DIAL Plan of Correction-MC

November 26, 2024

Complaint #120431-C

Level of Care: We hired a nurse consultant and were informed that our care staff is able to chart. Nurses will provide follow up progress notes as appropriate. Care staff has been educated to document difficult cares and transfers or changes related to tenant function. The nurses will be in contact with PCP and obtain orders as needed for therapies, pain management ect. If these are not effective, the nurses will file for a waiver when a consistent decline is noticed that exceeds AL level of care guidelines. If a waiver is denied or we feel we are unable to care for tenant, we will speak with the tenant and family about discharging to a hire level of care voluntarily. The nurses will help facilitate the move to a higher level of care. If family or tenant is not in agreement with the voluntary discharge, an involuntary 30-day discharge notice will be issued. Nurses will also help facilitate the move to a higher level of care with this method.

Date of compliance: 12/15/2024

Service Plan: Nurses met with a nurse consultant. Nurse consultant provided education on what is classified as a significant change. Nurse consultant assisted nurses to develop a schedule to keep service plans in compliance. Executive director has access to PCC and assessment schedule and will audit and meet with nurses quarterly to ensure compliance.

Date of compliance: 12/15/2024

Incident #122991-I and Incident #122992-I

1) DIAL Notification: Executive director will work with nurses to submit initial self report to DIAL within 24 hours or next working day with any fall with significant injury.

Date of compliance: 12/15/2024

Jennifer Stanley ED 11-26-24

RN 11/26/24

LPN 11/26/24

FORM APPROVED 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 09/26/2024

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

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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: 2 Number of tenants with cognitive impairment: 25 Total census: 27 The following regulatory insufficiencies were cited related the investigation of Complaint #120431-C, Incidents #120625-I, #122989-I, #122991-I, #122992-I and the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	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 related to completion of incident reports and the administration of as needed medications. This pertained to 2 of 6 current tenants reviewed (Tenants #2, #4) and 1 of 3 discharged tenants reviewed (Tenant C3). Findings follow: 1a. Review of Tenant #2's file on 8/28/24 revealed a Progress Note dated 7/31/24 indicating	A 150	1) Education will be provided to medication managers regarding PRN medications being used for their intended uses only. Nurses will ensure that intended uses or diagnosis are listed on the MAR for medication mangers to see. 2) Nurses will ensure that in the event of a medication error or fall an incident report is completed and the appropriate people are notified. Date of compliance: 12/15/2024	

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

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A 150	Continued From page 1 morphine sulfate solution 100/5 ml, give 0.25 ml by mouth three times daily as directed was held due to a medication error. Staff discovered the error as the count was off. When interviewed on 9/26/24 at 10:44 a.m. the Licesned Practical Nurse (LPN) said there was an error related to Tenant #2's lorazepam. There was a 1 ml order to be given for seizure activity but staff used it for behavior. She had a 0.5 ml dose of lorazepam for behaviors. She said the medication error was that staff administered 1 ml for the wrong reason. She informed hospice of the error. The tenant suffered no ill side effects. She said a medication error report was not completed. When interviewed on 9/26/24 at 10:12 a.m. the Registered Nurse (RN) stated staff administered 1 ml of lorazepam (which was to be given for seizures) instead of the ordered dose of 0.25 ml for agitation. It was charted in Progress Notes but an incident report was not completed. Review of the July 2024 MAR revealed the following: - Lorazepam concentrate 2 mg/ml give 1 ml by mouth every 15 minutes PRN (as needed) for seizures, may repeat up to four times before calling HCP for further orders. It was started on 6/26/24. It was administered 8 times and was charted as not effective 4 times. It should be noted the RN and Hospice Nurse #3 said in interviews there had been no seizure activity after her fall. The August 2024 MAR revealed the following: - Lorazepam concentrate 2 mg/ml give 1 ml by mouth every 15 minutes PRN for seizures, may repeat up to four times before calling HCP for	A 150		

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A 150	Continued From page 2 further orders. It was started on 6/26/24. It was administered 3 times and it was charted as not effective 1 time. It should be noted the RN and Hospice Nurse #3 said there had been no seizure activity. Medication error reports were not completed for Tenant #2 related to these errors. b. Review of Tenant #4's file on 8/29/24 revealed Progress Notes indicating the following: - On 7/1/24 Tenant #4 fell and complained of hip pain. Tramadol HCL 50 milligram (mg), one tablet PRN (as needed) for pain was administered but was not effective. - On 7/1/24 it was noted acetaminophen 500 mg, one tablet PRN for pain was administered but was not effective. - On 7/1/24 at 2:58 p.m. Tenant #4 came back from the Emergency Dept (ED) and was in much pain. Acetaminophen 500 mg, one tablet PRN for pain was administered but it was not effective at noted at 4:27 p.m. Continued review revealed an After Visit Summary (AVS) dated 7/1/24 from the ED indicated she was seen for a fall and had a contusion of the right hip and an abnormal CT scan. The AVS indicated to follow up with her PCP as soon as possible within three days. An incident report was not completed related to the fall on 7/1/24. c. Review of the Program's Incidents/Accidents policy and procedure indicated when an occurrence or event "leads to unintentional consequences and an unfortunate happening to a resident, visitor or staff member" an incident report would be completed. The policy indicated	A 150		

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A 150	Continued From page 3 when in doubt complete the form. 2a. Review of Tenant #1's file on 8/27/24 revealed the June, July and August 2024 medication administration records (MARs) reflected an order for lorazepam concentrate 2 mg/milliters (ml) give 0.25 ml (0.5 mg) by mouth/sublingual every two hours PRN (as needed). It was started on 1/13/23. It was documented as administered seven times from June to August and was charted as effective. Progress notes indicated on 6/14/24 the medication was given as Tenant #1 was agitated during changing checks and on 6/18/24 it was given for restlessness and agitation before rounds (check and change). On 7/19/24, 7/27/24, 7/31/24, 8/1/24 it was documented as administered without a reason documented. On 8/10/24 it indicated it was given as Tenant #1 was agitated. The order on the MAR did not have an intended use (reason) listed the for administration of the lorazepam. Staff administered seven doses of the PRN medication without a reason indicated on the MAR for administration. b. Review of Tenant #2's file on 8/29/24 file revealed the August 2024 MAR reflected an order for haloperidol concentrate 2 mg/ml, give 0.5 ml (1 mg) by mouth every four hours PRN. It started on 8/22/24. It was documented as administered three times and was charted two times as not effective. Tenant #2's Progress Notes indicated on 8/24/24 the medication was given for restlessness. On 8/25/24 at 12:43 a.m. it was given for restlessness and on 8/25/24 at 6:40 a.m. it was	A 150		

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A 150	Continued From page 4 given for agitation, restlessness and anxiety. The order on the MAR did not have a reason for administration of the haloperidol. Staff administered three doses of the PRN medication without a reason indicated on the MAR for administration. c. Review of Tenant C3's file on 8/27/24 revealed June and July 2024 MARs reflected an order for lorazepam 0.5 mg tablet, one tablet by mouth twice daily PRN. It was started on 5/6/24. It was documented as administered three times and was charted as effective two times. The MARs also reflected an order for Trazodone 50 mg tablet, take 1/2 by mouth as bedtime PRN. It was started on 8/22/22 and was documented as administered five times and was charted as effective four times. Continued record review revealed lorazepam was given for anxiousness on 6/7/24 and was charted as effective. Lorazepam was given on 6/8/24 but no reason was charted for the documentation and it was charted as not effective. On 6/24/24 it was noted lorazepam was charted as given for restlessness and Tenant C3 was uncomfortable. It was charted as effective. Trazadone was given on 6/7/24 to help Tenant C3 sleep and was effective. Trazodone was administered on 6/9/24 and no reason was charted for the documentation and it was charted as effective. On 6/10/24 Trazodone was administered for restlessness and was charted as not effective. On 6/12/24 Trazodone was administered as Tenant C3 was restless in bed and was not able to relax. It was charted as effective. On 7/6/24 it was noted Trazodone was administered as Tenant C3 was very anxious. It	A 150		

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A 150	Continued From page 5 was charted as effective. The order on the MAR did not have a reason for administration for the lorazepam or the Trazodone. Staff administered three doses of PRN lorazepam without a reason indicated on the MAR for administration and five doses of the Trazodone was administered without a reason indicated on the MAR for administration. d. Review of the Program's medication policy indicated all PRN orders should have a reason for administration documented on the MAR. 3. When interviewed on 9/5/24 at 1:44 p.m. the RN confirmed all incident reports and MARs were provided for the tenants reviewed.	A 150		
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 treatment and services that were adequate and appropriate related to a tenant's wound. This pertained to 1 of 1 discharged tenant reviewed who had a wound (Tenant C2). Findings follow:	A 160		

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A 160	Continued From page 6 Review of Tenant C2's file on 8/26/24 revealed wound clinic orders indicating the following: - On 3/5/24 it was noted he should return in two weeks and could bathe without the wound dressing. His weight should be positioned from left to right every one to two hours. A ROHO cushion was to be used in all chairs. Orders for Wound #3, located on the right lateral forearm, included to apply Bactroban once per day. Apply a thin layer to the wound. For Wound #4, located on the medial coccyx, staff were to apply a thin later to the wound bed. For Wound #5, right upper leg, staff were to apply Bactroban once per day, apply a thin layer to the wound bed, cover with Mepilex border flex (4 x 4) once per day. - On 3/19/24 it was noted he should return in two weeks and could bathe without the wound dressing. All orders for wound treatment remained the same. - On 4/2/24 it was noted he should return in three weeks and could bathe without the wound dressing. The orders remained the same except staff were to cover all three wounds with Mexiplex border flex after each administration of Bactroban. - On 4/23/24 it was noted he should return in three weeks and could bathe without the wound dressing. The order for Wound #5 located on the right upper leg was changed to Dakin's 0.125% soaked gauze to wound bed once daily, place a 5 x 9 ABD pad over wounded area once daily and 2" conform pack loosely into wounded area. A Recommended Plan of Treatment from a partnering wound care company indicated hospice was the provider, virtual consultation was ordered and information was provided per the hospice nurse on 4/27/24. The report was dated 4/29/24 by a Wound and Ostomy Specialist. The	A 160	1) Nurses received education regarding wound packing being performed by unlicensed staff is inadequate. 2) If facility receives orders to pack wound, nurses will obtain referral for home health to perform wound care or hospice services. Date of compliance: 12/15/2024	

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A 160	Continued From page 7 document indicated Tenant C2 was admitted to hospice on 4/26/24. He fell in October of 2023 and sustained a right hip fracture and had it surgically repaired. He had complications after surgery and had chronic osteomyelitis with exposed hardware. It was noted in 2/2024 he was treated with intravenous (IV) antibiotics; however, he pulled out the peripherally inserted central catheter (PICC) line three times and family elected for hospice. Tenant C2 had been seeing local wound clinics for the wounds. The current treatment to the right hip was cleansing the hip and coccyx wounds, applying Mupirion 2% topical ointment and covering with Mepilex. A cushion was to be used in the wheelchair. An alternating pressure mattress (APM) was ordered upon admission. The recommendations included to cleanse the coccyx wound and dry; cover it with a sacral silicone border and change three times per week; and discontinue the Mupirocin ointment. For the right hip wound staff were to cleanse the wound and dry; cover with sacral silicone border and change three times per week; and discontinue the Mupirocin ointment. It was noted the wound could be packed; however, he might not tolerate it. The notes indicated to continue use of the Roho cushion and reposition every two to three hours. Send pictures of the coccyx wound and lower extremity wounds when able and notify if the dressing was saturated with drainage before the next scheduled dressing change or if it was saturated with incontinence. It was noted the hip wound would likely continue to worsen due to osteomyelitis. The assessment and recommendations were emailed to Tenant C2's hospice nurse. Wound #1 was a coccyx wound (1.7 x 0.8 x 0.1 cm) and was not stageable. It was a pressure wound. Wound #2 was a surgical wound, on the right trochanter. It was 1.5 x 1.5 cm. The necrotic tissue was 25% to	A 160		

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A 160	Continued From page 8 50% of the wound covered. It was noted the hardware was visible in certain positions. There was purple discoloration observed to the superior aspect of the open wound. Tenant C2's April 2024 MAR reflected an order for H-Chlor 12 solution 0.125%. Staff were to soak gauze and apply to upper right leg daily. Use a small gauze roll and loosely pack into the hip wound. It was started on 4/25/24 and discontinued on 5/3/24. It was ordered once daily at 8:00 a.m. The May 2024 MAR reflected an order H-Chlor 12 solution 0.125%. Staff were to soak gauze and apply to upper right leg daily. Use a small gauze roll and loosely pack into the hip wound. It was started on 4/25/24 and discontinued on 5/3/24. The wound care in April and May 2024 for the hip wound that required packing (see order above) was documented as completed by Staff A, B, T, U and V. All were direct care staff and non-licensed staff that completed the packing of Tenant C2's hip wound. 2. When interviewed on 8/21/24 at 12:50 p.m. Staff B said Tenant C2 had a red sore on his hip from a procedure. It was packed for a bit and then packing was discontinued. It was eating the skin and it looked like new skin was affected. When interviewed on 9/3/24 at 10:12 a.m. Staff C said Tenant C2 took two to three people to transfer and he could not bear weight. He had a couple of open areas. He had a sore on his hip and they tried to pack the wound. She never personally packed it but saw it done. The medication aides did the packing and if they did not feel comfortable the nurses would do it.	A 160		

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A 160	Continued From page 9 On 9/3/24 at 10:41 a.m. Staff D said when Tenant C2 first arrived he required the assistance of two people. He had a hip wound and it opened and he required a third person. A lot of the time he was combative and a fourth person was needed. She said his wound was larger than a 50 cent piece and looked very painful. Medication aides were taught to pack the wound. When interviewed on 9/3/24 at 9:42 a.m. Staff E said medication aides did the wound care for Tenant C2. On 9/3/24 at 4:25 p.m. Staff H said Tenant C2 had a wound the right side on his hip bone. It was a deep wound. She helped with packing the wound. The LPN showed her how. She said the wound was 1/2 dollar in size. He was in a lot of pain. He also had a wound on his coccyx. She believed it was because he was sitting in bed so much. When interviewed on 9/9/24 at 1:43 p.m. the LPN said she and the RN assessed the tenant prior to admission and he was a one assist with a walker. He was on hospice at the nursing home (prior placement), got off of hospice and had PT there. When he got to the Program he struggled. She said he came to them with the wound from a prior surgical replacement. The wound was closed on the outside. It looked swollen, red and was tender. She said he was seen at the wound clinic. Staff ended up packing the wound. It was done once per day and as needed. Staff were shown how to the pack the wound, and the hospice nurse also showed them. Althogh she stated the majority of staff were shown, no documentation of this training could be located.	A 160		

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A 160	Continued From page 10 When interviewed on 9/5/24 at 1:44 p.m. the RN said he was at a nursing home prior to admission where she went there to assess him. She physically assisted him and he required the assistance of one person. He had previously had surgery and gone to the nursing home. The wound did not heal and it had something do to with the hardware. It was a chronic wound. When he came to the Program he declined pretty rapidly. He went to the wound clinic and was started on hospice services. She said the wound required minimal packing. It was about 1/2 dollar size and was on a hip incision. The medication managers were shown; however, there was no documentation of the training. He did not have other wounds. 3. In summary, Tenant C2 had a surgically repaired hip in 10/2023. He went to a nursing facility post surgical repair, had complications and had chronic osteomyletis and exposed hardware. Tenant C2 was admitted to the Program on 2/22/24 with the hip wound. He was seen by a wound clinic and had orders including orders to pack the hip wound dated 4/23/24. The MAR reflected unlicensed staff packed the wound from 4/26/24 to 5/3/24. Tenant C2 had a wound that required packing, which required on-going nursing assessment, nursing judgement and decision making through the completion of the task. The task could not be delegated to unlicensed staff (per Iowa Board of Nursing; Chapter 6). Unlicensed staff (Staff A, B, T, U and V) completed the task of packing the wound from 4/26/24 to 5/3/24. Tenant C2 did not receive care, treatment and services that were adequate and appropriate as unlicensed staff provided wound care that should only be provided by licensing nursing staff based on the type of wound.	A 160		

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A 200 A 200	Continued From page 11 481-67.4(1)a(2) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(1) Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. a. "Major injury" shall be defined as any injury which: (2) Requires admission to a higher level of care for treatment, other than for observation This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify the Department of accidents that caused major injuries within 24 hours or the next working day as required. This pertained to 1 of 2 discharged tenants reviewed who had a fall with significant injuries (Tenant C3). reviewed who had falls with significant injuries. Findings follow: 1. Review of Tenant C3's file on 8/26/24 revealed an Incident Report Form dated 7/16/24 at 2:15 a.m. indicating at 2:00 a.m. rounds, Tenant C3 was noted in bed. At 2:15 a.m. her alarm sounded and she yelled for help. She was observed on the floor on her right side. She said she had tried to get out of bed and that she was in pain. Her vital signs were taken and her blood	A 200 A 200	1) Executive director will work with nurses to submit initial self report to DIAL within 24 hours or next working day with any fall with significant injury. Date of compliance: 12/15/2024	

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 09/26/2024

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

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A 200	Continued From page 12 pressure was slightly elevated both times it was taken. She said her hip hurt and she was shaking and crying. The RN, 911 and family were called. She was transported to the hospital. Hospital records revealed Tenant C3 was admitted on 7/16/24 and discharged from the hospital on 7/19/24 to a skilled nursing facility. The diagnosis was a displaced intertrochanteric fracture of the right femur (right hip fracture). When interviewed on 9/5/24 at 1:44 p.m. the RN said she was notified the tenant needed to go the hospital on 7/16/24 after falling out of bed. She said the fall with fracture was reported to the Executive Director. The program did not report this incident to the Department until 8/26/24. When interviewed on 9/5/23 at 11:25 a.m. the Executive Director said Tenant C3 fell out of bed and was sent out for a fractured femur and hip. When asked about not reporting the incident, she said she was not told about the incident. She was also not aware she could report it after 24 hours.	A 200		
A 215	481-67.4(3) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(3) When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule,	A 215		

