DIAL Plan of Correction-AL

November 26, 2024

Complaint #120381-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 Plans: 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: 11/1/2024

Jennifer Stanley ED 11-26-24

RN 11/26/2024

LPN 11/26/24

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
	S0385	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN ASSISTED LI\	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

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A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 35 Number of tenants with cognitive disorder: 5 Total census: 40 The Program was dementia-specific by definition for the first recertification visit when the visit was initiated on 8/19/24. The following regulatory insufficiencies were cited during the investigation of Complaints #120381-C and #122375-C as well as the recertification visit conducted to determine compliance with certification for an 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 incident reports. This pertained to 1 of 5 current tenants reviewed (Tenant #4). Findings follow: Review of Tenant #4's file on 8/28/24 revealed diagnoses included mild cognitive impairment of unknown etiology, dementia without behavioral	A 150	1)Tenant #4 continues to reside in assisted living. No further incidents noted. 2) Current staff will be re-educated on what to do when a resident is unable to be located in facility. 3) Care staff will be re-educated on when to fill out an incident report. 4) Nurses will ensure incident reports are filled out after an incident of this type and documented appropriately. 5) Assessments and service plans will be updated in a timely manner to reflect any changes that need to be made. Date of compliance: 12/15/2024	

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A 150	Continued From page 1 disturbance and Alzheimer's disease. Tenant #4 was staged at a three on the Global Deterioration Scale (GDS) (mild cognitive decline) on 2/6/24 and a four (moderate cognitive decline) on the GDS on 8/23/24. Continued record review revealed Progress Notes indicating the following: - On 6/29/24 (late entry) staff reported Tenant #4 had said she was going to walk outside around the building. Her family member called and asked to let her and they would be coming for lunch. When staff went to her apartment she was not there. The staff looked throughout the building and was not able to locate her. The staff notified all care staff to help in the search. At that time Tenant #4 was observed entering the memory care (attached unit) doors. Tenant #4 had walked to the west but she was unsure where she was or how to get back and she knocked on someone's door. Tenant #4 mentioned trying to find the Program (called by name) and she was given a ride back to the building. Tenant #4's family member was notified of the situation and safety checks were increased to hourly. - On 7/15/24 it was noted safety checks resumed to every two hours. An incident report could not be located related to the incident documented in Progress Notes on 6/29/24 (late entry). When interviewed on 8/21/24 at 12:50 p.m. Staff B said Tenant #4 went for a walk, made a wrong turn, went to a residence and they brought her back. She knew she lived at the Program. She said Tenant #4 walked inside and outside and there were no safety concerns. Review of the Program's Incidents/Accidents	A 150		

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A 150	Continued From page 2 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 when in doubt complete the form. The Program did not follow the policy and procedure related to incidents for Tenant #4 regarding the incident noted above. When interviewed on 9/5/24 at 1:44 p.m. the Registered Nurse confirmed all incident reports 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 current tenants reviewed who had a wound vac (Tenant #3). Findings follow: Review of Tenant #3's file on 8/28/24 revealed Progress Notes indicating the following: - On 7/16/24 staff was called to Tenant #3's	A 160		

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A 160	Continued From page 3	A 160		

apartment. He had gotten up, lost his balance and fell. There were three skin tears noted, two on his legs and one on his chest. Tenant #3's right knuckles were bruised and a hematoma was noted to the right knee/shin. Tenant #3 initially had heat on it but switched to ice. His family requested physical therapy (PT).

- On 7/23/24 an assessment was completed related to increased weakness and many falls. After one fall Tenant #3 sustained a hematoma to his right knee that caused him pain. It had reduced the amount of time Tenant #3 spent outside of his apartment.
- On 8/7/24 Tenant #3 was seen by the wound clinic and the wound was debrided. Orders were received to leave dressing intact unless drainage came through. It was noted drainage through the dressing occurred. he dressing was removed, packed with saline soaked roll gauze, covered with an ABD pad and covered with roll gauze.

An After Visit Summary from the emergency department (ED) dated 7/30/24 indicated Tenant #3 was seen for cellulitis of the right lower leg and hematoma of the right lower leg. An order was received for cephalexin (antibiotic) 500 milligram (mg), one capsule by mouth three times per day for seven days. It also indicated to follow up with a wound care provider.

Review of wound clinic orders indicated the following:

- On 8/7/24 it was noted there was an appointment on 8/8/24 for general surgery and to obtain a wound vac to be placed at an appointment on 8/9/24. The wound treatment indicated the wound location was the right knee, the primary dressing was to pack loosely with saline moistened 2" conform, secondary dressing was an ABD pad 5 x 9, place over wound area as

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A 160	Continued From page 4 needed and secure with Kerlix (4 inch) as needed. The wound characteristics indicated it was 0 weeks in treatment, it was 7.2 centimeters (cm) in length, 5.6 cm in width , 2.5 depth, 31.667 square cm area and 79.168 cubic cm in volume. The wound was unclassifiable. The date it was acquired was 7/16/24. The wound type was trauma. - On 8/9/24 it was noted to assist with pain management take Tylenol or ibuprofen one hour prior to wound care appointment and return in one week. It indicated Tenant #3 could shower with protection but not to get the dressing wet. A wound vac would be obtained for the next appointment. The wound treatment for the right knee indicated to cleanse with normal saline, pack saline moistened conform (2") loosely into the wound area and place a ABD (5 x 9) pad over the wound area, and secure with Kerlix (4") once per day. It indicated edema stocking once per day. The wound characteristics indicated it was 0 weeks in treatment, it was 8.1 cm in length, 5.9 cm in width, 1.8 depth, 37.534 square cm in area and 67.562 cubic cm in volume. The wound was full thickness without exposed support structures. - On 8/16/24 it was noted to assist with pain management take Tylenol or ibuprofen one hour prior to wound care appointment and return in one week. It indicated Tenant #3 could shower with protection but not to get the dressing wet. It noted a wound vac to wound continuously at 125 mm/hg pressure (negative pressure wound therapy). Avoid standing for long periods of time and elevate the legs for 30 minutes, two to three times daily. The wound treatment indicated to cleanse with normal saline, wound vac with black foam at 125 once per day and edema wear stockings once per day. The wound characteristics indicated it was 1 weeks in treatment, it was 7.2 cm in length, 5.4 cm in	A 160		

