

If tenant is currently admitted to The Willows of Marshalltown and becomes an assist of more than 1, medications will be reviewed, PCP will be notified and nurse will request an order for a UA and/or Physical/Occupational Therapy. If thereafter tenant remains an assist of more than 1, and it is determined to be due to the advancing disease process, hospice services will be discussed with tenant/POA. If tenant is then admitted to hospice, nurse will apply for a waiver. If waiver is denied, tenant/POA will be given a 30 day discharge notice. If tenant/POA do not wish to pursue hospice services, a 30 day discharge notice will be given to tenant/POA. We now know that mechanical lifts are not allowed in Assisted Living facilities. If it is determined that tenant is only able to be transferred safely with a mechanical lift, a 30-day discharge notice will be given to tenant/POA.

Persons Responsible: Healthcare Director and Executive Director
Date Completed: 2/20/2023

A 160 At the onset of behaviors, nurse will communicate with PCP and request an order for a psych evaluation. Med managers will report behaviors to nurses and nurses will follow up with psych or PCP promptly. Nurses/med managers will ensure all medications are taken as prescribed and PRN medications will be utilized when appropriate. If new behaviors arise or accelerate, nurses will promptly communicate this to psych/PCP for med appropriation or lab orders. Nurses will work closely with psych/PCP to monitor and assess if meds are effective. If meds are not effective, this will be communicated with psych/PCP. As a team, if we are unable to control/manage verbal and physical aggression to a safe level for to themselves, other tenants or staff in a timely manner a 30 day discharge notice will be given to tenant/POA.

Persons Responsible: Healthcare Director and Memory Care Director
Date Completed: 2/20/2023

A395 Our nurses are knowledgeable in writing a service plan, however, we just learned that the use of PRN medication and behavioral interventions need to be included within the service plan. Nurses will review service plan every 90 days and update as needed. RN will provide change of condition service plan updates as necessary. Nurses will collaborate and update service plans to include any physical or verbal aggression, the interventions, and the use of PRN medications. If questions arise, nurses will contact DIA for guidance.

Persons Responsible: Healthcare Director and Memory Care Director
Date Completed: 2/27/2023

√ 3/31/23