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A 215	Continued From page 13 "pattern" means two or more times within a 30-day period. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify the Department of an act that caused major injury to a tenant. This pertained to 2 of 2 tenants reviewed involved in an act that caused major injury (Tenant #3 and Tenant #4). Findings follow: On 8/27/24 review of an Incident Report form indicated on 7/17/24 at 6:35 p.m. Tenant #3 had a fall in the living room area. Staff was called to the living room for Tenant #3's fall. It was noted another tenant pushed Tenant #3, which caused her to fall on her back. Tenant #3 had complaints of back and wrist pain. Tenant #3 also hit her head. Neurological checks were completed. A Witness Statement completed by Staff F indicated she was sweeping the kitchen when she heard Tenant #4 and Tenant #3 talking. Tenant #4 asked her where her car was and Tenant #3 told her she was not sure. Tenant #4 started screaming at her, told her she was dumb and was not making sense. Staff F turned towards them and observed Tenant #4 "run into" Tenant #3 with her walker angrily. Tenant #3 fell and landed on her back. Tenant #4 stumbled backward but caught her balance with the railing. Tenant #4 claimed Tenant #3 attacked her and that she did not do anything wrong. Tenant #3 cried and said she did not mean to upset her. Staff F called the medication aide and they took Tenant #3's vitals and then got her up. Tenant #3 complained of wrist and back pain. When interviewed on 9/3/24 at 4:25 p.m. Staff H	A 215	1) Executive director will work with nurses to submit initial self report to DIAL within 24 hours or next working day with any fall with significant injury. Date of compliance: 12/15/2024	

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A 215	Continued From page 14 said she was called to memory care because of the fall. She asked what happened and was told Tenant #3 and Tenant #4 were bickering and Tenant #4 pushed Tenant #3. Tenant #3 was laying on her back with her knee bent in front of one of the offices. Tenant #3 reported wrist pain so her vitals signs were taken and neurological checks were started. Staff assisted her up and her only complaint of pain was her wrist. The next day or two, staff could barely move her and she was sent out to the emergency department (ED). She was sent back to the program as they could find nothing wrong. A couple of days later Tenant #3 could not get out of bed and staff could barely touch her to sit her up. A medication aide was sent with her to the hospital. She had two compression fractures in her back. When interviewed on 9/5/24 at 1:44 p.m. the RN said she either received a telephone call or reviewed the incident report related to the incident. She said Tenant #4 was hard of hearing (HOH) and got frustrated if she could not hear the response. Tenant #4 was looking for her car and she rammed her walker into Tenant #3 who fell. Tenant #3 was sent to the hospital but did not have any fractures. She was sent out a second time where it was found she had compression fractures. She was admitted to the hospital and then went to skilled care. Record review revealed hospital records indicating Tenant #3 was admitted on 7/22/24 and discharged to an intermediate care facility on 7/30/24. Final diagnosis included a wedge compression fracture of the first lumbar vertebra. The report indicated she had closed compression fracture of the L1 lumbar vertebra and closed compression fracture of the L3 lumbar vertebra. It documented five or six days prior she was	A 215		

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A 215	Continued From page 15 accidentally shoved by another tenant, which caused her to fall backwards. When interviewed on 9/5/24 at 11:25 a.m. the Executive Director said she was not told about the incident with Tenant #3 and Tenant #4 when it happened. She said she was told Tenant #4 asked Tenant #3 about her car and Tenant #3 did not know. Tenant #4 was HOH. Tenant #4 rammed her walker into Tenant #3 and she fell backwards. Tenant #3 fractured her back, was sent out and went to skilled care. The Program did not report the incident between the two tenants that resulted in a major injury on 7/17/24 until 8/26/24, which was greater than 24 hours from the time of the known injuries that resulted from the incident.	A 215		
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 treatments as ordered. This pertained to 3 of 6 current tenants (Tenants #2, #4 and #6) and 2 of	A 285	1) Education will be provided to medication managers regarding PRN medications being used for their intended uses only. Nurses will ensure that intended uses or diagnosis are listed on the MAR for medication mangers to see. 2) Education will be provided to medication managers to provide a progress note with PRN medications stating the reason why a PRN medication is being given. 3) Nurses will audit the number of times PRN medications are being utilized and will communicate with provider on appropriateness. Nurses will utilize 24 hour report to audit PRN medications daily.	

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A 285	Continued From page 16 3 discharged tenants (Tenant C2 and Tenant C3) reviewed. Findings follow: 1. Review of Tenant 2's file on 8/28/24 revealed an Incident Report Form dated 6/24/24 at 3:55 p.m. reflecting Staff F was asked to come to hallway two. She noticed Tenant #2 on the floor unresponsive. She called the LPN (Licensed Practical Nurse) over and they took her vital signs and put her into a wheelchair. About 30 minutes later when she was in the bathroom she vomited. The Registered Nurse (RN) was contacted and she was sent to the emergency department. A progress note dated 6/24/24 revealed a nurse from the hospital called and reported Tenant #2 had an occipital fracture (skull fracture based of the neck where it meets the spine), subarachnoid hemorrhage (bleeding in the space between the brain and surrounding membrane, subdural hemorrhage (bleeding between the brain and skull) and cortical hemorrhage (blood pools inside the skull and puts pressure on the brain). Tenant #2 would be discharged back to the Program on comfort cares. Comfort medication orders were sent to the pharmacy. Progress notes for Tenant #2 revealed the following: - Between 6/25/24 and 8/21/24 the tenant had 13 recorded falls - On 7/31/24 the tenant's morphine sulfate solution 100/5 ml, 0.25 ml by mouth three times daily as directed was held due to a medication error. Staff discovered the error as the count was off. - On 8/25/24 (late entry) staff reported Tenant #2 was very anxious and agitated and attempted to get out of her chair. Staff sat with her one to one to ensure her safety. Staff called hospice and was	A 285		

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A 285	Continued From page 17 told to give PRN (as needed) medications and they would send a nurse out between 8 and 9 a.m. as the doctor on-call would not answer until then. - On 8/25/24 (late entry) staff reported Tenant #2 was very anxious and agitated and attempted to get out of her chair. Staff sat with her one to one to ensure her safety. Staff called hospice and was told to give PRN (as needed) medications and they would send a nurse out between 8 and 9 a.m. as the doctor on-call would not answer until then. - On 8/25/24 (late entry) staff called the Registered Nurse (RN) and reported Tenant #2 continued to be anxious, agitated and attempted to get up out of the chair. She did not sleep on third shift. They called hospice at 1:30 a.m. and reported the medications were not effective and they were sitting with her one to one all shift. The RN said she would call hospice. - On 8/25/24 (late entry) the RN called hospice and the situation and behaviors were reported to the hospice nurse (on-call). She was told the nurse could not reach the doctor on-call. She requested the hospice nurse keep trying as it was not fair for Tenant #2 to be anxious and have not slept. The hospice nurse called back with an order for lorazepam, which had just been discontinued as it had the opposite effect. She was told if Haldol and lorazepam were not working she was unsure what to do as those were only medications they could use for hospice. Another hospice nurse called and said she was in the building and would work to help her anxiety. During an interview on 8/21/24 at 12:50 p.m. Staff B said if Tenant #2 was awake on third shift staff would give lorazepam and morphine. She felt third shift staff wanted the tenants to sleep so they did not have as much to do. It had been	A 285		

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A 285	Continued From page 18 brought up to the nurse. When interviewed on 9/3/24 at 10:12 a.m. Staff C said third shift gave PRN medications to make sure tenants were sleeping. She said Tenant #2 was given PRNs to keep asleep. Tenant C3 was also given a PRN if she got up during the night. On 9/3/24 at 10:41 a.m. Staff D said PRN lorazepam and morphine sulfate were given on third shift to help the tenant get to sleep. She said Tenant #2 received a lot of lorazepam. When interviewed on 9/3/24 at 4:25 p.m. Staff H said she believed some staff over did it regarding giving PRN meds for Tenant #2. She said it was administered too frequently and perhaps the tenant had developed a tolerance to it. On 9/5/24 at 1:44 p.m. the RN said Tenant #2 did not have any seizure activity when at the Program. There was a question regarding the initial fall (6/24/24) when she fell backwards. When interviewed on 9/3/24 at 3:58 p.m. Hospice Nurse #3 said there was no noted seizure activity for Tenant #2. Review of the July 2024 MAR (medication administration record) revealed the following: - Lorazepam concentrate (benzodiazepine medication) 2 milligram (mg)/milliters (ml), give 0.5 ml by mouth every four hours PRN for anxiety was started on 7/1/24 and discontinued on 8/9/24. This medication was administered 11 times and twice it was charted as not effective. Most of the entries did not have a reason provided for the administration of the PRN medication. a. On 7/26/24 at 5:57 a.m. the reason it was	A 285		

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A 285	Continued From page 19 administered was Tenant #2 was restless and was not sitting still. b. On 7/31/24 at 11:33 p.m. it was administered as Tenant #2 was restless, she wanted to get up and stand and was agitated. - Lorazepam concentrate 2 mg/ml give 1 ml by mouth every 15 minutes PRN for seizures, may repeat up to four times before calling HCP for further orders. It was started on 6/26/24. It was administered 8 times and it was charted as not effective 4 times. a. On 7/17/24 4:04 a.m. there was no reason charted for why it was given. It was charted as not effective as 4:30 a.m. and another dose was administered on 7/17/24 at 4:31 a.m. and it was charted as effective at 5:25 a.m. b. On 7/19/24 at 5:58 p.m. there was no reason charted for why it was given and was charted as not effective at 6:09 p.m. c. On 7/19/24 at 7:56 p.m. there was no reason charted for why it was given. It was charted as effective at 8:48 p.m. d. On 7/20/24 at 2:32 a.m. it was documented as given and noted it was not effective. There was no reason charted for why it was given. It was documented as administered again at 3:35 a.m. with no reason provided. e. On 7/23/24 at 8:28 p.m. there was no reason why it as given and it was charted as not effective at 8:34 p.m. f. On 7/31/24 there was no reason charted for why it was given. It should be noted the RN and Hospice Nurse #3 said in interviews there had been no seizure activity reported after her fall. - Morphine Sulfate solution (opioid analgesic medication) 100/5 ml, give 0.25 ml (5 mg) by mouth/SL every 1 hour PRN for pain or shortness of breath. It was started on 6/25/24. It was administered 15 times and charted as not effective 1 time and unknown 5 times. Most of the	A 285		

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A 285	Continued From page 20 entries did not have a reason provided for the administration of the PRN medication. a. On 7/4/24 it was noted as given due to Tenant #2 having a fall and hitting her head. b. On 7/13/24 it was noted it was administered due to restlessness. The July MAR also reflected Tenant #2 had scheduled doses of lorazepam and morphine sulfate. Lorazepam concentrate 2 mg/ml 0.5 ml (1 mg) by mouth/SL was scheduled every six hours at 2:00 a.m., 8:00 a.m. and 2:00 p.m. and at bedtime. Tenant #2 also had morphine sulfate solution, 0.25 ml (5 mg) by mouth/SL three times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m. There was also an order for quetiapine (antipsychotic medication) 25 mg one tablet by mouth at bedtime scheduled at 8:00 p.m. It was started on 7/5/24 and discontinued on 8/12/24. The August MAR revealed the following: - The PRN Lorazepam for anxiety was administered 2 times before being discontinued on 8/9/24. - The PRN Lorazepam that was started on 8/9/24 was administered 8 times and 1 time it was charted as not effective. - The PRN Lorazepam for seizures was administered 3 times before being discontinued on 8/9/24. a. On 8/17/24 it was documented as administered with no reason provided. b. On 8/20/24 it was documented as administered with no reason provided. c. On 8/24/24 it was documented as administered with no reason provided. It should be noted the RN and Hospice Nurse #3 said there had been no seizure activity reported. - The PRN morphine sulfate was administered 38 times. It was charted as not effective 12 times.	A 285		

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A 285	Continued From page 21 Most of the entries did not have a reason provided for the administration of the medication. a. It was documented as given on 8/7/24 at 12:03 a.m. prior to a transfer. b. On 8/11/24 at 9:57 p.m. it was documented as given for restlessness. c. On 8/16/24 it was documented as given for Tenant #2 being very anxious. - The PRN Haloperidol concentrate (antipsychotic medication) 2 mg/ml give 0.5 ml (1 mg) every hour as needed was started on 8/22/24 and was administered 3 times. Twice it was charted as not effective. The August 2024 MARs also reflected Tenant #2 had scheduled doses of lorazepam, morphine sulfate, haloperidol and quetiapine. In summary, Tenant #2 was prescribed scheduled and PRN antipsychotic, benzodiazepines and narcotic analgesic medications. She received over 30 doses of PRN medications in July and over 60 doses of PRNs in August in addition to her scheduled medications. Lorazepam 1 ml, every fours for seizures was documented as administered 11 times despite no noted seizure activity reported to the RN or Hospice Nurse #3. Additionally, there were entries related to the administration of the lorazepam PRN for anxiety being administered due to her not sitting still, trying to stand. Morphine sulfate every 1 hours PRN for pain or shortness of breath was being administered for restlessness, anxiety and hitting her head post fall. Tenant #2 did not receive medications as ordered including for the intended use of the medication. 2. Review of Tenant #4's file on 8/26/24 revealed the July 2024 MAR indicated an order for lorazepam 0.5 mg, one tablet by mouth every 8	A 285		

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A 285	Continued From page 22 hours PRN for anxiety was administered on 7/5/24. A progress note dated 7/5/24 at 1:06 a.m. indicated the lorazepam was administered because Tenant #4 kept getting up. Tramadol HCL 50 mg, every 8 hours PRN for pain was also administered at 1:07 a.m. (no reason given for the administration of the medication). Both medications were charted as effective. To summarize, Tenant #4 received a dose of PRN lorazepam 0.5 tablet as needed for anxiety because she kept trying to get up. Additionally, PRN Tramadol 50 mg for pain was administered without a reason. Tenant #4 did not receive medications as ordered including for the intended use of the medication. 3. Review of Tenant #6's file on 8/29/24 revealed the May 2024 MAR reflected the following: - Clobetasol Propionate External Ointment 0.05% apply to the thighs up to the shoulder twice per day for skin condition. There were 16 times it was charted as medication not available. - Hydrocodone-acetaminophen tablet 5/325 mg, one tablet by mouth every 8 hours as needed for broken rib pain. It was started on 11/6/23 and discontinued on 8/22/24. It was charted as given on 5/1/24 and 5/5/24 and was charted as effective. Progress Notes indicated on 5/1/24 it was administered as Tenant #6 was having increased pain and behaviors. On 5/5/24 it was administered for Tenant #6 having leg and back pain. Tenant #6's June 2024 MAR indicated the following: - Hydrocodone-acetaminophen tablet 5/325 mg, one tablet by mouth every 8 hours PRN for	A 285		

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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 285	Continued From page 23 broken rib pain. It was started on 11/6/23 and discontinued on 8/22/24. It was documented as administered on 6/25/24 and 6/26/24 and was charted as effective. Progress Notes indicated it was administered on both dates as Tenant #6's spouse requested it be administered for leg pain. Further record review revealed Tenant #6's medication was not administered as ordered as the Clobetasol ointment was not available to administer and the hydrocodone-acetaminophen was not administered as ordered for the intended reason. 4. Review of Tenant C2's file on 8/26/24 revealed wound clinic orders indicating the following: - On 4/2/24 it was noted he should return in three weeks and could bathe without the wound dressing. His weight should be positioned from left to right every one to two hours. A ROHO cushion was to be used in all chairs. Orders for Wound #3, located on the right lateral forearm, included to apply Bactroban once per day. Apply a thin layer to the wound bed. cover with Mepilex border flex (4 x 4) once per day. For Wound #4, located on the medial coccyx, staff were to apply a thin later to the wound bed and cover with Mepilex border flex (4 x 4) once per day. For Wound #5, right upper leg, staff were to apply Bactroban once per day, apply a thin layer to the wound bed, cover with Mepilex border flex (4 x 4) once per day. - On 4/23/24 it was noted he should return in three weeks and could bathe without the wound dressing. His weight should be positioned from left to right every one to two hours. A ROHO cushion was to be used in all chairs. Orders for Wound #4, located on the medial coccyx, were apply Bactroban three times per week, apply a thin layer to the wound bed, cover with Mepilex	A 285		

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	S0379	A. BUILDING: _____ B. WING _____	C 09/26/2024

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A 285	Continued From page 24 border (4 x 4) three times per week. For Wound #5 located on the right upper leg, staff were to apply Dakin's 0.125% soaked gauze to wound bed once daily, place a 5 x 9 ABD pad over wounded area once daily and 2" conform pack loosely into wounded area. For Wound #6 on the left upper arm, staff were to Bactroban three times per week, apply a thin layer to the wound bed, cover with Mepilex border (4 x 4) three times per week. A Recommended Plan of Treatment document from a partnering wound care company indicated hospice was the provider, virtual consultation was ordered and information was provided per the hospice nurse on 4/27/24. It was dated 4/29/24 by a Wound and Ostomy Specialist. The document recommended to change previous dressing change orders to the following: - cleanse the coccyx wound and dry, cover it with a sacral silicone border and change three times per week and to discontinue the Mupirocin ointment. - for the right hip wound staff were to cleanse the wound and dry, cover with sacral silicone border and change three times per week and to discontinue the Mupirocin ointment. It was noted the wound could be packed; however, he might not tolerate it. A Physician's orders document (hospice) indicated to increase dressing changes to the right hip to twice daily due to excessive drainage. It was ordered on 5/2/24. The April 2024 MAR reflected the following orders: - soak gauze with H-Chlor 12 solution 0.125% and apply to upper right leg daily. Use a small gauze roll and loosely pack into the hip wound. It	A 285		