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A 160	Continued From page 5 width, 1 cm depth, 30.536 square cm in area and 30.536 cubic cm in volume. The wound was full thickness without exposed support structures. The notes indicated wound procedures on 8/7/24 and 8/16/24, which were debridements. - On 8/21/24 it was noted to assist with pain management take Tylenol or ibuprofen one hour prior to wound care appointment. It indicated Tenant #3 could shower with protection but not to get the dressing wet. Tenant #3's family would change the vac dressing on Saturday or Sunday that weekend. It noted a wound vac to wound continuously at 125 mm/hg pressure (negative pressure wound therapy) and use black foam when replacing the dressing. Avoid standing for long periods of time and elevate the legs for 30 minutes, two to three times daily. The wound treatment indicated to cleanse with the wound area with normal saline twice per week. For the primary dressing, tear Prisma 4.34 to fit the wound bed. If the wound was dry with minimal drainage Prisma could be moistened with a couple drops of normal saline. In indicated the wound vac with black foam at 125 and for edema wear stocking twice per week. The tenant's August 2024 medication administration records (MARs) reflected an order to cleanse the wound on the right knee with normal saline. Use the saline moistened rolled gauze and loosely pack the moistened rolled gauze into the wound area, filling the entire wound. Place an ABD pad over the wound and secure with tape. Place nettled elastic over top to hold in place. It was scheduled for once per day at 10:00 a.m. The order was started on 8/10/24 and discontinued on 8/16/24. From 8/10/24 to 8/15/24 the wound treatment was documented as completed by four direct care staff (Staff A, C, E and S). All four were unlicensed staff. The	A 160		

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A 160	Continued From page 6 packing wound treatment was not documented as completed by licensed staff. There was also no documented training on the wound treatment for Staff A, C, E and S, who completed the treatment. When interviewed on 9/3/24 at 10:12 a.m. Staff C said Tenant #3 had a wound vac and his family assisted with it. Before the wound vac staff packed the wound on his shin. She observed the Licensed Practical Nurse (LPN) do it once. When interviewed on 9/3/24 at 10:41 a.m. Staff D said when she first saw the wound it was covered with telfa. She watched the nurse pack it before the wound vac was placed. She said there was a question asked if it was supposed to be packed because of how deep it was. On 9/4/24 at 9:42 a.m. Staff E said now Tenant #3 had a wound vac and his family assisted with the wound. When it was first debrided, the nurse packed it with her and asked if she felt comfortable and she told her she did. Staff E said she packed Tenant #3's wound. When interviewed on 9/9/24 at 1:43 p.m. the LPN said after his fall the wound started as a closed hematoma and it opened at some point. A staff had reported to her she thought his wound looked worse. She notified Tenant #3's family. There had been some confusion and it was thought the wound was possibly related to infection. The LPN said it looked drastically different from before. Tenant #3 was sent to the ED. On 9/5/24 at 1:44 p.m. the Registered Nurse said Tenant #3 fell and had a hematoma. It was painful and the provider sent him to general surgery. The wound was debrided and he had a wound vac placed. After the first trip to the wound	A 160		

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A 160	Continued From page 7 clinic they were to pack the wound for a couple of days until the vac was placed. The medication managers were trained and completed it for a few days. He had the wound vac placed and now hospice helped with the wound. In summary, Tenant #3 fell on 7/16/24 and sustained injuries including a hematoma on his right leg/shin. He had complaints of pain in the leg and was seen in the ED on 7/30/24 and was diagnosed with cellulitis and a hematoma of the RLE and antibiotics were ordered. On 8/7/24, 8/9/24, 8/16/24 and 8/21/24 Tenant #3 was seen in the wound clinic. On 8/7/24 and 8/16/24 the area was surgically debrided and a wound vac was placed on 8/16/24. New orders were received on 8/9/24 to pack the wound daily (see order above). The MAR reflected unlicensed staff packed the wound from 8/10/24 to 8/15/24. Tenant #3 had a wound that required packing that 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, C, E and S) completed the task of packing the wound from 8/10/24 to 8/15/24. Although not allowed to pack the wound those staff that assisted also did not have documented training on the task. Tenant #3 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		
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	A 285		

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A 285	Continued From page 8 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 ensure medications and treatments were administered as ordered. This pertained to 2 of 3 current tenants reviewed who received medications administered by the Program (Tenant #1 and Tenant #3). Findings follow: 1. Review of Tenant #1's file on 8/26/24 and 8/27/24 revealed the July 2024 medication administration record (MAR) reflected the following: - An order to ensure the Dexcom was charging four times daily. The MAR reflected 6 times it was not documented as completed and was charted as a hold (see progress notes). - An order to check Tenant #1's blood glucose four times per day. The MAR reflected 11 times it was not documented as completed and was charted as either hold (see progress notes) or other (see progress notes). The tenant's Progress Notes indicated on 7/2/24 (multiple entries) it was charted that the Dexcom was expired. On 7/3/24 and 7/4/24 it was charted that Tenant #1 needed a new Dexcom put on, or the Dexcom was expired. On 7/6/24 it was charted as the Dexcom was off or had expired.	A 285	1.) Tenant #1 continues to reside in assisted living. 2) Dexcom charging- This was put in by nurses " per good nursing" to ensure the Dexcom monitor remains charged. If tenant is not in her apartment, this may not be completed at the scheduled time because the dexcom needs to stay with tenant in order to read blood glucose level. Will provide education to medciation managers to document the reason why the scheduled order or task is not being completed. Will provide education to medication managers to provide progress note to why this has not been completed. 3) Medication managers have been delegated and provided training on how to apply/change continuous blood glucose monitoring device. If blood glucose monitor is expired or is unable to be read due to malfunctioning, medication manager will check tenant's blood glucose manually with blood glucose monitor. 4) Although it was not documented on MAR under the order Check blood glucose four times per day, blood glucose level was indeed obtained 4 times a day and documented under the administration of Lantus and Insulin Lispro administrations.	