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A 285	Continued From page 25 was started on 4/25/24 and discontinued on 5/3/24. It was ordered once daily at 8:00 a.m. - for the right hip staff were to cleanse area, pat dry and apply mupirocin to the wound bed and cover with Mepilex dressing. It was started on 4/5/24 and discontinued on 5/6/24. - for the coccyx staff were to cleanse and pat dry and apply mupirocin to the area and cover with Mepilex once daily. It was started on 4/6/24 and discontinued on 5/3/24. The May 2024 MAR reflected the following orders: - soak gauze with H-Chlor 12 solution 0.125% and apply to upper right leg daily. Use a small gauze roll and loosely pack into the hip wound. It was started on 4/25/24 and discontinued on 5/3/24. - for the right hip staff were to cleanse area, pat dry and apply mupirocin to the wound bed and cover with Mepilex dressing. It was started on 4/5/24 and discontinued on 5/6/24. - cleanse the right hip, pat dry, cover with an ABD pad and tape twice daily. It was started on 5/6/24. - for the coccyx area staff were to cleanse and pat dry and apply mupirocin to the area and cover with Mepilex once daily. It was started on 4/6/24 and discontinued on 5/3/24. From 5/3/24 until 5/6/24 the order was to complete this procedure twice a day. On 5/6/24 an order was received to cleanse and cover with Mepilex twice daily, but to discontinue the use of mupirocin. Continued record review revealed mupirocin (Bactroban) and Mepilex dressing to the right upper leg (right hip) was not listed on the wound clinic orders as of 4/23/24; however, was not discontinued on the MAR until 5/6/24. The orders from 4/23/24 for the coccyx wound and left upper	A 285		

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A 285	Continued From page 26 arm wound were not updated to reflect the change in frequency from daily to three times per week. The wound consult orders dated 4/29/24 indicated to discontinue the prior treatments to the coccyx and right hip (mupirocin and Mepilex) but the orders were not discontinued on the MAR when received on 4/29/24. The right hip wound treatment continued to be completed as previously ordered until 5/3/24. The right hip dressing change was increased to twice daily on 5/2/24 due to excessive drainage but the order was not reflected the MAR until 5/6/24. The coccyx wound was reflected on the MAR to apply mupirocin and cover with Mepilex twice daily. An order was received to discontinue the mupirocin treatment on 4/29/24 but the order did not reflect the coccyx wound dressing was increased to twice daily. On 5/6/24 the MAR was updated to reflect the order to cleanse the area and cover with Mepilex border; however, it was started on 5/6/24 and reflected it was ordered twice daily. Tenant #2's wound care treatments were not completed as ordered. When interviewed on 9/26/24 at 10:44 a.m. the LPN said the orders from the wound consult dated 4/29/24 were put into the system on 4/30/24. The orders were not added to the MAR until 5/6/24. When interviewed on 9/26/24 at 10:12 a.m. the RN confirmed the wound care orders from the wound consult were added to the electronic system on 4/30/24. 5. Review of Tenant C3's file on 8/26/24 revealed the June 2024 MAR reflected an order to apply 4 grams of diclofenac gel 1% to knees and affected skin areas four times daily. It was charted as medication not available for five doses. Tenant	A 285		

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A 285	Continued From page 27 C3 did not receive medications as ordered. 6. When interviewed on 9/5/24 at 1:44 p.m. the RN confirmed all MARs were provided for the tenants reviewed.	A 285		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days of taking occupancy. This pertained to 1 of 1 current tenants (Tenant #2) and 1 of 1 discharged tenants (Tenant C2) reviewed who were admitted in 2024. Findings follow: 1. Review of Tenant #2's file on 8/28/24 revealed she was admitted on 5/10/24. Evaluations were not completed within 30 days of taking occupancy. 2. Review of Tenant C2's file on 8/26/24 revealed he was admitted on 2/22/24. Evaluations were not completed within 30 days of taking occupancy. 3. When interviewed on 9/5/24 at 1:44 p.m. the Registered Nurse confirmed all evaluations were provided for the tenants reviewed.	A 140	1) Nurses worked with a nurse consultant. Nurse consultant helped structure a calendar to keep evaluations in compliance including 30 day evaluations, 90 day evaluations, significant changes, and annual reviews starting 11/1/2024. Program assessments will remain up to date starting 11/1/2024. 2) Executive director has access to PCC and assessment schedule. Executive director will audit schedules and meet with nurses periodically to ensure compliance. Date of compliance: 11/1/2024	

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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 interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 6 of 6 currents tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6) and 2 of 3 discharged tenants reviewed (Tenant C2 and Tenant C3). Findings follow: 1. Review of Tenant #1's file on 8/27/24 revealed Progress Notes indicating the following: - On 6/12/24 staff reported Tenant #1 was incontinent of urine at the 3:00 a.m. rounds. She was very aggressive and staff were not able to change her. They attempted again at 5:00 a.m. She was still upset and had soaked through her clothes. As staff started to change her she allowed it at first and then punched one of the staff under the jaw. Tenant #1's finger was slightly red. The punch caused staff's teeth to clatter and	A 145	1) Nurse worked with a nurse consultant. Nurse consultant helped structure a calendar to keep evaluations in compliance including 30 day evaluations, 90 day evaluations, significant changes, and annual reviews starting 11/1/2024. Program assessments will remain up to date starting 11/1/2024. 2) Executive director has access to PCC and assessment schedule. Executive director will audit schedules and meet with nurses periodically to ensure compliance. Date of compliance: 11/1/2024	

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A 145	Continued From page 29 made her mouth sore. - On 7/2/24 (quarterly review) Tenant #1 was a standby to hands on assistance with for all transfers with a one person assist. She received hospice services and occasionally could get verbally and physically aggressive. - On 8/20/24 crushing her medications as needed was completed. A Client Coordination Note Report (hospice document) dated 8/5/24 indicated Tenant #1 ate 25 to 50 % at meals, fell asleep, and required feeding assistance for most of her meal. She was dependent with a max assistance of six of six activities of daily living (ADLs). She required the assistance of one with a wheelchair and needed max assistance of two to three to stand and pivot transfer to the wheelchair. She was not able to ambulate with a walker and assistance of two people. She was leaning more to her left side at the table and while transferring. Staff reported it was becoming more difficult for her to pivot transfer. She had a cushion in her wheelchair and a pressure reduction mattress on her bed. She was 100% incontinent of bladder and bowel. Continued record review revealed a Request for Waiver of Administrative Rule dated 8/28/24 was submitted to the Department. The waiver application indicated she required the assistance of one to two people with a front wheeled walker for transfers and ambulation and required the assistance of two people with behaviors When interviewed on 8/21/24 at 10:10 a.m. Staff A said for the past two weeks Tenant #1 required the assistance of at least two to three people. On 8/21/24 at 12:50 p.m. Staff B said Tenant #1 required the assistance of two to four people and	A 145		

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A 145	Continued From page 30 was on hospice. She said if tenants needed more assistance for lifting the Program tried to get them either into therapy or in hospice in order to keep them there. When interviewed on 9/3/24 at 10:12 a.m. Staff C said Tenant #1 had some good days and some not so good. Sometimes it took two staff if not more to transfer her. She said 50% or more of the time it took two staff. At times staff fed Tenant #1 at meals. During an interview on 9/3/24 at 10:41 a.m. Staff D said on a good day Tenant #1 took one to two staff for transfers. She took two staff to get out of bed almost daily. In the morning one to two staff were needed, but after breakfast it took three to four people for toileting including the transfers and cares. When interviewed on 9/4/24 at 9:42 a.m. Staff E said Tenant #1 required the assistance of two people for about two weeks. She said she could get "feisty." On 9/3/24 at 4:25 p.m. Staff H said at the beginning of the shift the tenant required one to two staff to transfer, but at the end of the night she required the assistance of three to four. She said Tenant #1 was combative. When interviewed on 9/9/24 at 1:43 p.m. the LPN (Licensed Practical Nurse) said most of the time staff took two people to assist Tenant #1. She had required the assistance of two people more consistently in the past couple of months. During an interview on 9/5/24 at 1:44 p.m. the RN (Registered Nurse) said Tenant #1 was a heavy two to three person assist. They had applied for a	A 145		

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A 145	Continued From page 31 waiver the previous week. She said Tenant #1 could bear weight if she wanted and said she could be "feisty." When interviewed on 8/29/24 at 1:44 p.m. Hospice Nurse #1 stated transfers were being worked on and it was thought the tenant had knee pain and back pain. She received Tylenol three times daily and had morphine sulfate as needed. The tenant required two to three people for transfers starting about 3 weeks prior. She said that week she had been feeding herself with cueing. When observed on 9/3/24 at 11:20 a.m. two staff transferred Tenant #1 from a lift chair to a wheelchair. The staff appeared to struggle to get her into the wheelchair as Tenant #1 attempted to sit before she was transferred into the chair. Tenant #1 did not fall; however, the transfer did not appear easy. Continued record review revealed evaluations were last completed on 7/2/24. Evaluations were not completed as needed with changes in ambulation, transfers, eating and physical behaviors towards staff. 2. Review of Tenant #2's file on 8/28/24 revealed an Incident Report Form dated 6/24/24 at 3:55 p.m. reflecting Staff F was asked to come to hallway two. She noticed Tenant #2 on the floor unresponsive. She called the LPN over and they took her vital signs and put her into a wheelchair. About 30 minutes later when she was in the bathroom she vomited. The RN was contacted and she was sent to the emergency department (ED). Continued review revealed an Emergency	A 145		

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A 145	Continued From page 32 Department discharge note documenting Tenant #2 was admitted on 6/24/24 at 4:58 p.m. and discharged on 6/24/24 at 8:00 p.m. She had both a skull fracture (occipital bone fracture) and bleeding around the brain. With her dementia her prognosis was poor and she qualified for hospice as it was a terminal illness The record revealed evaluations were completed on 6/26/24 which was 2 days after her return from the hospital on 6/24/24 on comfort cares and hospice after sustaining a skull fracture and brain bleed. The evaluations with significant change were not completed prior to returning from the hospital in order to determine the tenant's continued eligibility for the program and to determine any changes to services needed Review of Tenant #2's Progress Notes following her return from the hospital indicated the following: - On 6/25/24 Tenant #2 was observed on the floor in front of her bed during rounds. It appeared she rolled out of bed. - On 6/27/24 staff reported Tenant #2 had an unwitnessed fall. Tenant #2 was laying between the recliner and the couch. Staff had put her into the recliner. The alarm pad was under her but did not sound when she got up. - On 6/28/24 Tenant #2 had a fall. Tenant #2 fell sideways onto the couch. Hospice had left and medication manager noticed her climbing out of the chair. She repositioned her and continued passing medications. When staff came out she noticed her on the floor in the living room. - On 7/1/24 Tenant #2 had a fall. Staff heard her alarm and responded and found her on the floor next to her bed. She was assisted up and to the bathroom and back in bed. When she was in bed she tried climbing out again. Staff sat with her	A 145		

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A 145	Continued From page 33 one to one until she calmed down. - On 7/4/24 Tenant #2 had a fall. She was seated in the wheelchair and staff saw her trying to get up. She hit her head on the loveseat. She was assisted off the floor and to a recliner. She had an abrasion to her head. - On 7/5/24 Tenant #2 had a fall. Tenant #2 was observed on the floor in the memory care living room. - On 7/6/24 at 1:00 p.m. it was noted Tenant #2 had a fall. Tenant #2 was observed sitting on her fall mat in front of her bed. - On 7/6/24 at 1:30 p.m. hospice had just left and Tenant #2 had climbed out of her wheelchair and fell near the couch in the living room. - On 7/10/24 staff reported Tenant #2 had a fall, her alarm sounded and they observed her laying on the right ride near her bed. - On 7/18/24 it was reported Tenant #2 "passed out" at 4:06 p.m. yesterday. It was reported to the hospice nurse. - On 7/31/24 Tenant #2 had a fall. She was observed on the floor next to her wheelchair. - On 8/7/24 Tenant #2 had a fall. She was observed leaning against a recliner sitting up in the living room. - On 8/11/24 Tenant #2 had a fall. She was observed on the floor in the living room. She sustained a small skin tear to her right hand. - On 8/15/24 Tenant #2 had a fall. She attempted to stand and walk and fell to the side. She hit her head on the walker as she fell. Staff assisted her up and attended to her one to one. - On 8/21/24 staff tried to administer her medication but could not get her to wake up long enough to take the medications - On 8/21/24 Tenant #2 had a fall. She was observed on the floor in front of the recliner couch. Her alarm did not sound as the battery was out.	A 145		

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A 145	Continued From page 34 - On 8/25/24 (late entry) staff reported Tenant #2 was very anxious and agitated and attempted to get out of her chair. Staff sat with her one to one to ensure her safety. Staff called hospice and was told to give PRN (as needed) medications and they would send a nurse out between 8 and 9 a.m. as the doctor on-call would not answer until then. - On 8/25/24 (late entry) staff called the RN and reported Tenant #2 continued to be anxious, agitated and attempted to get up out of the chair. She did not sleep on third shift. They called hospice at 1:30 a.m. and reported the medications were not effective and they were sitting with her one to one all shift. The RN said she would call hospice. - On 8/25/24 (late entry) the RN called hospice and the situation and behaviors were reported to the hospice nurse (on-call). She was told the nurse could not reach the doctor on-call. She requested the hospice nurse keep trying as it was not fair for Tenant #2 to be anxious and have not slept. She called back with an order for lorazepam, which had just been discontinued as it had the opposite effect. She was told if Haldol and lorazepam were not working she was unsure what to do as those were only medications they could use for hospice. Another hospice nurse called and said she was in the building and would work to help her anxiety. - On 8/25/24 (late entry) the doctor spoke with Tenant #2's legal representative and they decided to admit her to the hospice house on an acute basis related to her medications. Evaluations completed after 6/26/24 could not be located relevant to the tenant's repeated falls, increased restlessness, and somnolence. 3. Review of Tenant #3's file on 8/28/24 revealed	A 145		

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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 145	Continued From page 35 Progress Notes indicating the following: - On 7/17/24 staff reported another tenant got agitated with Tenant #3 and pushed her over with her walker. Tenant #3 fell backwards, landed on her back and hit her head. Tenant #3 complained of wrist and back pain. She was assisted up off of the floor to the couch. - On 7/17/24 at 7:10 p.m. PRN (as needed) acetaminophen for pain was administered. At 8:24 p.m. it charted as not effective. Tenant #3's pain was rated at seven and she still complained of back pain. - On 7/18/24 the RN assessed Tenant #3 from her fall last night. She could move both wrists without pain and had no complaints of pain in her back. - On 7/18/24 at 4:48 p.m. PRN acetaminophen was administered. - On 7/19/24 at 8:54 a.m. PRN ibuprofen for pain was administered. - On 7/20/24 at 1:30 a.m. PRN acetaminophen was administered. Tenant #3 was in extreme pain, as she yelled and grimaced and voiced how uncomfortable she was due to back and hip pain. - On 7/20/24 staff called the nurse to report when they got Tenant #3 up to use the bathroom she was not able to bear weight and cried in pain. The medication aide thought she needed to be sent out to the ED for assessment. Tenant #3 was transported via ambulance to the hospital. - On 7/20/24 the hospital called and there were no fractures. Tenant #3 would be sent back. - On 7/20/24 at 10:21 a.m. PRN acetaminophen for pain was administered. It was noted Tenant #3 had hip pain when transferring. - On 7/20/24 at 9:38 p.m. PRN acetaminophen was administered. It was noted Tenant #3 had back pain. The follow up was documented at 12:25 a.m. and indicated the medication was not effective and she was in extreme pain. The pain	A 145		

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	S0379	A. BUILDING: _____ B. WING _____	C 09/26/2024

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A 145	Continued From page 36 was rated at a 10. - On 7/21/24 at 9:27 a.m. PRN acetaminophen for pain was administered. - On 7/22/24 at 7:47 a.m. PRN acetaminophen was administered. It was noted at 11:27 a.m. the medication was not effective and the pain was rated at eight. - On 7/22/24 at 6:40 p.m. staff called the nurse on-call and reported Tenant #3 was screaming out in pain. She would not move and would not allow staff to move her. He had a lot of pain on her right side. Tenant #3 was taken to the ED. - On 7/22/24 it was noted at the hospital two compression fractures were found in her back. She was going to be admitted. - On 8/23/24 a change of condition was completed. On 7/17/24 Tenant #3 had a fall on her back. On 7/20/24 staff reported she was in pain unable to bear weight. She was sent to the ED and was discharged back with no fractures. On 7/22/24 she was sent back to the ED due to increased pain. The ED staff reported she had two compression fractures. She was admitted to the hospital and then discharged to skilled care. She was planning on returning to the Program on 8/26/24. Evaluations completed as needed post fall with complaints of pain, non-weight bearing status and frequent use of PRN pain relievers could not be located. 4. Review of Tenant #4's file on 8/29/24 revealed Progress Notes indicating the following: - On 7/1/24 Tenant #4 fell and complained of hip pain. PRN Tramadol for pain was administered and was not effective. - On 7/1/24 PRN acetaminophen for pain was administered and was not effective. - On 7/1/24 at 2:58 p.m. Tenant #4 came back	A 145		

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A 145	Continued From page 37 from the ED and was in lots of pain. PRN Acetaminophen for pain was administered and it was not effective at noted at 4:27 p.m. - On 7/3/24 Tenant #4 screamed in pain (back). PRN Tramadol for pain was administered. - On 7/3/24 Tenant #4 was still having back pain and yelled. PRN Acetaminophen was administered. - On 7/3/24 Tenant #4 screamed in pain. PRN Tramadol for pain was administered. - On 7/6/24 it was noted daily weights were not taken as Tenant #4 was in too much pain. - On 7/7/24 it was noted daily weights were not taken as Tenant #4 could not stand due to pain. - On 7/14/24 Tenant #4 screamed and hit staff. - On 7/18/24 Tenant #4 became agitated in the living room area and used her walker to run into another tenant, which caused the other tenant to fall. Tenant #4 also screamed at and called the other tenant names. - On 7/26/24 Tenant #4 was upset as she thought she was missing her things. She was anxious. - On 8/1/24 a physical therapy (PT) staff reported Tenant #4 continued to require supervision for transfers. Continued record review revealed evaluations were most recently completed on 3/8/24. Evaluations could not be located as needed related to behaviors towards staff and the incident that occurred with another tenant, PT recommendations related to ambulation, increased pain and not being able to stand at times due to pain. 5. Review of Tenant #5's file on 8/29/24 revealed she received hospice services. The Hospice IDG Comprehensive Assessment and Plan of Care Update Report indicated she was consistently fed	A 145		

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A 145	Continued From page 38 most meals, she had left sided weakness and was no longer able to follow directions. She was dependent for six of six ADLs and was no longer ambulatory. She was unable to make her needs known. Tenant #5 needed one to two pillows to support her trunk while in the chair. She needed multiple cues to swallow food. The Hospice Aide Care Plan dated 8/7/24 reflected a home health aide (HHA) with hospice assisted with bathing (bed/bath) during the HHA visits. When observed on 8/21/24 at the time of the lunch meal Tenant #5 was asleep in a high back wheelchair. Staff W sat beside her with four dishes of pureed foods and fed her the meal. Staff W and hospice assisted Tenant #5 with her meal. When observed on 9/3/24 at 11:35 a.m. two staff assisted Tenant #5 up from the recliner. She walked slowly with the assistance of one staff and a walker. She was assisted to sit at the dining room table and a pillow was placed on her left side. She fell asleep at the table before her food arrived. When interviewed on 9/3/24 at 10:12 a.m. Staff C reported normally Tenant #5 took one for transfers; 10% of the time she required the assistance of two staff. When interviewed on 9/3/24 at 10:41 a.m. Staff D said some staff used one person to transfer Tenant #5 while others used two staff. On 9/3/24 at 2:34 p.m. Staff G said she generally transferred Tenant #5 by herself, but some staff used two due to her frailty. When interviewed on 9/5/24 at 1:44 p.m. the RN	A 145		

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A 145	Continued From page 39 said most of the time Tenant #5 required the assistance of one person for transfers. It depended on the day if she required cueing or hands on assistance for eating. During an interview on 8/29/24 at 3:46 p.m. Hospice Nurse #2 said the tenant was starting to use her wheelchair and noted she had really lost the ability to walk more and more. Transfers required one to two staff to assist and she was weight bearing. Continued record review revealed the tenant's most recent evaluations were dated 5/30/24. Evaluations could not be located as needed regarding the need for 2-person transfers at times, decreased ambulation and the increased assistance needed at meals. 6. Review of Tenant #6's file on 8/29/24 revealed Progress Notes indicating the following: - On 5/1/24 PRN lorazepam for agitation was administered. The note indicated Tenant #6 used profanity and was hitting. The follow up indicated Tenant #6 was still very agitated with staff. - On 5/4/24 (late entry) staff reported that during a safety check Tenant #6 was observed laying on the end of the bed. Staff approached Tenant #6 and asked what he was doing and he told them to get away and don't touch him. Staff attempted to redirect him and he was told for his safety they needed to stand him up to lay at the top of the bed. Tenant #6 stood up and threw his walker which hit the wall near the bathroom. He sat on the edge on the bed and, when he lifted his feet up into bed, he kicked staff in the chest and attempted to punch the other staff. He laid back into bed with his feet and buttocks hanging off of the side of the bed. The staff called for additional staff to assist. He agreed to get into bed but	A 145		

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A 145	Continued From page 40 grabbed the gait belt and started hitting the staff which caused him to slip to the floor. He sustained a small skin tear to the right lower forearm. Staff called Tenant #6's spouse as he refused to allow staff to help him off of the floor. His spouse came in and was able to redirect him. He was assisted off of the floor and back into bed. - On 5/5/24 (late entry) second shift staff reported she was called into Tenant #6's apartment and observed him screaming and hitting the other staff. The medication aide asked the other staff to leave as Tenant #6 did not do well with multiple people in his apartment at one time. The aide was hit in the stomach and he tried hitting the other aide. The nurse was informed and told all staff to exit his apartment to allow him to calm down. Staff returned to the apartment 20 minutes later and he allowed cares to be completed. - On 5/6/24 (late entry) third shift staff reported during rounds he was found lying at the end of the bed without clothing. The staff attempted to redirect him to the top of his bed. He started hitting and using profanity towards staff. The staff left and apartment and checked on him again at 1:30 a.m. He was laying at the end of the bed again but refused assistance. Staff continued to check on Tenant #6 during safety checks. - On 6/18/24 staff reported Tenant #6 tried to bite or punch staff. He refused his medications and used profanity towards staff. Staff re-approached him to take his medications and he tried to punch her and told her to get out of his apartment. - On 6/27/24 staff asked the nurse to help give Tenant #6's his medications due to his refusal earlier. Staff was not able to get him up, dressed or change his protective undergarment that morning due to combative behaviors. The nurse	A 145		

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A 145	Continued From page 41 was able to get him up and seated on the side of the bed and his medications were taken. He wanted to lay back down before the other cares were completed. When attempting to help him stand up he became agitated. He was allowed to lay back in bed and staff would re-approach. - On 8/12/24 (late entry) staff changed his bed as it was soiled. He started to hit and kick staff when they attempted to change and dress him. He slid off of the bed onto the floor. He would not allow staff to assist him without lashing out. Staff provided him a pillow and blanket on the floor and left him to calm down. After several checks staff were able to get him up. He sustained a small skin tear to his right hand. - On 8/14/24 (late entry) staff assisted Tenant #6 from his recliner to his bed. He stood up and then sat right back down. Staff called another staff to assist. When he was being assisted with two people his knees buckled and he ended up sliding down to the floor with the assistance of staff. They attempted to get him up and he started pinching and punching at them. Staff made him comfortable with a pillow and blanket and left him to calm down. He was checked on several times and re-approached by different staff and his behaviors were the same. He balled his fists up and refused to get up. He obtained a small skin tear to the right elbow. Staff were able to get him up off of the floor and up for the day when first shift arrived. - On 8/16/24 (late entry) staff reported a golf ball size lump on the backside of his calf and he reported pain. He had multiple behaviors when he had kicked and hit staff which may have caused the injury. - On 8/17/24 (late entry) Tenant #6's spouse reported she was transferring him and he fell into the side of the wheelchair. She noticed a red mark on the bottom right side of his back that	A 145		

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A 145	Continued From page 42 appeared to be starting to bruise. - On 8/18/24 staff reported he was very aggressive. During a staff assisted transfer to bed he attempted to bite staff on the arm. Once he was in bed he slammed his fist down onto her head, which caused a hair clip in staff's hair to "jam into her head causing a lump and a headache." When interviewed on 8/21/24 at 10:10 a.m. Staff A said if Tenant #6 ended up on the floor it took two to three staff to get him up. He was aggressive at least once per shift. She said sometimes it was a reaction to how he was approached by staff. He had not been aggressive towards other tenants. His medications were being adjusted and at times he was aggressive towards his spouse who visited frequently. On 8/21/24 at 12:50 p.m. Staff B said Tenant #6 sometimes needed two people to assist with transfers. The tenant used to walk but now stopped and was more confused. It took a lot of cues to transfer him. The tenant struck out at staff times. When he was on the floor his spouse said to give him a blanket and pillow. At times he refused assistance. He did not like it loud. During an interview on 9/3/24 at 10:12 a.m. Staff C said Tenant #6 required the assistance of two people 30% of the time. A lot of the time he required the assistance of one person. He was combative fairly often. He refused to get up, and sometimes refused medications. He displayed both verbal and physical behaviors. He tried to kick, hit and grab staff. When interviewed on 9/3/24 at 10:41 a.m. Staff D said Tenant #6 did not walk anymore. Sometimes it took two or three staff to assist him. She had	A 145		

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A 145	Continued From page 43 been able to assist him by herself. When he was combative he kicked and hit staff. She said a soft approach worked with him and he did much better with one person. On 9/3/24 at 2:37 p.m. Staff G said Tenant #6 required the assistance of one to two staff for transfers depending on his mood and behavior. She said he had verbal and physical behaviors and the frequency was every few days. He punched, hit, grabbed and used profanity towards staff. She said there had not been any injuries. When interviewed on 9/3/24 at 4:25 p.m. Staff H said one to two staff were needed to assist Tenant #6 with transfers, dependent on his behaviors. When interviewed on 9/9/24 at 1:43 p.m. the LPN said it took one to two staff to transfer him dependent on his behaviors. He displayed both verbal and physical behaviors. For physical behaviors he punched and kicked. He hit one staff with his fist and her hair clip than went into her head. He had also slapped someone on the face and it left a mark. When interviewed on 9/5/24 at 1:44 p.m. the RN said Tenant #6 required the assistance of one to two people for transfers based on his behavior. She said he had been aggressive, including hitting and kicking. He hit someone who then had a migraine. Last week he was on the floor (not a fall) and was kicking. Staff left him in a safe position on the floor and checked on him every five minutes. She said Tenant #6 became overwhelmed. Education was provided to staff that only one person needed to go help the tenant initially, and to call for assistance if another staff was needed.	A 145		

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A 145	Continued From page 44 Evaluations could not be located as needed including when Tenant #6 required the assistance of two staff at times for transfers, changes in ambulation, behaviors (including physical behaviors towards staff) and refusals of medications, cares and at times getting up off of the floor. 7. Review of Tenant C2's file on 8/26/24 revealed he was admitted on 2/22/24 and discharged on 5/7/24. Progress Notes indicated the following: - On 2/22/24 Tenant C2 hit and kicked staff when they attempted to help him get ready for bed. Staff left and re-approached. - On 2/25/24 third shift staff reported the tenant made inappropriate comments to staff regarding asking if she would lay down with him. - On 2/27/24 second shift reported Tenant C2 was violent last night and hit and punched staff. He needed to be assisted by two people. - On 2/27/24 Tenant C2's pressure alarm sounded and he was found in front of his bed. He was assisted off of the floor with two people. - On 3/15/24 a PT staff reported Tenant C2 had very tight bilateral lower extremities which limited his ability to stand with good posture. He was able to stand for 30 to 40 seconds. - On 3/18/24 it was noted medications were crushed due to difficulty swallowing. - On 3/18/24 Tenant C2 was discharged from his PT provider to move to another PT provider. - On 3/29/24 staff reported Tenant C2 obtained a skin tear to his left lower arm while transferring to the toilet. The transfer was difficult to the toilet and he slid his arm against the wall which caused a skin tear. - On 4/2/24 staff reported he had been transferring with the assistance of two or three staff. He struggled to bear weight and pivot. He	A 145		

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A 145	Continued From page 45 was working with PT. - On 4/9/24 staff reported Tenant C2 was very aggressive during third shift rounds. He punched and squeezed staff while they were changing him. He appeared to be in pain when they rolled him. - On 4/9/24 staff reported he had a right swollen hand when get got up. He appeared to be in a lot of pain and grimaced during transfers. It took three staff to transfer him. He refused to move his right wrist. An appointment was made to have his right hand checked for fracture. - On 4/10/24 staff reported he had a fall. Staff checked on him and observed him sitting on the floor at the foot of the recliner that was still reclined. It was tipped forward. His pad alarm slid with him. He was still leaning on it which is why it had not sounded. - On 4/10/24 a call was made to the wound clinic to get his appointment moved up due to his hip being red and swollen. They said he needed to be seen in the ED. - On 4/14/24 Tenant C2 was in pain during transfers. - On 4/15/24 staff reported Tenant C2 often hit, yelled and called staff names during transfers and repositioning on late second shift and third shift. Staff reported he appeared to be in pain when he stood and it took three people to transfer him. - On 4/17/24 Tenant C2 had a lot pain with any movement. It was noted he seemed okay once he was up but he hurt a lot with cares or moving him. - On 4/28/24 a PRN medication was administered and staff charted it was not effective. It was noted he was screaming a lot and hitting. - On 4/28/24 a PRN medication was administered and staff charted Tenant C2 was in major pain. - On 5/1/24 a PRN medication was administered	A 145		

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A 145	Continued From page 46 and staff charted it was given for severe pain and hollering out in pain during rounds. - On 5/1/24 it was noted Tenant C2 was unable to take medications. - On 5/2/24 a PRN medication was administered and Tenant C2 was in extreme pain. - On 5/5/24 it was noted Tenant C2 was not able to take his medications. - On 5/6/24 a call was received from hospice that Tenant C2 was actively dying. New orders were received for morphine sulfate 0.5 ml every hour as needed and oxygen 1 to 3 liters to maintain oxygen saturation above 90%. - On 5/7/24 it was noted Tenant C2 passed away. On 8/21/24 at 12:50 p.m. Staff B said Tenant C2 required the assistance of two to three staff for transfers with a walker and gait belt the entire time he was there. At the very end he was bed bound. Staff repositioned him. When interviewed on 9/3/24 at 10:12 a.m. Staff C said Tenant C2 took two to three people to transfer and he could not bear weight. During an interview on 9/3/24 at 10:41 a.m. Staff D said when Tenant C2 first arrived he required the assistance of two people. He had a hip wound and it opened and he then required a third person. She said a lot of the time he was combative and a fourth person was needed. When interviewed on 9/3/24 at 9:42 a.m. Staff E said Tenant C2 required the assistance of two to four staff for transfers. He was bed bound at times and did not get up. He had required the assistance of two pretty much from when he was admitted.	A 145		

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A 145	Continued From page 47 On 9/3/24 at 4:25 p.m. Staff H said Tenant C2 required the assistance of two staff, sometimes three, for transfers. He had a wound the right side on his hip bone. He was in a lot of pain. He also had a wound on his coccyx. When interviewed on 9/9/24 at 1:43 p.m. the LPN said she and the RN assessed him prior to admission and he was a one assist with a walker. He was on hospice at the nursing home (prior placement), got off of hospice and had PT there. When he got to the Program he struggled. She said almost immediately transfers were rough with him. He became very angry. Progressively he got worse and required the assistance of two for transfers which he needed for a fair amount of time. He was started on hospice services. When interviewed on 9/5/24 at 1:44 p.m. the RN said he was at a nursing home prior to admission where she went there to assess him. She physically assisted him and he required the assistance of one person. He had previously had surgery and gone to the nursing home. The wound did not heal and it had something do to with the hardware. It was a chronic wound. When he came to the Program he declined pretty rapidly. She said within less than a month he required the assistance of two people. He went to the wound clinic and was started on hospice services. Further record review revealed evaluations were completed on 2/8/24 (prior to admission) and a cognitive evaluation was completed on 5/3/24. There were no other evaluations located that were completed during Tenant C2's time at the Program from 2/22/24 to 5/7/24. Evaluations could not be located as needed with significant changes including increased transfer assistance	A 145		

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	S0379	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAR	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 145	Continued From page 48 requiring two or more staff, behaviors, pain during transfers and movement, the initiation and discharge from PT services, the initiation of hospice services, and when Tenant C2 became bed bound and end of life cares were provided. 8. Review of Tenant C3's file on 8/26/24 revealed Progress Notes indicating the following: - On 4/2/24 Tenant C3 struggled with transfers today. Staff reported she required the assistance of two to three staff and was non-weight bearing on either foot. - On 4/11/24 (late entry) Tenant C3 was sitting on her bedroom floor next to her bed. The assistance of two people wasrequired to transfer her from the floor to the bathroom. Her alarm was noted to be on but was found under her on the floor. - On 6/12/24 PT started that day. - On 7/16/24 at 2:15 a.m. staff heard Tenant C3 yell for help and observed her laying on her right side. She stated she fell when she tried to get out of bed. She complained of hip pain and was shaking and crying. She was sent to the hospital for evaluation. - On 7/16/24 she was transferred from the local hospital to another hospital for closed intertrochanteric fracture of the right hip. - On 7/18/24 Tenant C3 was admitted to a facility for skilled care. When interviewed on 9/4/23 at 9:42 a.m. Staff E said on Tenant C3's good days she could transfer with 1 staff. She had back pain and struggled to stand. She required the assistance of two staff 50 % of the time. On 9/3/24 at 2:37 p.m. Staff G said Tenant C3 took one to two staff for transfers. She had arthritis in her knees.	A 145		

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A 145	Continued From page 49 When interviewed on 9/4/24 at 11:29 a.m. Staff M many times due to staffing she was assisted with one person. It took two staff to safely assist her. She said before PT it would take two staff and she was "dead weight." When interviewed on 9/9/24 at 1:43 p.m. the LPN said Tenant C3 required the assistance of one person but occasionally would require the assistance of two. She had terrible knees. Continued record review revealed evaluations were last completed on 5/10/24. Evaluations could not be located as needed when changes occurred and Tenant C3 required the assistance of two people at times, or with the addition of PT services. 9. When interviewed on 9/5/24 at 1:44 p.m. the RN confirmed all evaluations were provided for the tenants reviewed.	A 145		
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 observation, interview and record review the Program failed to discharge tenants who required routine assistance of at least two	A 155	1) When resident is determined to require an assist of 2 or more with cares, transfers, or ambulation, nurse will notify PCP and obtain orders for therapies, pain management ect. If these are not effective, nurses will submit a waiver to DIAL. If waiver is denied or we feel we are unable to care for tenant, we will speak to tenant and family about discharging to a hire level of care voluntarily. If tenant or family is not in agreement with the voluntary discharge, an involuntary 30- day discharge notice will be issued. Nurses will help facilitate move to high level of care with both circumstances. Date of compliance: 12/15/2024	

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A 155	Continued From page 50 people for transfers. This pertained to 1 of 6 current tenants (Tenant #1) and 1 of 3 discharged tenants (Tenant C2) reviewed. Findings follow: 1. Review of Tenant #1's file on 8/27/24 revealed she received hospice services and was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. A Request for Waiver of Administrative Rule was submitted to the Department dated 8/28/24 (onsite visit was initiated on 8/19/24). The waiver application indicated she required the assistance of one to two people with a front wheeled walker for transfers and ambulation and required the assistance of two people with behaviors. Progress Notes indicated the following: - On 7/2/24 (quarterly review) Tenant #1 was a standby to hands on assistance with for all transfers with a one person assist. She received hospice services and occasionally could get verbally and physically aggressive. A Client Coordination Note Report (hospice document) dated 8/5/24 indicated Tenant #1 required the assistance of one with a wheelchair and needed max assistance of two to three to stand and pivot transfer to the wheelchair. She was not able to ambulate with a walker and assist of two people. She was leaning more to her left side at the table and while transferring. Staff reported it was becoming more difficult for her to pivot transfer. When observed on 9/3/24 at 11:20 a.m. two staff transferred Tenant #1 from a lift chair to a wheelchair in the living room area. The staff appeared to struggle to get her into the wheelchair as Tenant #1 attempted to sit before she was transferred into the chair. Tenant #1 did	A 155		