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A 285	Continued From page 9 Review of the August 2024 MAR reflected the following: - An order to ensure the Dexcom was charging four times daily. The MAR reflected 2 times it was not documented as completed and was charted to see progress notes. - An order to check Tenant #1's blood glucose four times per day. The July reflected 4 times it was not documented as completed and was charted to see progress notes. The tenant's Progress Notes indicated on 8/12/24 the Dexcom was not working. Tenant #1's orders to check her glucose via the Dexcom (continuous glucometer) four times daily were not completed as ordered in July and August 2024 due to the Dexcom being expired, needing a new Dexcom sensor or the Dexcom was not working. 2. Review of Tenant #3's file on 8/28/24 revealed the June 2024 MAR reflected the following: - Eliquis (anticoagulant medication) 2.5 milligram (mg) tablet twice daily was ordered at 8:00 a.m. and 8:00 p.m. It was documented as not available to administer on 6/26/24 (8:00 p.m. dose), 6/27/24 (both doses), 6/28/24 (both doses), 6/29/24 (both doses) and 6/30/24 (both doses). - Doxycycline hyclate (antibiotic) 100 mg oral tablet, three times a day for 10 days for a toe infection. It was started on 6/8/24 and discontinued on 6/11/24. It was not available to administer from 6/8/24 through 6/10/24 (all doses). The first dose administered was on 6/11/24 at 9:00 a.m. - Doxycycline hyclate 100 mg capsule, twice daily for 10 days. It was started on 6/11/24 and discontinued on 6/17/24. It was documented as	A 285	1) Tenant #3 resides in assisted living. 2) Education will be provided to medication managers to notifiy the nurse promptly when a medication is not available and chart a progress note explaining this. Date of compliance: 12/15/24	

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A 285	Continued From page 10 not available to administer on 6/11/24 (8:00 p.m. dose), 6/12/24 (8:00 p.m. dose) and 6/17/24 (8:00 a.m. dose). - Doxycycline hyclate 100 mg tablet, two times per day for infection. It was started on 6/18/24 and discontinued on 7/3/24. It was documented as not available to administer on 6/30/24 (8:00 p.m. dose). Review of the July 2024 MAR reflected the following: - Eliquis (anticoagulant medication) 2.5 milligram (mg) tablet, twice daily was ordered at 8:00 a.m. and 8:00 p.m. It was documented as not available to administer on 7/1/24 (8:00 p.m. dose), 7/2/24 (both doses), 7/3/24 (8:00 p.m. dose), 7/5/24 (8:00 p.m. dose), 7/6/24 (both doses), 7/7/24 (8:00 p.m. dose), 7/8/24 (both doses), 7/9/24 (8:00 p.m. dose) - Doxycycline hyclate (antibiotic) 100 mg tablet, twice daily for infection. It was started on 6/18/24 and discontinued on 7/3/24. It was documented as not available to administer on 7/1/24 (both doses), 7/2/24 (8:00 p.m. dose) and 7/3/24 (8:00 a.m. dose). 3. When interviewed on 9/5/24 at 1:44 p.m. the Registered Nurse confirmed all MARs and orders were provided for the tenants reviewed.	A 285		
A 355	481-67.9(4)d Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: d. Certified and noncertified staff shall receive	A 355		

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A 355	Continued From page 11 training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse delegated training related to assistance with bathing when a wound vac was utlized. This pertained to 1 of 1 current tenants reviewed who had a wound vac (Tenant #3). Findings follow: Review of Tenant #3's file on 8/28/24 revealed Progress Notes indicated the following: - On 7/16/24 staff was called to Tenant #3's apartment. He had gotten up, lost his balance and fell. There were three skin tears noted, two on his legs and one on his chest. Tenant #3's right knuckles were bruised and a hematoma was noted to the right knee/shin. Tenant #3 initially had heat on it but switched to ice. His family requested physical therapy (PT). - On 7/23/24 an assessment was completed related to increased weakness and many falls. After one fall Tenant #3 sustained a hematoma to his right knee that caused him pain. It had reduced the amount of time Tenant #3 spent outside of his apartment. - On 8/7/24 Tenant #3 was seen by the wound clinic and the wound was debrided. Orders were received to leave dressing intact unless drainage came through. It was noted drainage through the dressing occurred. The dressing was removed, packed with saline soaked roll gauze, covered with an ABD pad and covered with roll gauze.	A 355	1) Program worked with a nurse consultant. Nurses were educated on knowing the steps needed for delegating to unlicensed staff. 2) Proper delegation will be documented for each individual task. Date of compliance: 12/15/2024	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN ASSISTED LI\	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

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A 355	Continued From page 12 An After Visit Summary from the emergency department (ED) dated 7/30/24 indicated Tenant #3 was seen for cellulitis of the right lower leg and hematoma of the right lower leg. An order was received for cephalexin (antibiotic) 500 milligram (mg), one capsule by mouth three times per day for seven days. It also indicated to follow up with a wound care provider. Further record review revealed wound clinic orders indicating the following: - On 8/7/24 it was noted there was an appointment on 8/8/24 for general surgery and to obtain a wound vac to be placed at an appointment on 8/9/24. - On 8/9/24 it was noted Tenant #3 could shower with protection but not to get the dressing wet. It was noted a wound vac would be obtained for the next appointment. - On 8/16/24 the tenant had a wound vac to wound continuously at 125 mm/hg pressure (negative pressure wound therapy). - On 8/21/24 it was noted Tenant #3 could shower with protection but not to get the wound vac dressing wet. Tenant #3's family would change the vac dressing on Saturday or Sunday that weekend. It noted a wound vac to wound continuously at 125 mm/hg pressure (negative pressure wound therapy). When interviewed on 9/3/24 at 10:12 a.m. Staff C said now Tenant #3 had a wound vac. She said for bathing staff clipped off the wound vac. On 9/3/24 at 2:37 p.m. Staff G said for bathing the wound vac had to be clamped off to get into the shower. When interviewed on 9/3/24 at 4:25 p.m. Staff H said Tenant #3 had a wound vac and staff	A 355		

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A 355	Continued From page 13 clamped it off, disconnected it and put on a plastic bag for showers. On 9/5/24 at 1:44 p.m. the Registered Nurse (RN) said staff were taught to clamp the wound vac off and keep a bag around it for bathing. Tenant #3's service plan reflected staff assisted with bathing daily in the evening. The Documentation Survey Report for August 2024 reflected Tenant #3 received staff assistance with bathing daily on second shift. Since the time of the placement of the wound vac on 8/16/24 to the time the task log was printed on 8/26/24, staff assisted with bathing. On 9/26/24 at 10:12 a.m. the RN said Tenant #3 did not have the wound vac anymore. She said for bathing staff had clamped it off and bagged it, similar to what would be done for a cast. Tenant #3 had daily bathing on second shift. She went over the task with staff; however, it was not documented. Documented nurse delegated training was not completed related to the assistance provided with Tenant #3's wound vac for bathing.	A 355		
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.	A 140		

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A 140	Continued From page 14 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 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review of Tenant C1's file on 8/26/24 and 8/27/24 revealed Tenant C1 was admitted on 8/1/23. Evaluations were dated 10/3/23 and were noted as 30 day evaluations. The evaluations were not completed within 30 days of taking occupancy. 2. Review of Tenant C2's file on 8/26/24 and 8/27/23 revealed Tenant C2 was admitted on 8/1/23. Evaluations were dated 10/3/23 and were noted as 30 day evaluations. The 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 tenants reviewed.	A 140	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 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	A 145		

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A 145	Continued From page 15 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 5 of 5 current tenants (Tenants #1, #2, #3, #4 and #5) and 2 of 2 discharged tenants (Tenant C1 and Tenant C2) reviewed. Findings follow: 1. Review of Tenant #1's file on 8/26/24 and 8/27/24 revealed Progress Notes indicating the following: - On 6/3/24 staff reported Tenant #1 seemed more confused than normal and was seated at the front door waiting for a group to bring in children for a performance. An order was sent to the primary care provider (PCP) to request a urinalysis. - On 6/23/24 staff reported Tenant #1 woke up very confused that morning. She wondered why she was getting her medications and why she and the staff were the only people left in the building. She was unaware it was the morning. - On 6/28/24 staff reported Tenant #1 had redness to her groin and abdominal fold and yeast was present. A fax was sent to the PCP to request an order for Nystatin powder. - On 7/8/24 Tenant #1's family voiced concerns regarding increased confusion. A message was sent to another provider (mental health services) about getting Tenant #1 on the list to be seen next time the provider was there.	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 16 - On 7/9/24 Tenant #1's blood glucose reading was 59 at 12:30 a.m. Tenant #1 seemed very confused and did not remember why she was there. She was given a peanut butter sandwich and chocolate milk. At 1:15 a.m. her blood glucose reading was 127 and she went back to sleep in her chair. - On 7/24/24 it was noted a significant change assessment was completed due to her requiring more assistance with cares and being increasingly more forgetful and incontinent. - On 7/24/24 third shift staff reported Tenant #1 was observed wandering around the main entrance looking for her children. She was ambulating without her walker. Her blood glucose was 57. She was given two pieces of peanut butter toast and orange juice. Her blood sugar came back up to 89. Tenant #1's daughter called and reported the tenant had called her and said she was looking for her children and car and also asked to speak to her former spouse (who was deceased). - On 7/25/24 Tenant #1's blood glucose was 101 and was dropping per the continuous glucometer. Tenant #1 was asleep. - On 8/13/24 insulin was held due to her blood glucose reading of 58. Continued record review revealed the June, July and August 2024 medication administration records (MARs) reflected orders for to use the Dexcom (continuous glucometer) four times per day. It also indicated to inject Insulin Lisp 100/milliliters, 10 units subcutaneously, three times daily with meals and to hold the insulin for blood glucose readings less than 100. A review of the tenant's Weights and Vitals Summary documents indicated the following: - In June 2024 Tenant #1 had 4 blood glucose	A 145		

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A 145	Continued From page 17 readings below 100, including a reading of 54 on 6/14/24. - In July 2024 Tenant #1 had 11 blood glucose readings below 100, including a reading of 59 on 7/9/24. - In August 2024 Tenant #1 had 22 blood glucose readings below 100, including a reading of 57 on 8/14/24. Further record review revealed evaluations were completed on 5/30/24 and on 7/24/24. Evaluations were not completed as needed between 5/30/24 to 7/24/24 when Tenant #1 had increased confusion, mental health services, and blood glucose readings outside of the parameters that resulted in insulin being held. Evaluations were completed on 7/24/24; however, did not address the frequent blood glucose readings below 100 or increased confusion. 2. Review of Tenant #2's file on 8/27/24 revealed Progress Notes indicating the following: - On 7/5/24 Tenant #2 reported his left toes and top of his foot were swollen, numb and painful. An appointment was made with the primary care provider (PCP) for 7/8/24. - On 7/8/24 Tenant #2 was seen but did not get lab work or x-rays completed as ordered. The PCP indicated Tenant #2 needed to be seen in the emergency department (ED) to have the tests completed. - On 7/8/24 staff took Tenant #2 to the ED. He was admitted and was to see podiatry in the morning. - On 7/12/24 it was noted there was a significant change. Tenant #2 was seen by his PCP on 7/8/24 for a wound on the left great toe but he left the clinic before getting lab work or x-rays completed. The PCP reported there were maggots in his wound. The PCP called to report	A 145		

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A 145	Continued From page 18	A 145		

the tests she ordered did not get done and he needed to go to the ED to be seen. Tenant #2 was admitted overnight until he could see podiatry and was discharged back to the Program with new orders to apply triple antibiotic ointment (TAO) to the toe and fissure on the dorsal side the foot. They did not report any maggots. An appointment was made with the wound clinic due to maggots being present on the dressing change when the RN (program nurse) removed it to change it. Tenant #2 was seen by the wound clinic on 7/11/24 and there were no maggots present. The wound clinic indicated he had peripheral vascular disease, should wear compression hose and elevate his legs. The TAO treatment was discontinued.