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A 155	Continued From page 51 not fall; however, the transfer did not appear easy. When interviewed on 8/21/24 at 10:10 a.m. Staff A said for the past two weeks Tenant #1 required the assistance of at least two to three people. On 8/21/24 at 12:50 p.m. Staff B said Tenant #1 required the assistance of two to four people and was on hospice. She said if tenants needed more assistance for lifting the Program tried to get them either into therapy or in hospice in order to keep them there. When interviewed on 9/3/24 at 10:12 a.m. Staff C said Tenant #1 had some good days and some not so good. Sometimes it took two staff if not more to transfer her. She said 50% or more of the time it took two staff. During an interview on 9/3/24 at 10:41 a.m. Staff D said on a good day Tenant #1 took one to two staff for transfers. She took two staff to get out of bed almost daily. In the morning one to two staff were needed, but after breakfast it took three to four people for toileting including the transfers and cares. When interviewed on 9/4/24 at 9:42 a.m. Staff E said Tenant #1 required the assistance of two people for about two weeks. She said she could get "feisty." On 9/3/24 at 4:25 p.m. Staff H said at the beginning of the shift the tenant required one to two staff to transfer, but at the end of the night she required the assistance of three to four. She said Tenant #1 was combative. When interviewed on 9/9/24 at 1:43 p.m. the LPN	A 155		

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A 155	Continued From page 52 (Licensed Practical Nurse) said most of the time staff took two people to assist Tenant #1. She had required the assistance of two people more consistently in the past couple of months. During an interview on 9/5/24 at 1:44 p.m. the RN (Registered Nurse) said Tenant #1 was a heavy two to three person assist. They had applied for a waiver the previous week. She said Tenant #1 could bear weight if she wanted and said she could be "feisty." When interviewed on 8/29/24 at 1:44 p.m. Hospice Nurse #1 stated transfers were being worked on and it was thought the tenant had knee pain and back pain. She received Tylenol three times daily and had morphine sulfate as needed. The tenant required two to three people for transfers starting about 3 weeks prior. 2. Review of Tenant C2's file on 8/26/24 revealed he was admitted on 2/22/24 and discharged on 5/7/24. Progress Notes indicated the following: - On 2/27/24 second shift reported Tenant C2 was violent last night and hit and punched staff. He needed to be assisted by two people. - On 2/27/24 Tenant C2's pressure alarm sounded and he was found in front of his bed. He was assisted off of the floor with two people. - On 3/15/24 a PT staff reported Tenant C2 had very tight bilateral lower extremities which limited his ability to stand with good posture. He was able to stand for 30 to 40 seconds. - On 4/2/24 staff reported he had been transferring with the assistance of two or three staff. He struggled to bear weight and pivot. He was working with PT. - On 4/14/24 Tenant C2 was in pain during transfers. - On 4/15/24 staff reported Tenant C2 often hit,	A 155		

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A 155	Continued From page 53 yelled and called staff names during transfers and repositioning on late second shift and third shift. Staff reported he appeared to be in pain when he stood and it took three people to transfer him. On 8/21/24 at 12:50 p.m. Staff B said Tenant C2 required the assistance of two to three staff for transfers with a walker and gait belt the entire time he was there. At the very end he was bed bound. Staff repositioned him. When interviewed on 9/3/24 at 10:12 a.m. Staff C said Tenant C2 took two to three people to transfer and he could not bear weight. During an interview on 9/3/24 at 10:41 a.m. Staff D said when Tenant C2 first arrived he required the assistance of two people. He had a hip wound and it opened and he then required a third person. She said a lot of the time he was combative and a fourth person was needed. When interviewed on 9/3/24 at 9:42 a.m. Staff E said Tenant C2 required the assistance of two to four staff for transfers. He was bed bound at times and did not get up. He had required the assistance of two pretty much from when he was admitted. On 9/3/24 at 4:25 p.m. Staff H said Tenant C2 required the assistance of two staff, sometimes three, for transfers. He had a wound on his hip bone. He also had a wound on his coccyx. He was in a lot of pain. When interviewed on 9/9/24 at 1:43 p.m. the LPN said she and the RN assessed him prior to admission and he was needed the assistance of one staff with a walker. He was on hospice at the nursing home (prior placement), got off of	A 155		

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A 155	Continued From page 54 hospice and had PT there. When he got to the Program he struggled. She said almost immediately transfers were rough with him. He became very angry. Progressively he got worse and required the assistance of two for transfers which he needed for a fair amount of time. He was started on hospice services. When interviewed on 9/5/24 at 1:44 p.m. the RN said he was at a nursing home prior to admission where she went there to assess him. She physically assisted him and he required the assistance of one person. He had previously had surgery and gone to the nursing home. The wound did not heal and it had something do to with the hardware. It was a chronic wound. When he came to the Program he declined pretty rapidly. She said within less than a month he required the assistance of two people. He went to the wound clinic and was started on hospice services. She said she was in the process of submitting the waiver (of administrative rule) but it was never submitted.	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	A 160		

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A 160	Continued From page 55 by: Based on interview and record review the Program failed to discharge a tenant who was physically and verbally aggressive. This pertained to tenants reviewed 1 of 6 current tenants reviewed (Tenant #6). Findings follow: Review of Tenant #6's file on 8/29/24 revealed diagnoses including neurocognitive disorder with lewy bodies, dementia with agitation, major depressive disorder, claustrophobia and Alzheimer's disease. Tenant #6 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline Progress Notes indicated the following: - On 5/1/24 PRN (as needed) lorazepam for agitation was administered. The note indicated Tenant #6 used profanity and was hitting. The follow up indicated Tenant #6 was still very agitated with staff. - On 5/4/24 (late entry) staff reported that during a safety check Tenant #6 was observed laying on the end of the bed. Staff approached Tenant #6 and asked what he was doing and he told them to get away and don't touch him. Staff attempted to redirect him and he was told for his safety they needed to stand him up to lay at the top of the bed. Tenant #6 stood up and threw his walker which hit the wall near the bathroom. He sat on the edge on the bed and, when he lifted his feet up into bed, he kicked staff in the chest and attempted to punch the other staff. He laid back into bed with his feet and buttocks hanging off of the side of the bed. The staff called for additional staff to assist. He agreed to get into bed but grabbed the gait belt and started hitting the staff which caused him to slip to the floor. He sustained a small skin tear to the right lower forearm. Staff called Tenant #6's spouse as he	A 160	1) If tenant is observed to be verbal, physically, sexually abusive or chronically elope, nurses will consult with PCP or psychiatry for medication changes as appropriate and non-pharmacological interventions. Education will also be provided to care staff on how to approach tenant via service plan. 2) If interventions are ineffective, nurses will communicate with tenant or family about discharging to a higher level of care and voluntary discharge. If tenant or family is not in agreement, an involuntary 30-day discharge notice will be issued. Nurses will help facilitate all moves to higher level of care. Date of compliance: 12/15/2024	

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A 160	Continued From page 56 refused to allow staff to help him off of the floor. His spouse came in and was able to redirect him. He was assisted off of the floor and back into bed. - On 5/5/24 (late entry) second shift staff reported she was called into Tenant #6's apartment and observed him screaming and hitting the other staff. The medication aide asked the other staff to leave as Tenant #6 did not do well with multiple people in his apartment at one time. The aide was hit in the stomach and he tried hitting the other aide. The nurse was informed and told all staff to exit his apartment to allow him to calm down. Staff returned to the apartment 20 minutes later and he allowed cares to be completed. - On 5/6/24 (late entry) third shift staff reported during rounds he was found lying at the end of the bed without clothing. The staff attempted to redirect him to the top of his bed. He started hitting and using profanity towards staff. The staff left and apartment and checked on him again at 1:30 a.m. He was laying at the end of the bed again but refused assistance. Staff continued to check on Tenant #6 during safety checks. - On 6/18/24 staff reported Tenant #6 tried to bite or punch staff. He refused his medications and used profanity towards staff. Staff re-approached him to take his medications and he tried to punch her and told her to get out of his apartment. - On 6/27/24 staff asked the nurse to help give Tenant #6's his medications due to his refusal earlier. Staff was not able to get him up, dressed or change his protective undergarment that morning due to combative behaviors. The nurse was able to get him up and seated on the side of the bed and his medications were taken. He wanted to lay back down before the other cares were completed. When attempting to help him	A 160		

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A 160	Continued From page 57 stand up he became agitated. He was allowed to lay back in bed and staff would re-approach. - On 8/12/24 (late entry) staff changed his bed as it was soiled. He started to hit and kick staff when they attempted to change and dress him. He slid off of the bed onto the floor. He would not allow staff to assist him without lashing out. Staff provided him a pillow and blanket on the floor and left him to calm down. After several checks staff were able to get him up. He sustained a small skin tear to his right hand. - On 8/14/24 (late entry) staff assisted Tenant #6 from his recliner to his bed. He stood up and then sat right back down. Staff called another staff to assist. When he was being assisted with two people his knees buckled and he ended up sliding down to the floor with the assistance of staff. They attempted to get him up and he started pinching and punching at them. Staff made him comfortable with a pillow and blanket and left him to calm down. He was checked on several times and re-approached by different staff and his behaviors were the same. He balled his fists up and refused to get up. He obtained a small skin tear to the right elbow. Staff were able to get him up off of the floor and up for the day when first shift arrived. - On 8/16/24 (late entry) staff reported a golf ball size lump on the backside of his calf and he reported pain. He had multiple behaviors when he had kicked and hit staff which may have caused the injury. - On 8/18/24 staff reported he was very aggressive. During a staff assisted transfer to bed he attempted to bite staff on the arm. Once he was in bed he slammed his fist down onto her head, which caused a hair clip in staff's hair to "jam into her head causing a lump and a headache."	A 160		

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A 160	Continued From page 58 Continued record review new orders were received on 5/7/24 for quetitapine 25 mg twice daily PRN (as needed) and 50 mg every p.m. around 4 p.m. to best manage behaviors (agitation and aggression). An order was also received for duloxetine 30 mg, take 60 mg in the morning and 30 mg at bedtime (for depression and neuropathic pain). New orders were received 7/31/24 for quetiapine 25 mg, two tablets every morning, one tablet at noon and three tablets every evening. Take one tablet by mouth twice daily PRN for agitation and aggression. It noted to take the evening doses between 3 and 4 p.m. New orders were received on 8/22/24 for Lorazepam 0.5 mg, take twice daily PRN. Continued quetiapine current orders and add 12.5 mg 30 minutes prior to cares as needed. When interviewed on 8/21/24 at 10:10 a.m. Staff A said if Tenant #6 ended up on the floor it took two to three staff to get him up. He was aggressive at least once per shift. She said sometimes it was a reaction to how he was approached by staff. He had not been aggressive towards other tenants. His medications were being adjusted and at times he was aggressive towards his spouse who visited frequently. On 8/21/24 at 12:50 p.m. Staff B said Tenant #6 struck out at staff times. When he was on the floor his spouse said to give him a blanket and pillow. At times he refused assistance. He did not like it loud. During an interview on 9/3/24 at 10:12 a.m. Staff C said Tenant #6 was combative fairly often. He refused to get up, and sometimes refused	A 160		

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A 160	Continued From page 59 medications. He displayed both verbal and physical behaviors. He tried to kick, hit and grab staff. When interviewed on 9/3/24 at 10:41 a.m. Staff D said Tenant #6 did not walk anymore. Sometimes it took two or three staff to assist him. She had been able to assist him by herself. When he was combative he kicked and hit staff. She said a soft approach worked with him and he did much better with one person. On 9/3/24 at 2:37 p.m. Staff G said Tenant #6 required the assistance of one to two staff for transfers depending on his mood and behavior. She said he had verbal and physical behaviors and the frequency was every few days. He punched, hit, grabbed and used profanity towards staff. She said there had not been any injuries. When interviewed on 9/9/24 at 1:43 p.m. the LPN said it took one to two staff to transfer him dependent on his behaviors. He displayed both verbal and physical behaviors. For physical behaviors he punched and kicked. He hit one staff with his fist and her hair clip then went into her head. He had also slapped someone on the face and it left a mark. When interviewed on 9/5/24 at 1:44 p.m. the RN said Tenant #6 required the assistance of one to two people for transfers based on his behavior. She said he had been aggressive, including hitting and kicking. He hit someone who then had a migraine. She said Tenant #6 became overwhelmed. Education was provided to staff that only one person needed to go help the tenant initially, and to call for assistance if another staff was needed. She said he was not appropriate based on his behavior.	A 160		

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	S0379	A. BUILDING: _____ B. WING _____	C 09/26/2024

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

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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 current tenants reviewed (Tenants #4, #5 and #6). Findings follow: 1. Review of Tenant #4's file on 8/29/24 revealed Progress Notes indicating the following: - On 7/1/24 Tenant #4 fell and complained of hip pain, Tramadol HCL 50 milligram (mg) PRN (as needed) for pain was administered and was not effective. - On 7/1/24 acetaminophen 500 mg, PRN for pain was administered and was not effective. - On 7/1/24 at 2:58 p.m. (administration note for PRN medications) Tenant #4 came back from the emergency department (ED) and was in so much pain. Acetaminophen 500 mg, PRN for pain was administered and it was not effective at noted at 4:27 p.m. An After Visit Summary (AVS) dated 7/1/24 from the ED indicated she was seen for a fall and had a contusion of the right hip and an abnormal computed tomography scan. The AVS indicated	A 290	1) Program met with nursing consultant and was educated on examples of significant changes, when to chart follow up's and order notes. Nurses will chart a progress note when a fax is sent out to PCP and when a new order is obtained from PCP. RN will complete significant change assessments in a timely manner and provide follow ups as needed. Date of compliance: 11/1/2024	

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A 290	Continued From page 61 to follow up with her primary care provider (PCP) as soon as possible within three days. Further record review revealed nurse's notes were not documented by exception when Tenant #4 went to the ED, when she returned or the instructions from the ED. 2. Review of Tenant #5's file on 8/29/24 revealed Progress Notes indicating the following: - On 6/10/24 (late entry) staff reported Tenant #5 had a flaky area in the middle of her chest. Tenant #5 reported it was very itchy. Hospice was notified. - On 8/27/24 Tenant #5 was administered Chest Congestion Liquid 100/5 ml, 20 ml by mouth PRN was administered for a cough. Continued record review revealed nurse's notes were not documented by exception related to follow up to the skin issue reported on 6/10/24 or with the administration of a liquid cough syrup and cough noted on 8/27/24. 3. Review of Tenant #6's file on 8/29/24 revealed the August 2024 medication administration records (MARs) reflected an order for doxycycline hyclate oral capsule, 100 mg, one capsule by mouth twice daily for five days for an upper respiratory infection (URI). It was noted with a start date of 8/9/24. The last dose was administered on 8/14/24 at 8:00 a.m. Continued record review revealed nurse's notes were not documented by exception related to the URI and treatment when it was started or when the antibiotic therapy was completed to monitor for further signs and symptoms of the URI. 4. When interviewed on 9/5/24 at 1:44 p.m. the	A 290		

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A 290	Continued From page 62 RN confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
A 300	481-69.25(1)k Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: k. Advance health care directives as applicable This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to maintain advance health care directives. This pertained to 1 of 1 discharged tenants reviewed who had a fall and died (Tenant C1). Findings follow: 1. Review of Tenant C1's file on 8/21/24 revealed an Incident Report Form dated 5/3/24 at 6:00 p.m. reflecting the medication aide noted Tenant C1 was laying on her back, head on the ground with a towel under the head to hold pressure on the wound. Tenant C1 was not responsive and was bleeding from the back of the head. The color in Tenant C1's face was very pale and gray. The medication aide called Tenant C1's name loudly several times without a response. The electronic system was checked and Tenant C1 was identified as a do not resuscitate (DNR). The only vital sign she was able to to obtain was temperature, which was 96 degrees. The RN was contacted via phone to tell her that staff needed to send Tenant C1 out to the ED due to her head injury and she was not responding. The medication aide notified the family. Paramedics arrived and asked for Tenant C1's code status and they were showed in the electronic records system where it indicated she was a DNR. One of	A 300	1) IPOST will be completed upon admission and faxed to PCP for signature. Once PCP signature is obtained, Code status is updated in chart. 2) Nurses are working to obtain code status from all tenants. 3) The chart has been updated for care staff to obtain advanced directive by clicking hyperlink in chart header. Date of compliance: 12/15/2024	

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A 300	Continued From page 63 the a paramedics requested to see the actual DNR signed by a doctor. They hooked Tenant C1 up to a heart monitor and could not find a pulse. At 6:16 p.m. they received an order to pronounce Tenant C1 deceased. Staff was told by paramedics Tenant C1 was not to be moved until the medical examiner arrived. The funeral home transported Tenant C1 to the state medical examiner's office for further evaluation. The reported indicated Tenant C1 had a witnessed fall with head injury. A written statement dated 5/3/24 was provided by Staff I that indicated she was walking down the hallway to give medications to another tenant and she observed Tenant C1 "double back and try to catch her self." Staff I ran to catch her but was too late and she hit her head on another tenant's door. Staff I went to see if her head was bleeding. She was laying there and took a couple of breaths and turned blue. Staff I noted trying to find if she was a DNR or not and 911 was called to send her out for a head injury. She passed when EMTs were there. Staff I stayed with her and held her head from where she was bleeding. Staff I had walked by her when she was returning from break approximatley two minutes prior to her falling. At that time she was seated on her walker but asked Staff I to open the door so she could leave to babysit. Two of the aides went to break. Tenant C1 observed them open the door and she thought that was when Tenant C1 got up so that she could leave. Her feet were facing one tenant's apartment door and her head was inside the apartment of another tenant. A written statement dated dated 5/3/24 was provided by Staff J. She was on her way to break and she saw Tenant C1 sitting on her walker by the memory care door. When she walked out of	A 300		