The hospital After Visit Summary dated 7/8/24 to 7/9/24 indicated he was seen for a skin ulcer of the left great toe and fissure in skin on the left foot. An order was received for neomycin-bacitracin-polymyxin ointment, apply topically, two times daily.

Further review revealed evaluations were completed dated 7/10/24; however, did not reflect the issues with Tenant #2's left great toe. The skin assessment portion of the evaluation reflected no open area and there was nothing written in the comments. Evaluations were not completed as needed that addressed the change in condition with the toe pain, numbness, swelling and left great toe wound.

3. Review of Tenant #3's file on 8/28/24 revealed Progress Notes indicating the following:
- On 7/5/24 Tenant #3 fell. He went to sit on the walker but it was not locked and he slipped and fell.
- On 7/8/24 staff reported Tenant #3 fell in his

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A 145	Continued From page 19 bathroom. He reported he slipped and fell in front of his sink. A skin tear was noted to the right upper arm. - On 7/16/24 staff was called to Tenant #3's apartment. He had gotten up, lost his balance and fell. There were three skin tears noted, two on his legs and one on his chest. Tenant #3's right knuckles were bruised and a hematoma was noted to the right knee/shin. Tenant #3 initially had heat on it but switched to ice. His family requested physical therapy (PT). - On 7/17/24 Tenant #3 was encouraged to go to the fitness room. He had a lot of falls recently and had been staying in his apartment. - On 7/19/24 Tenant #3 complained of pain in the right lower extremity (RLE) related to a hematoma and edema. It was noted Tenant #3 had an open blister. A fax was sent to the PCP requesting orders for Tramadol and wound care. - On 7/20/24 Tramadol HCL 50 milligram (mg) one tablet was administered for pain and was ineffective. - On 7/20/24 acetaminophen 500 mg tablet (two tablets) for pain were administered and were ineffective. - On 7/22/24 Tramadol HCL 50 mg one tablet was administered for pain and was ineffective. It was noted Tenant #3's pain level was very high especially when walking. - On 7/23/24 Tramadol HCL 50 mg one tablet was administered for pain and was ineffective. - On 7/23/24 an assessment was completed related to increased weakness and many falls. After one fall Tenant #3 sustained a hematoma to his right knee that caused him pain. It had reduced the amount of time Tenant #3 spent outside of his apartment. - On 7/24/24 Tramadol HCL 50 mg one tablet was administered for pain and was ineffective. The follow up pain scale was a 10.	A 145		

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A 145	Continued From page 20 - On 8/5/24 acetaminophen 500 mg tablet (two tablets) for pain were administered for extreme pain when walking on the right leg. - On 8/5/24 Tramadol HCL 50 mg one tablet was administered for pain. It was noted Tenant #3 was in extreme pain when walking on the right leg. - On 8/7/24 Tenant #3 was seen by the wound clinic and the wound was debrided. Orders were received to leave dressing intact unless drainage came through. It was noted drainage through the dressing occurred. The dressing was removed, packed with saline soaked roll gauze, covered with an ABD pad and covered with roll gauze. - On 8/16/24 the treatment was not completed as Tenant #3 went to the wound clinic and had a wound vac. - On 8/22/24 hospice staff stopped by and requested information on Tenant #3. Hospice was going to speak with Tenant #3 and his family. - On 8/22/24 a new wheelchair and cushion were received. An After Visit Summary from the ED dated 7/30/24 indicated Tenant #3 was seen for cellulitis of the right lower leg and hematoma of the right lower leg. An order was received for cephalexin 500 mg, one capsule by mouth three times per day for seven days. It also indicated to follow up with a wound care provider. Further record review revealed wound clinic orders indicating the following: - On 8/7/24 it was noted there was an appointment on 8/8/24 for general surgery and to obtain a wound vac to be placed at an appointment on 8/9/24. - On 8/9/24 it was noted Tenant #3 could shower with protection but not to get the dressing wet. It was noted a wound vac would be obtained for the next appointment.	A 145		

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A 145	Continued From page 21 - On 8/16/24 the tenant had a wound vac to wound continuously at 125 mm/hg pressure (negative pressure wound therapy). - On 8/21/24 it was noted Tenant #3 could shower with protection but not to get the wound vac dressing wet. Tenant #3's family would change the vac dressing on Saturday or Sunday that weekend. It noted a wound vac to wound continuously at 125 mm/hg pressure (negative pressure wound therapy). Evaluations were completed on 7/23/24, however they did not address the wound, extreme pain, wound treatment, wound clinic involvement or the wound vac. 4. Review of Tenant #4's file on 8/28/24 revealed diagnoses included mild cognitive impairment of unknown etiology, dementia without behavioral disturbance and Alzheimer's disease. Tenant #4 was staged at a three on the Global Deterioration Scale (GDS) (mild cognitive decline) on 2/6/24 and a four (moderate cognitive decline) on the GDS on 8/23/24. Continued record review revealed Progress Notes indicating the following: - On 6/29/24 (late entry) staff reported Tenant #4 had said she was going to walk outside around the building. Her family member called and asked to let her and they would be coming for lunch. When staff went to her apartment she was not there. The staff looked throughout the building and was not able to locate her. The staff notified all care staff to help in the search. At that time Tenant #4 was observed entering the memory care (attached unit) doors. Tenant #4 had walked to the west but she was unsure where she was or how to get back and she knocked on someone's door. Tenant #4 mentioned trying to find the	A 145		

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A 145	Continued From page 22 Program (called by name) and she was given a ride back to the building. Tenant #4's family member was notified of the situation and safety checks were increased to hourly. - On 7/15/24 it was noted safety checks resumed to every two hours. Further record review revealed evaluations were dated 2/6/24 and 8/23/24. The Nurse Review dated 8/23/24 reflected Tenant #4 enjoyed going on walks; however, did not reflect the incident that had occurred. Evaluations were not completed as needed related to the incident noted above and the temporary increased safety checks. 5. Review of Tenant #5's file on 8/29/24 revealed diagnoses included major depressive disorder (recurrent, moderate) and anxiety disorder. The Adult Services Monitoring Entrance Form completed by the Program identified Tenant #5 as a tenant who had suicidal ideations. Progress Notes indicated the following: - On 6/21/24 a fax was sent to the PCP requesting an order for psych evaluation and treatment. Tenant #5 had agreed to see a psychologist to assist with coping with a family member's death. - On 8/11/24 (late entry) staff reported Tenant #5 was very tearful and made comments that she wished she was dead so she could be with a family member. A fax was sent to the PCP dated 6/21/24 indicating Tenant #5 was depressed and said she was having a difficult time coping with the loss of a family member. An order was received for a psych evaluation and treatment. Evaluations were completed on 6/19/24 but were	A 145		

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A 145	Continued From page 23 not completed as needed with the order for the psych evaluation and treatment, her difficulty coping with a family member's death and comments she made related to not wanting to be alive. 6. Review of Tenant C1's file on 8/26/24 revealed Progress Notes indicating the following: - On 2/4/24 when ambulating back to her chair from the bathroom, Tenant C1's knee gave out. Staff lowered her to the floor. She was assisted up with the assistance of two staff. No injuries were noted. - On 2/12/24 it was noted that on 2/9/24 Tenant C1 was very weak and difficult to transfer. She did not let staff complete perineal cares. - On 2/13/24 (late entry) first shift staff reported Tenant C1 was a hard transfer all shift. She was not able to lift any of her weight and relied on staff 100%. - On 2/14/24 first shift reported Tenant C1 was a difficult transfer and required the assistance of two people. - On 2/20/24 staff attempted to transfer Tenant C1 into the vehicle for her appointment. Tenant C1 threw her body to the side and landed on the lap of the staff (who was positioned near the ground). Staff called for help and Tenant C1 was assisted up and into the vehicle with assistance of three people. When transferring in the vehicle to come back, Tenant C1 required the assistance of two people. Staff reported she was a heavy transfer and was unable to lift her feet with cueing. - On 2/21/24 first shift staff reported Tenant C1 required the assistance of two staff all shift. She did not assist to push herself up from the wheelchair, recliner or toilet. She told staff to pull her up and refused to accept verbal guidance from the staff.	A 145		

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A 145	Continued From page 24 - On 3/6/24 Tenant C1 complained of shortness of breath. Expiratory wheezes were heard in bilateral upper lobes and it was diminished in the bilateral bases. Tenant C1 requested to the ED via ambulance. - On 3/6/24 Tenant C1 was admitted to the hospital for respiratory syncytial virus and acute respiratory failure with hypoxia. - On 3/12/24 a call was received from the hospital and Tenant C1 would be discharged to skilled care. - On 4/15/24 second shift staff reported Tenant C1 was assisted with two people and a gait belt to get off of the toilet. Tenant C1 continued to require the assistance of two people for the rest of the shift. - On 4/15/24 third shift reported Tenant C1 was very difficult to transfer off of the toilet. It took two people. - On 4/17/24 third shift staff reported Tenant C1 was a very hard transfer. The staff reported she refused to wear a gait belt. - On 4/17/14 first shift staff reported Tenant C1 was a very hard transfer from the toilet. She required the assistance of two to three people. Orders were received for PT/OT. A toileting riser with handles was ordered. - On 4/18/24 staff reported when transferring Tenant C1 from her wheelchair to the toilet, she said she could not make it and fell to the ground. - On 4/19/24 it was noted Tenant C1 went out via ambulance on 3/6/24 and was admitted to the hospital. She was discharged to skilled care. She was assessed on 4/12/24 and required the assistance of one for transfers and ambulation. She was discharged back to the Program on 4/15/24 and upon arrival required the routine assistance of two people and at times required the assistance of more than two people. A referral was received for PT/OT. Tenant C1 was not	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 25	A 145		

appropriate for assisted living and it was noted Tenant C1 would be given 30 days to work with therapy to see if improvements could be made with ambulation and transfers.
- On 4/20/24 staff assisted Tenant C1 to the bathroom. She ambulated back from the bathroom but made it just inside the bedroom door and was no longer able to walk and was lowered to the ground. It took the assistance of three staff and a gait belt to assist her up off of the floor.
- On 4/21/24 third shift staff reported Tenant C1 transferred with the assistance of two staff all shift and she refused to stand up when getting off of the toilet.
- On 4/21/24 staff reported Tenant C1 had very poor heavy transfers today. Tenant C1 required the assistance of two staff with all transfers.

Continued record review revealed a notice was given (dated 8/7/23 error) that indicated a 30 day notice was given with the effective date of 5/23/24 related to exceeding level of care due to transfers that required the assistance of two or more staff.

Evaluations were completed 10/3/23 and 4/19/24. The notes indicated Tenant C1 was assessed at the skilled care facility prior to her return; however, no evaluations were documented. Evaluations were not completed as needed when Tenant C1 started to require the assistance of two people for transfers and with her hospitalization, skilled stay and return to the Program.

7. Review of Tenant C2's file on 8/26/24 and 8/27/24 revealed Progress Notes indicating the following:
- On 2/5/24 staff reported Tenant C2 would stand up from his wheelchair when transferring to his bed. He would not pivot his feet, but threw

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himself onto the bed. It caused the staff to fall.
- On 2/12/24 staff reported on 2/9/24 that Tenant C2 had hard transfers and required the assistance of two people.
- On 2/13/24 it was noted Tenant C2 required the assistance of two staff for transfers all shift and was not standing well. He was unable to take steps to pivot to his wheelchair. He was throwing his body for transfers.
- On 2/14/24 first shift staff reported Tenant C2 required the assistance of two people for transfers. He was barely bearing any weight, did not take steps to pivot and tried to throw himself into the recliner and wheelchair.
- On 2/21/24 first shift staff reported Tenant C2 required the assistance of two to three people all shift. He would not follow verbal cues and threw himself back into the chair.
- On 3/27/24 first shift reported Tenant C2 had a poor transfer. Staff attempted with one person but his knees gave out. Staff was able to get him back into the wheelchair to call for assistance. He was then transferred with the assistance of two people.
- On 4/2/24 staff reported Tenant C2 continued to transfer with not less than the assistance of two people. He struggled to move his feet to pivot when going to and from the wheelchair to the recliner
- On 4/19/24 it was noted Tenant C2 was currently working with PT but required the assistance of two or more people for transfers with a gait belt and walker. Tenant C2 was not appropriate for assisted living but it would be re-evaluated when he was discharged from PT.
- On 4/22/24 staff reported they transferred Tenant C2 from the bed with the assistance of two people. He stood up with the assistance of two people and started to lean to the side but staff could not correct it. Tenant C2 fell to the