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A 300	Continued From page 64 the door she saw Tenant C1 stand up so she made sure the door closed fully so the tenant would not get out. She saw Staff I running and realized something was wrong. Staff J saw the tenant fall at an angle and hit her head on another tenant's door. She opened the memory care door and Staff I asked her to get another staff. 2. When interviewed on 9/4/24 at 2:05 p.m. Staff I said she had just gotten back from her break about 5:30 p.m. and Tenant C1 was seated on her walker. Staff I went to give another tenant's medications and was walking down the hallway Tenant C1 was located in. She saw Tenant C1 get up and start to double back. She tripped backwards and was holding her walker. She started running towards the tenant to try and catch her but she fell and her head bounced off of the floor. She was halfway in the doorway and halfway in the hall. She had hit her head on the door. Staff I held her head as it was bleeding and called for assistance. Staff N responded and Staff I told to her call 911. Staff N called the RN and the nurse told her to call 911. EMTs arrived about five minutes later and did a quick assessment of her. She was breathing (one to two breaths when they were there). They requested a paper code status document and staff could not find it or print it off. The EMTs were shown the electronic MAR (listed her code status) but told staff they could not use it. The EMTs called someone and she was pronounced deceased. On 9/4/24 at 12:45 p.m. Staff N said she was assigned to memory care and came in at about 5:50 p.m. that day. She was by the microwave and received a page for assistance. Several other people responded. She observed Tenant C1 between the memory care door and an apartment door. She was laying on her back and was not	A 300		

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A 300	Continued From page 65 responsive but was breathing. She saw her take a breath, her color was off and she was very pale. She could not get a pulse when she got to her. It was determined she was a DNR. The first telephone call was to the RN and the RN said to call the family. The RN was informed there was no response and she told her to call 911 and she called family. The EMTs came out and wanted paperwork. In the electronic records system it indicated she was a DNR. The paramedics wanted to see an I-Post. She went to the documents but could not get access to it. Several people were asked and it could not be found. She reached out to the RN, as she did not have access to it. She said there were folders in the closet and but it was not accessible. The paperwork was not there for her. When interviewed on 9/10/24 at 9:19 a.m. Staff J said she worked second shift in memory care and in the middle of her shift she was on her way to break. Tenant C1 was seated on her walker by the door (north side). She heard Staff I say Tenant C1's name, then the door closed. She turned around and saw Tenant C1 was standing and tipped over. She could not really see. Staff I and others ran over. She was not involved much from that point as she kept other tenants away from Tenant C1. During an interview on 9/3/24 at 4:25 p.m. Staff H said Staff I was the medication aide and texted to see if she could assist. She came in and was told Tenant C1 was walking the down the hallway to leave and went to turn around, tripped and hit her head on the doorframe. Staff I ran to try to catch her. She was bleeding from the back of her head. EMTs got there and after they left the medical examiners arrived. Staff H stayed to assist with moving her with the medical examiners. When	A 300		

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A 300	Continued From page 66 the funeral home arrived she was moved to a cot. Tenant C1's code status was on the MAR on the tablet but her actual paperwork could not be found. When interviewed on 9/5/24 at 1:44 p.m. the RN said she received a telephone call as she was on-call and staff reported a fall by a door and she had hit her head on the door frame. She said it was not uncommon for her to be by the door. Tenant C1 was not responding but was breathing and she told staff to call 911. EMTs arrived and pronounced her deceased and told staff to wait for the medical examiner. She said staff sat with her. The RN was told by staff that Tenant C1 was by the north side door and she said she had to look for her grandchildren. She lost her balance and Staff I tried to get to her. Another staff had just left for her break. Staff I witnessed the fall and Staff N took over so Tenant I could continued to pass medications. After she received the phone call she told them call 911. Staff were not able to locate the DNR document in her file. She said in the electronic record there were code status and documents tab. It was not in the file in the electronic records for Tenant C1. It was verified with the family that she was a DNR. 3. Review of Tenant C1's file on 8/21/24 revealed her Move In Record (face sheet) indicated her advance directives were DNR. She was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Review of the ambulance report through the hospital indicated an ambulance responded on 5/3/24 at 6:04 p.m. The reasons for the visit indicated cardiac arrest, respiratory arrest and unspecified injury of the head. The external causes of injury indicated unspecified place in	A 300		

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A 300	Continued From page 67 nursing home as the place of occurrence of the external cause. 4. In summary, Tenant C1 had a fall and died on 5/3/24. Staff called the RN and then called 911. EMTs arrived and she was still breathing (one to two breaths) per interview and requested Tenant C1's code status paperwork. Staff showed the EMTs the electronic MAR; however, staff was not able to provide the code status paperwork requested by the EMTs. They pronounced her deceased at 6:16 p.m. The staff indicated she was a DNR based on the electronic record system; however, the advance directive documents were not maintained by the program and could not be provided to the EMTs when they responded to the building.	A 300		
A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the Program failed to maintain task sheets as required. This pertained to 1 of 1 discharged	A 330	1) These sheets were an internal document made by the nurses for repositioning and for family to acknowledge how their loved one was doing while they were not present. These documents are no longer being utilized. 2) All repositioning and tasks are documented in PCC. Date of compliance: 11/1/2024	

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A 330	Continued From page 68 tenants reviewed who was on hospice (Tenant C2). Findings follow: 1. Review of Tenant C2's file on 8/26/24 revealed he was admitted on 2/22/24 and discharged on 5/8/24. Tenant C2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. He was admitted to hospice on 4/26/24. 2. When interviewed on 8/21/24 at 12:50 p.m. Staff B said Tenant C2 required the assistance of two to three staff for transfers with a walker and gait belt the entire time he was there. At the very end he was bed bound. Staff repositioned him. During an interview on 9/3/24 at 10:12 a.m. Staff C said towards the end he stayed in bed and staff provided perineal care, repositioned him, provided fluids. When interviewed on 9/3/24 at 10:41 a.m. Staff D said staff checked and changed Tenant C2 in bed and repositioned him. She said he was put on hospice. On 9/3/24 at 2:37 p.m. Staff G said towards the end of his stay he was bed bound and was on hospice. When interviewed on 9/3/24 at 4:25 p.m. Staff H when he stopped getting out of bed staff repositioned him every two hours. On 9/9/24 at 1:43 p.m. the LPN said at the end he was bed bound and he was checked on every two hours, repositioned and was checked and changed. Staff documented the cares in a paper in the folder. The forms were created to hold staff accountable.	A 330		

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A 330	Continued From page 69 When interviewed on 9/5/24 at 1:44 p.m. the RN said the last few days the tenant was bed bound. There were sheets for documentation for end of life cares including repositioning and check and changing. She was not sure she kept the sheets. 3. When the tasks sheets for end of life cares were requested for Tenant C2, the RN indicated in an email dated 9/5/24 that the sheets were only to hold the staff accountable and they had not been saved. 4. Tenant C2's file lacked documentation of personal and health related cares, including repositioning, for a tenant with multiple service providers wh could not advoate for himself. The Program failed to maintain the documentation of those task sheets for Tenant C2.	A 330	1) Program has changed the method of communication with care staff. Program no longer utilizes the 24 hour report format. 2) A communication log has been started between care staff and nurses. Care staff have been educated to document concerns regarding tenants on the communication log and nurses can provide a reply. This log will be obtained for 3 years. Date of compliance: 11/1/2024	
A 340	481-69.25(2) Tenant Documents 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to maintain nurse communication documents. This affected all current tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6). Findings follow: 1. On 9/5/24 review of the Program policy regarding 24 hour reports/nurse communication indicated the 24 hour sheet was used. All staff were to use the form to communicate to the next shift. A new 24 hour sheet was started each day.	A 340		

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A 340	Continued From page 70 At the end of the month all 24 hour reports were turned into the nurse. The nurse would scan the report and store electronically for three years. A nurse communication form was also utilized that went into greater detail about the event that had occurred as the 24 hour log did not allow enough space. Behaviors, refusals of medications, refusals of cares or other concerns would be put on the nurse communication form. The nurse would read the nurse communication form and chart on the reported concerns. The forms would be provided to nurses in the work room or under the locked office door. 2. Reviews of files for Tenant #1, #2, #3, #4, #5 and #6 files revealed no nurse communication sheets. 3. When interviewed on 9/5/24 at 1:44 p.m. the RN said the 24 hour log was the initial report from staff. The staff/nurse communication sheets provided more of a description. Once the staff/nurse communication sheet was entered into the nurse's notes the documents were shredded. The 24 hour logs were kept for three years. 4. Further record review revealed the Program failed to maintain staff/nurse communication sheets as required.	A 340		
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	A 350		

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A 350	Continued From page 71 needed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to update service plans as needs changed. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6) and 3 of 3 discharged tenants reviewed (Tenants C1, C2 and C3). Findings follow: 1. Review of Tenant #1's file on 8/27/24 revealed Progress Notes indicating the following: - On 6/12/24 staff reported Tenant #1 was incontinent of urine at the 3:00 a.m. rounds. She was very aggressive and staff were not able to change her. They attempted again at 5:00 a.m. She was still upset and had soaked through her clothes. As staff started to change her she allowed it at first and then punched one of the staff under the jaw. Tenant #1's finger was slightly red. The punch caused staff's teeth to clatter and made her mouth sore. - On 7/2/24 (quarterly review) Tenant #1 was a standby to hands on assistance with for all transfers with a one person assist. She received hospice services and occasionally could get verbally and physically aggressive. - On 8/20/24 crushing her medications as needed was completed. A Request for Waiver of Administrative Rule was submitted dated 8/28/24. The waiver application indicated she required the assistance of one to two people with a front wheeled walker for	A 350	1) Nurse worked with a nurse consultant. Nurse consultant helped structure a calendar to keep evaluations in compliance including 30 day evaluations, 90 day evaluations, significant changes, and annual reviews starting 11/1/2024. Program assessments will remain up to date starting 11/1/2024. 2) Executive director has access to PCC and assessment schedule. Executive director will audit schedules and meet with nurses periodically to ensure compliance. Date of compliance: 11/1/2024	

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	S0379	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 350	Continued From page 72 transfers and ambulation and required the assistance of two people with behaviors. A Client Coordination Note Report (hospice document) dated 8/5/24 indicated Tenant #1 ate 25 to 50 % at meals, fell asleep, and required feeding assistance for most of her meal. She was dependent with a max assistance of six of six activities of daily living (ADLs). She required the assistance of one with a wheelchair and needed max assistance of two to three to stand and pivot transfer to the wheelchair. She was not able to ambulate with a walker and assistance of two people. She was leaning more to her left side at the table and while transferring. Staff reported it was becoming more difficult for her to pivot transfer. She had a cushion in her wheelchair and a pressure reduction mattress on her bed. She was 100% incontinent of bladder and bowel. When interviewed on 8/21/24 at 10:10 a.m. Staff A said for the past two weeks Tenant #1 required the assistance of at least two to three people. On 8/21/24 at 12:50 p.m. Staff B said Tenant #1 required the assistance of two to four people and was on hospice. She said if tenants needed more assistance for lifting the Program tried to get them either into therapy or in hospice in order to keep them there. When interviewed on 9/3/24 at 10:12 a.m. Staff C said Tenant #1 had some good days and some not so good. Sometimes it took two staff if not more to transfer her. She said 50% or more of the time it took two staff. At times staff fed Tenant #1 at meals. During an interview on 9/3/24 at 10:41 a.m. Staff D said on a good day Tenant #1 took one to two staff for transfers. She took two staff to get out of	A 350		

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A 350	Continued From page 73 bed almost daily. In the morning one to two staff were needed, but after breakfast it took three to four people for toileting including the transfers and cares. When interviewed on 9/4/24 at 9:42 a.m. Staff E said Tenant #1 required the assistance of two people for about two weeks. She said she could get "feisty." On 9/3/24 at 4:25 p.m. Staff H said at the beginning of the shift the tenant required one to two staff to transfer, but at the end of the night she required the assistance of three to four. She said Tenant #1 was combative. When interviewed on 9/9/24 at 1:43 p.m. the LPN (Licensed Practical Nurse) said most of the time staff took two people to assist Tenant #1. She had required the assistance of two people more consistently in the past couple of months. During an interview on 9/5/24 at 1:44 p.m. the RN (Registered Nurse) said Tenant #1 was a heavy two to three person assist. They had applied for a waiver the previous week. She said Tenant #1 could bear weight if she wanted and said she could be "feisty." When interviewed on 8/29/24 at 1:44 p.m. Hospice Nurse #1 stated transfers were being worked on and it was thought the tenant had knee pain and back pain. She received Tylenol three times daily and had morphine sulfate as needed. The tenant required two to three people for transfers starting about 3 weeks prior. She said that week she had been feeding herself with cueing. When observed on 9/3/24 at 11:20 a.m. two staff	A 350		

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A 350	Continued From page 74 transferred Tenant #1 from a lift chair to a wheelchair. The staff appeared to struggle to get her into the wheelchair as Tenant #1 attempted to sit before she was transferred into the chair. Tenant #1 did not fall; however, the transfer did not appear easy. Review of Tenant #1's service plan dated 7/2/24 revealed Tenant #1 used a walker for ambulation and required the assistance of one person for transfers. The service plan was not updated as needed to reflected changes with transfers, ambulation, assistance at meals and staff assistance for changing her in bed on third shift for toileting. The service plan reflected Tenant #1 occasionally became angry if approached to do cares and provided interventions. The service plan did not reflect Tenant #1 had physical behaviors towards staff. The service plan also reflected staff administered medications; however, did not reflect the order for crush medications as needed. The service plan also did not reflect the use a wheelchair, a cushion in the wheelchair or pressure reduction mattress. 2. Review of Tenant #2's file on 8/28/24 revealed an Incident Report Form dated 6/24/24 at 3:55 p.m. reflecting Staff F was asked to come to hallway two. She noticed Tenant #2 on the floor unresponsive. She called the LPN over and they took her vital signs and put her into a wheelchair. About 30 minutes later when she was in the bathroom she vomited. The RN was contacted and she was sent to the emergency department (ED). Review of Tenant #2's Progress Notes following her return from the hospital indicated the following: - On 6/25/24 Tenant #2 was observed on the	A 350		

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A 350	Continued From page 75 floor in front of her bed during rounds. It appeared she rolled out of bed. - On 6/27/24 staff reported Tenant #2 had an unwitnessed fall. Tenant #2 was laying between the recliner and the couch. Staff had put her into the recliner. The alarm pad was under her but did not sound when she got up. - On 6/28/24 Tenant #2 had a fall. Tenant #2 fell sideways onto the couch. Hospice had left and medication manager noticed her climbing out of the chair. She repositioned her and continued passing medications. When staff came out she noticed her on the floor in the living room. - On 7/1/24 Tenant #2 had a fall. Staff heard her alarm and responded and found her on the floor next to her bed. She was assisted up and to the bathroom and back in bed. When she was in bed she tried climbing out again. Staff sat with her one to one until she calmed down. - On 7/4/24 Tenant #2 had a fall. She was seated in the wheelchair and staff saw her trying to get up. She hit her head on the loveseat. She was assisted off the floor and to a recliner. She had an abrasion to her head. - On 7/5/24 Tenant #2 had a fall. Tenant #2 was observed on the floor in the memory care living room. - On 7/6/24 at 1:00 p.m. it was noted Tenant #2 had a fall. Tenant #2 was observed sitting on her fall mat in front of her bed. - On 7/6/24 at 1:30 p.m. hospice had just left and Tenant #2 had climbed out of her wheelchair and fell near the couch in the living room. - On 7/10/24 staff reported Tenant #2 had a fall, her alarm sounded and they observed her laying on the right ride near her bed. - On 7/18/24 it was reported Tenant #2 "passed out" at 4:06 p.m. yesterday. It was reported to the hospice nurse. - On 7/31/24 Tenant #2 had a fall. She was	A 350		

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A 350	Continued From page 76 observed on the floor next to her wheelchair. - On 8/7/24 Tenant #2 had a fall. She was observed leaning against a recliner sitting up in the living room. - On 8/11/24 Tenant #2 had a fall. She was observed on the floor in the living room. She sustained a small skin tear to her right hand. - On 8/15/24 Tenant #2 had a fall. She attempted to stand and walk and fell to the side. She hit her head on the walker as she fell. Staff assisted her up and attended to her one to one. - On 8/21/24 staff tried to administer her medication but could not get her to wake up long enough to take the medications - On 8/21/24 Tenant #2 had a fall. She was observed on the floor in front of the recliner couch. Her alarm did not sound as the battery was out. - On 8/25/24 (late entry) staff reported Tenant #2 was very anxious and agitated and attempted to get out of her chair. Staff sat with her one to one to ensure her safety. Staff called hospice and was told to give PRN (as needed) medications and they would send a nurse out between 8 and 9 a.m. as the doctor on-call would not answer until then. - On 8/25/24 (late entry) staff called the RN and reported Tenant #2 continued to be anxious, agitated and attempted to get up out of the chair. She did not sleep on third shift. They called hospice at 1:30 a.m. and reported the medications were not effective and they were sitting with her one to one all shift. The RN said she would call hospice. - On 8/25/24 (late entry) the RN called hospice and the situation and behaviors were reported to the hospice nurse (on-call). She was told the nurse could not reach the doctor on-call. She requested the hospice nurse keep trying as it was not fair for Tenant #2 to be anxious and have not	A 350		

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A 350	Continued From page 77 slept. She called back with an order for lorazepam, which had just been discontinued as it had the opposite effect. She was told if Haldol and lorazepam were not working she was unsure what to do as those were only medications they could use for hospice. Another hospice nurse called and said she was in the building and would work to help her anxiety. - On 8/25/24 (late entry) the doctor spoke with Tenant #2's legal representative and they decided to admit her to the hospice house on an acute basis related to her medications. Review of Tenant #2's service plan dated 5/13/24 revealed it was not updated after her fall with skull fracture and brain bleeds, admission to hospice, increased restlessness, and repeated falls. 3. Review of Tenant #3's file on 8/28/24 revealed Progress Notes indicating the following: - On 7/17/24 staff reported another tenant got agitated with Tenant #3 and pushed her over with her walker. Tenant #3 fell backwards, landed on her back and hit her head. Tenant #3 complained of wrist and back pain. She was assisted up off of the floor to the couch. - On 7/17/24 at 7:10 p.m. PRN (as needed) acetaminophen for pain was administered. At 8:24 p.m. it charted as not effective. Tenant #3's pain was rated at seven and she still complained of back pain. - On 7/18/24 the RN assessed Tenant #3 from her fall last night. She could move both wrists without pain and had no complaints of pain in her back. - On 7/18/24 at 4:48 p.m. PRN acetaminophen was administered. - On 7/19/24 at 8:54 a.m. PRN ibuprofen for pain was administered.	A 350		