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A 145	Continued From page 27 floor. He was not able to move his legs during the transfer and was not able to move his legs when he was assisted up from the ground. He required the assistance of four people to get him up off of the floor. - On 4/22/24 staff reported Tenant C2 had required the assistance (heavy) of two people all shift. - On 4/27/24 staff reported Tenant C2 had a fall in front of the toilet. He laid on the floor in front of the toilet with his feet towards the wall and his head towards the door. He was assisted to the toilet by two staff when he lost his balance and fell. - On 5/3/24 staff reported Tenant C2 was a difficult transfer and he could not stand or bear weight. He required max assistance of two people with the transfer. Continued record review revealed a notice was given (dated 8/7/23 error) that indicated a 30 day notice was given with the effective date of 5/23/24 related to exceeding level of care due to transfers that required the assistance of two or more staff. Further record review revealed evaluations were completed 10/3/23 and 4/19/24. Evaluations were not completed as needed when Tenant C2 started to require the assistance of two people or more for transfers. 8. When interviewed on 9/5/24 at 1:44 p.m. the RN indicated all evaluations requested were provided.	A 145		
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:	A 290		

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A 290	Continued From page 28 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 2 of 5 current tenants (Tenant #1 and Tenant #3) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Review of Tenant #1's file on 8/26/24 and 8/27/24 revealed Progress Notes indicating the following: - On 6/3/24 staff reported Tenant #1 seemed more confused than normal and was seated at the front door waiting for a group to bring in children for a performance. An order was sent to the primary care provider (PCP) to request a urinalysis. - On 6/28/24 staff reported Tenant #1 had redness to her groin and abdominal fold and yeast was present. A fax was sent to the primary care provider (PCP) to request an order for Nystatin powder. Review of the tenant's June, July and August 2024 medication administration records (MARs) revealed orders to use the Dexcom (continuous glucometer) four times per day. It also indicated to inject Insulin Lisp 100/milliliters, 10 units subcutaneously, three times daily with meals and to hold the insulin for blood glucose readings less than 100.	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 29 A review of the tenant's Weights and Vitals Summary documents revealed the following: - In June 2024 Tenant #1 had 4 blood glucose readings below 100, including a reading of 54 on 6/14/24. - In July 2024 Tenant #1 had 11 blood glucose readings below 100, including a reading of 59 on 7/9/24. - In August 2024 Tenant #1 had 22 blood glucose readings below 100, including a reading of 57 on 8/14/24. The July 2024 MAR also reflected an order for Nyamyc Powder 100000, apply topically to the groin and abdominal fold three times daily for seven days. It was ordered on 7/1/24. Nurse's notes were not documented by exception for Tenant #1 related to the follow up to the request for the UA that was sent to the PCP, when the order was received for the Nyamyc topical powder or to follow up on the repeated low blood glucose readings and held scheduled insulin. 2. Review of Tenant #3's file on 8/28/24 revealed Progress Notes indicating the following: - On 7/16/24 staff was called to Tenant #3's apartment. He had gotten up, lost his balance and fell. There were three skin tears noted, two on his legs and one on his chest. Tenant #3's right knuckles were bruised and a hematoma was noted to the right knee/shin. Tenant #3 initially had heat on it but switched to ice. His family requested physical therapy (PT). - On 7/23/24 an assessment was completed related to increased weakness and many falls. After one fall Tenant #3 sustained a hematoma to his right knee that caused him pain. It had	A 290		

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reduced the amount of time Tenant #3 spent outside of his apartment.
- On 8/7/24 Tenant #3 was seen by the wound clinic and the wound was debrided. Orders were received to leave dressing intact unless drainage came through. It was noted drainage through the dressing occurred. The dressing was removed, packed with saline soaked roll gauze, covered with an ABD pad and covered with roll gauze.
- On 8/16/24 the treatment was not completed as Tenant #3 went to the wound clinic and had a wound vac.

An After Visit Summary from the Emergency Department (ED) dated 7/30/24 indicated Tenant #3 was seen for cellulitis of the right lower leg and hematoma of the right lower leg. An order was received for cephalexin 500 mg, one capsule by mouth three times per day for seven days. It also indicated to follow up with a wound care provider.

Further record review revealed wound care orders were received on 8/7/24, 8/9/24, 8/16/24 and 8/21/24. Tenant #3 had two surgical debridements on 8/7/24 and 8/16/24, and had a wound vac placed on 8/16/24.

Nurse's notes were not documented by exception for Tenant #3's ED visit and new orders with the wound care visits on 8/9/24, 8/16/24 and 8/21/24 or with the surgical debridement on 8/16/24 and placement of the wound vac.

3. Review of Tenant C1's file on 8/26/24 revealed he was discharged on 5/21/24 due to exceeding level of care.

Further record review revealed Progress Notes indicating the following:
- On 3/6/24 Tenant C1 complained of shortness

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A 290	Continued From page 31 of breath. Expiratory wheezes were heard in bilateral upper lobes and it was diminished in the bilateral bases. Tenant C1 requested to the ED via ambulance. - On 3/6/24 Tenant C1 was admitted to the hospital for respiratory syncytial virus and acute respiratory failure with hypoxia. - On 3/12/24 a call was received from the hospital and Tenant C1 would be discharged to skilled care. - On 4/15/24 second shift staff reported Tenant C1 was assisted with two people and a gait belt to get off of the toilet. Tenant C1 continued to require the assistance of two people for the rest of the shift. - On 4/19/24 it was noted Tenant C1 went out via ambulance on 3/6/24 and was admitted to the hospital. She was discharged to skilled care. She was assessed on 4/12/24 and required the assistance of one for transfers and ambulation. She was discharged back to the Program on 4/15/24 and upon arrival required the routine assistance of two people and at times required the assistance of more than two people. A referral was received for PT/OT. Tenant C1 was not appropriate for assisted living and it was noted Tenant C1 would be given 30 days to work with therapy to see if improvements could be made with ambulation and transfers. A nurse's note was not completed when Tenant C1 returned to the Program from the hospitalization and skilled care stay on 4/15/24. 4. When interviewed on 9/5/24 at 1:44 p.m. the RN confirmed all nurse's notes were provided for the tenants reviewed.	A 290		