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A 350	Continued From page 78 - On 7/20/24 at 1:30 a.m. PRN acetaminophen was administered. Tenant #3 was in extreme pain, as she yelled and grimaced and voiced how uncomfortable she was due to back and hip pain. - On 7/20/24 staff called the nurse to report when they got Tenant #3 up to use the bathroom she was not able to bear weight and cried in pain. The medication aide thought she needed to be sent out to the ED for assessment. Tenant #3 was transported via ambulance to the hospital. - On 7/20/24 the hospital called and there were no fractures. Tenant #3 would be sent back. - On 7/20/24 at 10:21 a.m. PRN acetaminophen for pain was administered. It was noted Tenant #3 had hip pain when transferring. - On 7/20/24 at 9:38 p.m. PRN acetaminophen was administered. It was noted Tenant #3 had back pain. The follow up was documented at 12:25 a.m. and indicated the medication was not effective and she was in extreme pain. The pain was rated at a 10. - On 7/21/24 at 9:27 a.m. PRN acetaminophen for pain was administered. - On 7/22/24 at 7:47 a.m. PRN acetaminophen was administered. It was noted at 11:27 a.m. the medication was not effective and the pain was rated at eight. - On 7/22/24 at 6:40 p.m. staff called the nurse on-call and reported Tenant #3 was screaming out in pain. She would not move and would not allow staff to move her. He had a lot of pain on her right side. Tenant #3 was taken to the ED. - On 7/22/24 it was noted at the hospital two compression fractures were found in her back. She was going to be admitted. - On 8/23/24 a change of condition was completed. On 7/17/24 Tenant #3 had a fall on her back. On 7/20/24 staff reported she was in pain unable to bear weight. She was sent to the ED and was discharged back with no fractures.	A 350		

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A 350	Continued From page 79 On 7/22/24 she was sent back to the ED due to increased pain. The ED staff reported she had two compression fractures. She was admitted to the hospital and then discharged to skilled care. She was planning on returning to the Program on 8/26/24. A Home Discharge Instructions sheet (from skilled care) dated 8/22/24 indicated for Tenant #3 to have the brace on during transfers and off when laying down. Further review revealed a service plan dated 6/20/24. The plan was not updated as needed post fall, with complaints of pain, non-weight bearing status and frequent use of as needed pain relievers, at times without effectiveness related to her pain management. A service plan updated on 8/23/24 did not reflect the use of the brace as indicated in the discharge orders from skilled care. 4. Review of Tenant #4's file on 8/29/24 revealed Progress Notes indicating the following: - On 7/6/24 it was noted daily weights were not taken as Tenant #4 was in too much pain. - On 7/7/24 it was noted daily weights were not taken as Tenant #4 could not stand due to pain. - On 7/14/24 Tenant #4 screamed and hit staff. - On 7/18/24 Tenant #4 became agitated in the living room area and used her walker to run into another tenant, which caused the other tenant to fall. Tenant #4 also screamed at and called the other tenant names. - On 7/26/24 Tenant #4 was upset as she thought she was missing her things. She was anxious. - On 8/1/24 a physical therapy (PT) staff reported Tenant #4 continued to require supervision for transfers.	A 350		

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A 350	Continued From page 80 Continued record review revealed the service plan was dated 3/8/24. The service plan was not updated to reflect changes as noted above including behaviors towards staff and a tenant, PT recommendations related to ambulation and increased pain and not being able to stand at times due to pain. 5. Review of Tenant #5's file on 8/29/24 revealed she received hospice services. The Hospice IDG Comprehensive Assessment and Plan of Care Update Report indicated she was consistently fed most meals, she had left sided weakness and was no longer able to follow directions. She was dependent for six of six ADLs and was no longer ambulatory. She was unable to make her needs known. Tenant #5 needed one to two pillows to support her trunk while in the chair. She needed multiple cues to swallow food. The Hospice Aide Care Plan dated 8/7/24 reflected a home health aide (HHA) with hospice assisted with bathing (bed/bath) during the HHA visits. When observed on 8/21/24 at the time of the lunch meal Tenant #5 was asleep in a high back wheelchair. Staff W sat beside her with four dishes of pureed foods and fed her the meal. Staff W and hospice assisted Tenant #5 with her meal. When observed on 9/3/24 at 11:35 a.m. two staff assisted Tenant #5 up from the recliner. She walked slowly with the assistance of one staff and a walker. She was assisted to sit at the dining room table and a pillow was placed on her left side. She fell asleep at the table before her food arrived. When interviewed on 9/3/24 at 10:12 a.m. Staff C	A 350		

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A 350	Continued From page 81 reported normally Tenant #5 took one for transfers; 10% of the time she required the assistance of two staff. When interviewed on 9/3/24 at 10:41 a.m. Staff D said some staff used one person to transfer Tenant #5 while others used two staff. On 9/3/24 at 2:34 p.m. Staff G said she generally transferred Tenant #5 by herself, but some staff used two due to her frailty. When interviewed on 9/5/24 at 1:44 p.m. the RN said most of the time Tenant #5 required the assistance of one person for transfers. It depended on the day if she required cueing or hands on assistance for eating. During an interview on 8/29/24 at 3:46 p.m. Hospice Nurse #2 said the tenant was starting to use her wheelchair and noted she had really lost the ability to walk more and more. Transfers required one to two staff to assist and she was weight bearing. The tenant's service plan was most recently dated 5/30/24 and did not reflect the need of more than one person for transfers at times, or the increased assistance needed at meals. The service plan reflected Tenant #5 received hospice services; however, did not reflect the services provided including bathing (bed/bath) with HHA visits. The service plan also did not reflect Tenant #5 leaned and a pillow was used to provide trunk support. 6. Review of Tenant #6's file on 8/29/24 revealed Progress Notes indicating the following: - On 5/1/24 PRN lorazepam for agitation was administered. The note indicated Tenant #6 used	A 350		

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A 350	Continued From page 82 profanity and was hitting. The follow up indicated Tenant #6 was still very agitated with staff. - On 5/4/24 (late entry) staff reported that during a safety check Tenant #6 was observed laying on the end of the bed. Staff approached Tenant #6 and asked what he was doing and he told them to get away and don't touch him. Staff attempted to redirect him and he was told for his safety they needed to stand him up to lay at the top of the bed. Tenant #6 stood up and threw his walker which hit the wall near the bathroom. He sat on the edge on the bed and, when he lifted his feet up into bed, he kicked staff in the chest and attempted to punch the other staff. He laid back into bed with his feet and buttocks hanging off of the side of the bed. The staff called for additional staff to assist. He agreed to get into bed but grabbed the gait belt and started hitting the staff which caused him to slip to the floor. He sustained a small skin tear to the right lower forearm. Staff called Tenant #6's spouse as he refused to allow staff to help him off of the floor. His spouse came in and was able to redirect him. He was assisted off of the floor and back into bed. - On 5/5/24 (late entry) second shift staff reported she was called into Tenant #6's apartment and observed him screaming and hitting the other staff. The medication aide asked the other staff to leave as Tenant #6 did not do well with multiple people in his apartment at one time. The aide was hit in the stomach and he tried hitting the other aide. The nurse was informed and told all staff to exit his apartment to allow him to calm down. Staff returned to the apartment 20 minutes later and he allowed cares to be completed. - On 5/6/24 (late entry) third shift staff reported during rounds he was found lying at the end of the bed without clothing. The staff attempted to	A 350		

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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 83 redirect him to the top of his bed. He started hitting and using profanity towards staff. The staff left and apartment and checked on him again at 1:30 a.m. He was laying at the end of the bed again but refused assistance. Staff continued to check on Tenant #6 during safety checks. - On 6/18/24 staff reported Tenant #6 tried to bite or punch staff. He refused his medications and used profanity towards staff. Staff re-approached him to take his medications and he tried to punch her and told her to get out of his apartment. - On 6/27/24 staff asked the nurse to help give Tenant #6's his medications due to his refusal earlier. Staff was not able to get him up, dressed or change his protective undergarment that morning due to combative behaviors. The nurse was able to get him up and seated on the side of the bed and his medications were taken. He wanted to lay back down before the other cares were completed. When attempting to help him stand up he became agitated. He was allowed to lay back in bed and staff would re-approach. - On 8/12/24 (late entry) staff changed his bed as it was soiled. He started to hit and kick staff when they attempted to change and dress him. He slid off of the bed onto the floor. He would not allow staff to assist him without lashing out. Staff provided him a pillow and blanket on the floor and left him to calm down. After several checks staff were able to get him up. He sustained a small skin tear to his right hand. - On 8/14/24 (late entry) staff assisted Tenant #6 from his recliner to his bed. He stood up and then sat right back down. Staff called another staff to assist. When he was being assisted with two people his knees buckled and he ended up sliding down to the floor with the assistance of staff. They attempted to get him up and he started pinching and punching at them. Staff	A 350		

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	S0379	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 84 made him comfortable with a pillow and blanket and left him to calm down. He was checked on several times and re-approached by different staff and his behaviors were the same. He balled his fists up and refused to get up. He obtained a small skin tear to the right elbow. Staff were able to get him up off of the floor and up for the day when first shift arrived. - On 8/16/24 (late entry) staff reported a golf ball size lump on the backside of his calf and he reported pain. He had multiple behaviors when he had kicked and hit staff which may have caused the injury. - On 8/17/24 (late entry) Tenant #6's spouse reported she was transferring him and he fell into the side of the wheelchair. She noticed a red mark on the bottom right side of his back that appeared to be starting to bruise. - On 8/18/24 staff reported he was very aggressive. During a staff assisted transfer to bed he attempted to bite staff on the arm. Once he was in bed he slammed his fist down onto her head, which caused a hair clip in staff's hair to "jam into her head causing a lump and a headache." When interviewed on 8/21/24 at 10:10 a.m. Staff A said if Tenant #6 ended up on the floor it took two to three staff to get him up. He was aggressive at least once per shift. She said sometimes it was a reaction to how he was approached by staff. He had not been aggressive towards other tenants. His medications were being adjusted and at times he was aggressive towards his spouse who visited frequently. On 8/21/24 at 12:50 p.m. Staff B said Tenant #6 sometimes needed two people to assist with transfers. The tenant used to walk but now stopped and was more confused. It took a lot of	A 350		

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A 350	Continued From page 85 cues to transfer him. The tenant struck out at staff times. When he was on the floor his spouse said to give him a blanket and pillow. At times he refused assistance. He did not like it loud. During an interview on 9/3/24 at 10:12 a.m. Staff C said Tenant #6 required the assistance of two people 30% of the time. A lot of the time he required the assistance of one person. He was combative fairly often. He refused to get up, and sometimes refused medications. He displayed both verbal and physical behaviors. He tried to kick, hit and grab staff. When interviewed on 9/3/24 at 10:41 a.m. Staff D said Tenant #6 did not walk anymore. Sometimes it took two or three staff to assist him. She had been able to assist him by herself. When he was combative he kicked and hit staff. She said a soft approach worked with him and he did much better with one person. On 9/3/24 at 2:37 p.m. Staff G said Tenant #6 required the assistance of one to two staff for transfers depending on his mood and behavior. She said he had verbal and physical behaviors and the frequency was every few days. He punched, hit, grabbed and used profanity towards staff. She said there had not been any injuries. When interviewed on 9/3/24 at 4:25 p.m. Staff H said one to two staff were needed to assist Tenant #6 with transfers, dependent on his behaviors. When interviewed on 9/9/24 at 1:43 p.m. the LPN said it took one to two staff to transfer him dependent on his behaviors. He displayed both verbal and physical behaviors. For physical behaviors he punched and kicked. He hit one	A 350		

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A 350	Continued From page 86 staff with his fist and her hair clip than went into her head. He had also slapped someone on the face and it left a mark. When interviewed on 9/5/24 at 1:44 p.m. the RN said Tenant #6 required the assistance of one to two people for transfers based on his behavior. She said he had been aggressive, including hitting and kicking. He hit someone who then had a migraine. Last week he was on the floor (not a fall) and was kicking. Staff left him in a safe position on the floor and checked on him every five minutes. She said Tenant #6 became overwhelmed. Education was provided to staff that only one person needed to go help the tenant initially, and to call for assistance if another staff was needed. Further review revealed the unsigned service plan indicated the last service plan review was dated 2/20/24. The service plan reflected Tenant #6 required the assistance of one person for transfers with a walker, and ambulated around the building with assist of one person and a walker. The service plan was not updated as needed to reflect the assistance of two staff at times for transfers, and that Tenant #6 did not ambulate or if any additional assistive devices were used. The service plan documented Tenant #6 had inappropriate behavior, however did not reflect physical behaviors towards staff and refusals of medications, cares and at times to get up off of the floor. 7. Review of Tenant C1's file on 8/21/24 revealed an Incident Report Form dated 5/3/24 at 6:00 p.m. reflecting the medication aide noted Tenant C1 was laying on her back, head on the ground with a towel under the head to hold pressure on the wound. Tenant C1 was not responsive and	A 350		

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A 350	Continued From page 87 was bleeding from the back of the head Paramedics were called. The reported indicated Tenant C1 had a witnessed fall with head injury. A written statement dated 5/3/24 by Staff I that indicated she was walking down the hallway to give medications to another tenant and she observed Tenant C1 "double back and try to catch herself." She ran to catch her but was too late and she hit her head on another tenant's door. Staff I had walked by her when she was returning from break approximately two minutes prior to her falling. At that time she was seated on her walker and asked Staff I to open the door so she could leave to babysit. Two of the aides going to break went through the door to leave the unit. Tenant C1 observed them open the door and Staff I thought that was when the tenant got up so she could leave. A written statement dated 5/3/24 was provided by Staff J. She was on her way to break and she saw Tenant C1 sitting on her walker by the memory care door. When she walked out of the door she saw Tenant C1 stand up so she made sure the door closed fully so she would not get out. When interviewed on 9/4/24 at 12:45 p.m. Staff N said Tenant C1's wandering around was not out of the norm for her. When interviewed on 9/5/24 at 1:44 p.m. the RN said it was not uncommon for Tenant C1 to be by the memory care door. Continued record review revealed the service plan dated 4/10/24 did not reflect Tenant C1's wandering or being by the exit doors and interventions related to redirection.	A 350		

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A 350	Continued From page 88 8. Review of Tenant #6's file on 8/29/24 revealed Progress Notes indicating the following: - On 5/1/24 PRN lorazepam for agitation was administered. The note indicated Tenant #6 used profanity and was hitting. The follow up indicated Tenant #6 was still very agitated with staff. - On 5/4/24 (late entry) staff reported that during a safety check Tenant #6 was observed laying on the end of the bed. Staff approached Tenant #6 and asked what he was doing and he told them to get away and don't touch him. Staff attempted to redirect him and he was told for his safety they needed to stand him up to lay at the top of the bed. Tenant #6 stood up and threw his walker which hit the wall near the bathroom. He sat on the edge on the bed and, when he lifted his feet up into bed, he kicked staff in the chest and attempted to punch the other staff. He laid back into bed with his feet and buttocks hanging off of the side of the bed. The staff called for additional staff to assist. He agreed to get into bed but grabbed the gait belt and started hitting the staff which caused him to slip to the floor. He sustained a small skin tear to the right lower forearm. Staff called Tenant #6's spouse as he refused to allow staff to help him off of the floor. His spouse came in and was able to redirect him. He was assisted off of the floor and back into bed. - On 5/5/24 (late entry) second shift staff reported she was called into Tenant #6's apartment and observed him screaming and hitting the other staff. The medication aide asked the other staff to leave as Tenant #6 did not do well with multiple people in his apartment at one time. The aide was hit in the stomach and he tried hitting the other aide. The nurse was informed and told all staff to exit his apartment to allow him to calm down. Staff returned to the apartment 20	A 350		

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A 350	Continued From page 89	A 350		

minutes later and he allowed cares to be completed.
- On 5/6/24 (late entry) third shift staff reported during rounds he was found lying at the end of the bed without clothing. The staff attempted to redirect him to the top of his bed. He started hitting and using profanity towards staff. The staff left and apartment and checked on him again at 1:30 a.m. He was laying at the end of the bed again but refused assistance. Staff continued to check on Tenant #6 during safety checks. - On 6/18/24 staff reported Tenant #6 tried to bite or punch staff. He refused his medications and used profanity towards staff. Staff re-approached him to take his medications and he tried to punch her and told her to get out of his apartment.
- On 6/27/24 staff asked the nurse to help give Tenant #6's his medications due to his refusal earlier. Staff was not able to get him up, dressed or change his protective undergarment that morning due to combative behaviors. The nurse was able to get him up and seated on the side of the bed and his medications were taken. He wanted to lay back down before the other cares were completed. When attempting to help him stand up he became agitated. He was allowed to lay back in bed and staff would re-approach. - On 8/12/24 (late entry) staff changed his bed as it was soiled. He started to hit and kick staff when they attempted to change and dress him. He slid off of the bed onto the floor. He would not allow staff to assist him without lashing out. Staff provided him a pillow and blanket on the floor and left him to calm down. After several checks staff were able to get him up. He sustained a small skin tear to his right hand.
- On 8/14/24 (late entry) staff assisted Tenant #6 from his recliner to his bed. He stood up and then sat right back down. Staff called another staff to

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A 350	Continued From page 90 assist. When he was being assisted with two people his knees buckled and he ended up sliding down to the floor with the assistance of staff. They attempted to get him up and he started pinching and punching at them. Staff made him comfortable with a pillow and blanket and left him to calm down. He was checked on several times and re-approached by different staff and his behaviors were the same. He balled his fists up and refused to get up. He obtained a small skin tear to the right elbow. Staff were able to get him up off of the floor and up for the day when first shift arrived. - On 8/16/24 (late entry) staff reported a golf ball size lump on the backside of his calf and he reported pain. He had multiple behaviors when he had kicked and hit staff which may have caused the injury. - On 8/17/24 (late entry) Tenant #6's spouse reported she was transferring him and he fell into the side of the wheelchair. She noticed a red mark on the bottom right side of his back that appeared to be starting to bruise. - On 8/18/24 staff reported he was very aggressive. During a staff assisted transfer to bed he attempted to bite staff on the arm. Once he was in bed he slammed his fist down onto her head, which caused a hair clip in staff's hair to "jam into her head causing a lump and a headache." Continued record review revealed wound clinic orders dated 3/25/24 through 5/3/24 related to wounds on his right lateral forearm, upper leg, hip and medial coccyx. Various changes were made regarding how to dress the wounds and how often to so on a daily basis. A fax to the PCP dated 4/15/24 reflected Tenant C2 complaint of pain with any movement of his	A 350		

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A 350	Continued From page 91 right left at night mostly. In the morning he seemed sore but did well with transfers and movement. He worked with PT several times weekly without complaints. Starting in the evening he grimaced anytime the leg was moved or he bore weight. Staff had to transfer him with an assist of three people at times. When staff repositioned him in bed he would hit, yell and call them names. He had a pressure sore on his coccyx and both hips had red/open areas. A request was made for hydrocodone 5/325 mg, one tablet, every hours as needed for pain. The order was received. Further review revealed on 4/23/24 a fax was sent to the PCP which indicated Tenant C2 had been discharged from PT due to not progressing. He had a steady decline since moving in. An order for hospice was requested and received if okay with family. A hospice order to apply Calmoseptine external ointment to buttocks as needed for skin care with A & D ointment with check and changes and apply to buttock topically three times per day for skin care mix equal parts with A & D ointment was signed by the provider 5/3/24. A Physician Orders document dated 5/5/24 reflected to give Alprazolam Intensol 1 mg/ml by mouth 0.5 ml every four hours as needed for anxiety/restlessness, give morphine 20 mg/ml by mouth 0.5 ml every four hours as needed for pain, change twice daily morphine 20 mg/ml to 0.5 ml twice daily and apply oxygen 1-3 liters as needed for comfort to maintain oxygen saturation greater than 90%. When interviewed on 8/21/24 at 12:50 p.m. Staff B said Tenant C2 required the assistance of two	A 350		

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A 350	Continued From page 92 to three staff for transfers with a walker and gait belt the entire time he was there. At the very end he was bed bound. Staff repositioned him. She said he had a red sore from a procedure on his right hip. On 9/3/24 at 10:12 a.m. Staff C said Tenant C2 took two to three people to transfer and he could not bear weight. He had a couple of open areas. He had a sore on his hip and they tried to pack the wound. Tenant C2 did not get up a lot. He had quite a bit of pain and she assumed it was from the bad hip wound. He had his hip replaced (before he moved in) and had an infection in it. Towards the end he stayed in bed and staff provided perineal care, repositioned him and provided fluids. She said he would try to fight with staff and would get a skin tear. When interviewed on 9/3/24 at 10:41 a.m. Staff D said when Tenant C2 first arrived he required the assistance of two people. He had a hip wound and it opened and he required a third person. She a lot of the time he was combative and a four person was needed. She said staff were checking and changing Tenant C2 in bed and repositioned him. She said he was put on hospice. During an interview on 9/3/24 at 9:42 a.m. Staff E said Tenant C2 required the assistance of two to four staff for transfers. He was bed bound at times and did not get up. When interviewed on 9/3/24 at 2:37 p.m. Staff G said towards the end of his stay he was bed bound and was on hospice. On 9/3/24 at 4:25 p.m. Staff H said Tenant C2 required the assistance of two staff; sometimes three for transfers. A week after he moved in he	A 350		

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A 350	Continued From page 93 required a two to three assist. When he was not getting out of bed staff repositioned him every two hours. When interviewed on 9/9/24 at 1:43 p.m. the LPN said she and the RN assessed him prior to admission and he was a one assist with walker. She said he was on hospice at the nursing home (prior placement), got off of hospice and had PT there. When he got to the Program he struggled. She said almost immediately transfers were rough with him. He became very angry. Progressively he got worse and required the assistance of two for transfers. He was started on hospice services. She said for a fair amount of time he was consistently a two person assist. The tenant came to them with the wound from a prior surgical replacement. At the end he was bed bound and was checked on every two hours for repositioning and checking to see if he needed to be changed. On 9/5/24 at 1:44 p.m. the RN said he was at a nursing home prior to admission she went there to assess him. She physically assisted him and required the assistance of one person. He had previously had surgery and gone to the nursing home. The wound did not heal and it had something do to with the hardware. It was a chronic wound. When he came to the Program he pretty rapidly declined. She said within less than a month we required the assistance of two people. He went to the wound clinic and was started on hospice services. Further record review revealed one service dated 2/8/24 (preliminary service plan). The service plan was not updated as needed with increased transfer assistance requiring the assistance of two or more staff, behaviors, pain during transfers	A 350		

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A 350	Continued From page 94 and movement, the initiation and discharge from PT services, the initiation of hospice services, wound clinic visits and wound care orders and when Tenant C2 became bed bound and end of life cares were provided. 9. Review of Tenant C3's file on 8/26/24 revealed Progress Notes indicating the following: - On 4/2/24 it was noted Tenant C3 struggled with transfers that day. Staff reported she required the assistance of two to three staff and was non-weight bearing on either foot. - On 4/11/24 (late entry) Tenant C3 was found sitting on her bedroom floor next to her bed. The assistance of two people was required to transfer her from the floor to the bathroom. Her bed alarm was noted to be on but was found under her on the floor. - On 6/12/24 PT was started. - On 7/16/24 it was noted at 2:15 a.m. staff heard Tenant C3 yell for help and observed her laying on the right side. She said it hurt repeatedly. She said she was trying to get out of bed. Tenant C3 complained of hip and was shaking and crying. She was sent to the hospital for evaluation. - On 7/16/24 the tenant was transferred from the local hospital to another hospital for closed intertrochanteric fracture of the right hip. - On 7/18/24 it was noted Tenant C3 was admitted to a facility for skilled care and she might be there long term. When interviewed on 9/4/23 at 9:42 a.m. Staff E said on good days the tenant could transfer with 1 person. She had back pain and struggled to stand. She required the assistance of two staff 50% of the time. On 9/3/24 at 2:37 p.m. Staff G stated Tenant C3	A 350		

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A 350	Continued From page 95 took one to two staff for transfers. She had arthritis in her knees. When interviewed on 9/4/24 at 11:29 a.m. Staff M said it took two staff to safely assist her. During an interview on 9/9/24 at 1:43 p.m. the LPN said Tenant C3 required the assistance of one person but occasionally would require the assistance of a second person. She had terrible knees. She had contacted Tenant C3's family regarding the size of her bed and that it was a safety issue and needed to be replaced. It had been discussed for months and they had finally agreed to replace it; however, it was not done prior to Tenant C3's fall. Continued record review revealed the service plan dated 5/10/24 reflected Tenant C3 required the assistance of one person for transfer and ambulation. The service plan did not reflect at times Tenant C3 required the assistance of two people, PT services or the bed issue discussed with family. The service plan also did not reflect the bed alarm as indicated above. 10. When interviewed on 9/5/24 at 1:44 p.m. the RN confirmed all service plans were provided for the tenants reviewed.	A 350		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.	A 360		

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	S0379	A. BUILDING: _____ B. WING _____	C 09/26/2024

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

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A 360	Continued From page 96 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days of taking occupancy. This pertained to 1 of 1 current tenants (Tenant #2) and 1 of 1 discharged tenants (Tenant C2) reviewed who were admitted in 2024. Findings follow: 1. Review of Tenant #2's file on 8/28/24 revealed she was admitted on 5/10/24. A service plan was not completed within 30 days of taking occupancy. 2. Review of Tenant C2's file on 8/26/24 revealed he was admitted on 2/22/24. A service was not completed within 30 days of taking occupancy. 3. When interviewed on 9/5/24 at 1:44 p.m. the Registered Nurse confirmed all service plans were provided for the tenants reviewed.	A 360	1) Nurse worked with a nurse consultant. Nurse consultant helped structure a calendar to keep evaluations in compliance including 30 day evaluations, 90 day evaluations, significant changes, and annual reviews starting 11/1/2024. Program assessments will remain up to date starting 11/1/2024. 2) Executive director has access to PCC and assessment schedule. Executive director will audit schedules and meet with nurses periodically to ensure compliance. Date of compliance: 11/1/2024	
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes	A 430		

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WILLOWS OF MARSHALLTOWN MEMORY CAR	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

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A 430	Continued From page 97 in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews every 90 days. This pertained to 3 of 6 current tenants reviewed (Tenants #1, #4 and #6). Findings follow: 1. Review of Tenant #1's file on 8/27/24 revealed Tenant #1 received personal or health-related care. Tenant #1 had evaluations completed on 1/4/24 to bring the chart back into compliance and 7/2/24 as a quarterly review to bring the chart back into compliance. There were no nurse reviews completed between 1/4/24 and 7/2/24. Nurse reviews were not completed every 90 days. 2. Review of Tenant #4's file on 8/29/24 revealed Tenant #4 received personal or health-related care. Tenant #4 had evaluations completed on 3/8/24 related to a significant change. There were no 90 day nurse reviews provided from 3/8/24 to the time of the review of Tenant #4's file on 8/29/24. Nurse reviews were not completed every 90 days. 3. Review of Tenant #6's file on 8/29/24 revealed Tenant #6 received personal or health-related care. No evaluations were provided when Tenant #6's file was requested. A service plan indicated the last service plan review was 2/20/24. Nurse reviews were not completed every 90 days. 4. When interviewed on 9/5/24 at 1:44 p.m. the RN confirmed all nurse reviews were provided for the tenants reviewed.	A 430	1) Nurse worked with a nurse consultant. Nurse consultant helped structure a calendar to keep evaluations in compliance including 30 day evaluations, 90 day evaluations, significant changes, and annual reviews starting 11/1/2024. Program assessments will remain up to date starting 11/1/2024. 2) Executive director has access to PCC and assessment schedule. Executive director will audit schedules and meet with nurses periodically to ensure compliance. Date of compliance: 11/1/2024	

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A 460	Continued From page 98	A 460		
A 460	481-69.28(4) Food Service 69.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced registered nurse practitioner. A current copy of the Iowa Simplified Diet Manual published by the Iowa Dietetic Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to have a licensed dietician responsible for reviewing food preparation and service for therapeutic diets. This pertained 1 of 1 tenant reviewed who had a therapeutic diet (Tenant #5). Findings follow: 1. When observed on 8/21/24 at the time of the lunch meal the items served included Salisbury steak, bun with butter, mashed potatoes with gravy, carrots, fluff dessert and assorted beverages. Tenant #5 was seated in a high back wheelchair and she was asleep at the table. Staff W sat beside her with four dishes of pureed foods and fed her the meal. Staff W took the juice to Staff B. Staff B made a new glass with additional thickener as she thought the juice looked a little thin. Staff W and hospice assisted Tenant #5 with her meal. When observed on 9/3/24 at approximately 11:35 a.m. Tenant #5 was assisted up and walked	A 460	1) Program will schedule an education regarding special diets and thickened liquids with US Foods or hospice dietitian. Date of compliance: 12/15/2024	

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A 460	Continued From page 99 slowly to the table. She was positioned at the table with a pillow on her left. Two beverages (water and juice) were put in front of her with the thickening agent. Tenant #5 fell asleep at the table. Her food arrived at 12:10 p.m. Staff D took both her water and juice back to add more thickening agent to it. Staff D confirmed in interview she added more thickening agent to it and said it separated in the water. The items served were tacos with various toppings and tortilla chips. 2. Review of Tenant #5's file on 8/29/24 revealed a Hospice Certification and Plan of Care dated 10/11/23 indicating a diagnoses of dysphasia and an order for nectar thickened fluids. A Hospice order dated 11/2/23 indicated she had puree diet with desserts for pleasure. Continued record review revealed the service plan dated 5/20/24 indicated her diet was a pureed diet, nectar thick liquids and desserts allowed per hospice. It indicated she needed preparation of all meals. 3. When interviewed on 8/29/24 at 3:46 p.m. Hospice Nurse #2 confirmed Tenant #5 had pureed diet, thickened liquids (nectar) and desserts for pleasure. When interviewed on 9/3/24 after the noon meal Staff Q (cook) said all the cooks could puree food for Tenant #5 and they used a food processor to do so. When asked, he said no dietician had reviewed the techniques for preparing a pureed diet since he had been there. He said the Executive Director had gone over things when he started. He was not aware of a Simplified Diets Manual that was available to staff.	A 460		

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A 460	Continued From page 100 On 9/4/24 at approximately 12:08 p.m. Staff P (cook) said a chopper device was used to puree Tenant #5's food. The direct care staff prepared her beverages and kitchen staff prepared the pureed foods. She said the Executive Director helped with the menus. She said a dietician had not been involved with Tenant #5's food; however, the food provider had a dietician and hospice had a dietician. When interviewed on 9/9/24 at 1:43 p.m. the LPN said Tenant #5 had orders for pureed foods and thickened liquids. She could have any dessert. She said direct care staff assisted with her beverages and she had covered the training at staff meetings and staff huddles. Tenant #5 preferred orange juice and water. On 9/5/24 at 11:25 a.m. the Executive Director said they used the menus from their food provider and made changes based on staffing issues or issues with the truck (delivery). Tenant #5 was the only current tenant with a therapeutic diet. She was on a pureed diet and had been so for awhile. All staff (kitchen) had worked with pureed diets. Drinks were prepared by the direct care staff. She believed the LPN had worked with the direct care staff. She said hospice had a dietician but she was not sure if hospice had worked with her. She confirmed there was not documentation of training for staff on pureed diets. 4. On 9/10/24 review of training provided for the therapeutic diets indicated an in-services were held on 12/6/23 and 12/8/23 regarding thickened liquids and said how to thicken drinks. Another in-service was held on 5/15/24 which included a topic regarding thickened liquids. No documentation could be located regarding	A 460		

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A 460	Continued From page 101 training by a registered dietitian. Continued record review revealed instructions from the thickening agent indicated how many teaspoons or tablespoons to use based on the type of liquid serviced and consistency ordered. It indicated to let water and juices stand for one minute and let milk and supplements stand for 5 to 10 minutes. It indicated for best results to consume within 30 minutes of mixing. Further record review revealed menus were provided from Assisted Dining Solutions and listed regular, mechanical soft, finger food, dysphasia, bland/soft and liberal renal diets. The menu had a place for a registered dietician to sign off and a signature was provided. Additionally, a Diet Manual & Nutrition Practice Guidelines was provided. It was a Manual of the Georgia academy of Nutrition and Dietetics. In summary, Tenant #5 had physician ordered therapeutic diet of pureed foods, nectar consistency thickened liquids and desserts for pleasure. On 8/21/24 and 9/3/24 the juice and water, were reported to be too thin and more thickening agent was added. It was noted on 9/3/24 Tenant #5's beverages sat for greater than 30 minutes. The kitchen staff interviewed had not receiving any training from a registered dietitian regarding the preparation and service of the pureed diet. In-services were provided for direct care staff related to training on how to thicken liquids; however, the training occurred in December 2023 and May 2024. One of the trainings indicated to read the label. A manual was provided related to diets; however, was not the 9th edition of the Simplified Diets Manual as required.	A 460		

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A 635	Continued From page 102	A 635		

A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to have an operating alarm system connected to each exit door. This potentially affected all tenants in the dementia-specific program (census of 27). Findings follow: 1. When observed on 8/19/24 at approximately 12:40 p.m. the door that went from the building to the courtyard was not alarmed. The Executive Director was present when the observation occurred. Direct care staff present verified it did not go to their phone. The screen door was locked. Neither the screen door or the inside door were alarmed when the observation occurred. When interviewed on 8/19/24 at 12:45 p.m. the Maintenance Staff said there was not an alarm and they were not required to have one. He thought previously there might have been one that went to the phones. Review of a statement provided by the Maintenance Staff (undated) indicated from 9:00 p.m. to 6:00 a.m. all exterior doors sent alerts to all phones (SARA) if the doors were opened. The doors were also locked at that time. The memory care courtyard door was also locked during the day when no one was in the courtyard.	A 635	1) On 8/19/2024 it was reported that the MC courtyard door alarm was not operating. Maintenance corrected this issue at the time it was noticed on 8/19/2024. Each time the door is opened, it sends an alert to the SARA phones. Care staff is then prompted to check the door for tenants. The exterior door will be locked between 9pm to 6am. 2) The maintenance director will test door alarm monthly.	

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A 635	Continued From page 103 When interviewed on 8/21/24 at 10:10 a.m. Staff A said the courtyard door in memory care did not alarm until now. It came across the SARA phone. It had not been doing so 24 hours per day before. When observed on 8/21/24 at approximately 2:20 p.m. the courtyard door was tested again and an alert was sent to the staffs' SARA phone that the door was opened. 2. Review of a Memory Care Courtyard Door policy and procedure indicated effective 9/1/19 the memory care exterior door was locked between 9:00 p.m. to 6:00 a.m. (screen door). The larger door had an alarm that was connected to the SARA phones. The staff would go to the door and assess the situation. The notification would be acknowledged by the staff and needed to be cleared from the SARA phones after the staff checked the door. The screen door was always locked unless the courtyard door was supervised by staff. The inside door had a built-in alarm and would be in use 24/7 when the door opened and closed. Each time the door was opened an alert was sent to the SARA phones. 3. When interviewed on 8/21/24 at 2:23 p.m. the Maintenance Staff indicated it had been alerting from 9 p.m. to 7:00 a.m. At one point the alarm was set for 24 hours per day 7 days per week. The mode was changed yesterday (8/20/24).	A 635		

Amy RN 11/26/24
Jennifer Stanley ED 11-26-24
UPN 11/26/24