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A 350	Continued From page 32	A 350		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed with significant change. This pertained to 5 of 5 current tenants (Tenants #1, #2, #3, #4 and #5) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review of Tenant #1's file on 8/26/24 and 8/27/24 revealed Progress Notes indicating the following: - On 6/3/24 staff reported Tenant #1 seemed more confused than normal and was seated at the front door waiting for a group to bring in children for a performance. An order was sent to the primary care provider (PCP) to request a urinalysis. - On 6/23/24 staff reported Tenant #1 woke up very confused that morning. She wondered why she was getting her medications and why she and the staff were the only people left in the building. She was unaware it was the morning. - On 6/28/24 staff reported Tenant #1 had redness to her groin and abdominal fold and	A 350	1) Nurses met with nurse consultant and received education related to determining significant changes and when to initiate them. RN will complete significant change evaluations within a timely manner. Date of compliance 11/1/2024	

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yeast was present. A fax was sent to the PCP to request an order for Nystatin powder.
- On 7/8/24 Tenant #1's family voiced concerns regarding increased confusion. A message was sent to another provider (mental health services) about getting Tenant #1 on the list to be seen next time the provider was there.
- On 7/9/24 Tenant #1's blood glucose reading was 59 at 12:30 a.m. Tenant #1 seemed very confused and did not remember why she was there. She was given a peanut butter sandwich and chocolate milk. At 1:15 a.m. her blood glucose reading was 127 and she went back to sleep in her chair.
- On 7/24/24 it was noted a significant change assessment was completed due to her requiring more assistance with cares and being increasingly more forgetful and incontinent.
- On 7/24/24 third shift staff reported Tenant #1 was observed wandering around the main entrance looking for her children. She was ambulating without her walker. Her blood glucose was 57. She was given two pieces of peanut butter toast and orange juice. Her blood sugar came back up to 89. Tenant #1's daughter called and reported the tenant had called her and said she was looking for her children and car and also asked to speak to her former spouse (who was deceased).
- On 7/25/24 Tenant #1's blood glucose was 101 and was dropping per the continuous glucometer. Tenant #1 was asleep.
- On 8/13/24 insulin was held due to her blood glucose reading of 58.

Continued record review revealed the June, July and August 2024 medication administration records (MARs) reflected orders for to use the Dexcom (continuous glucometer) four times per day. They also indicated to inject Insulin Lisp

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A 350	Continued From page 34 100/milliters, 10 units subcutaneously, three times daily with meals and to hold the insulin for blood glucose readings less than 100. A review of the tenant's Weights and Vitals Summary documents indicated the following: - For June 2024 Tenant #1 had 4 blood glucose readings below 100, including a reading of 54 on 6/14/24. - For July 2024 Tenant #1 had 11 blood glucose readings below 100, including a reading of 59 on 7/9/24. - For August 2024 Tenant #1 had 22 blood glucose readings below 100, including a reading of 57 on 8/14/24. Tenant #1 had a service plan dated 5/30/24 and an unsigned service plan that indicated the last service plan review date was 7/24/24. The service plan was not updated as needed between 5/30/24 and 7/24/24 when Tenant #1 had increased confusion, redness and yeast in her groin and abdominal folds that required treatment, mental health services, and blood glucose readings outside of the parameters that resulted in insulin being held. The service plan updated on 7/24/24 indicated to offer or encourage her to have a snack before bed to help with her diabetes. The service plan reflected mental health services and deficits in her judgement. The service plan updated on 7/24/24 did not reflect the frequent blood glucose readings below 100, or her her increased confusion. Additionally, the service plan reflected staff administered her medications and administered her insulin; however, did not reflect staff took her blood glucose readings and did not reflect the use of the Dexcom (continuous glucometer)	A 350		

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A 350	Continued From page 35 2. Review of Tenant #2's file on 8/27/24 revealed Progress Notes indicating the following: - On 7/5/24 Tenant #2 reported his left toes and top of his foot were swollen, numb and painful. An appointment was made with the primary care provider (PCP) for 7/8/24. - On 7/8/24 Tenant #2 was seen but did not get lab work or x-rays completed as ordered. The PCP indicated Tenant #2 needed to be seen in the emergency department (ED) to have the tests completed. - On 7/8/24 staff took Tenant #2 to the ED. He was admitted and was to see podiatry in the morning. - On 7/12/24 it was noted there was a significant change. Tenant #2 was seen by his PCP on 7/8/24 for a wound on the left great toe but he left the clinic before getting lab work or x-rays completed. The PCP reported there were maggots in his wound. The PCP called to report the tests she ordered did not get done and he needed to go to the ED to be seen. Tenant #2 was admitted overnight until he could see podiatry and was discharged back to the Program with new orders to apply triple antibiotic ointment (TAO) to the toe and fissure on the dorsal side the foot. They did not report any maggots. An appointment was made with the wound clinic due to maggots being present on the dressing change when the RN (program nurse) removed it to change it. Tenant #2 was seen by the wound clinic on 7/11/24 and there were no maggots present. The wound clinic indicated he had peripheral vascular disease, should wear compression hose and elevate his legs. The TAO treatment was discontinued. Further record review revealed an unsigned service plan with a last review completed date of	A 350		

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	S0385	A. BUILDING: _____ B. WING _____	C 09/26/2024

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A 350	Continued From page 36 7/12/24 that reflected Tenant #2 took medications which caused bleeding/bruising and to report any changes to the nurse. The service plan was not updated to reflect the issue with the left great toe wound, swelling, pain and numbness and the compression hose. 3. Review of Tenant #3's file on 8/28/24 revealed Progress Notes indicating the following: - On 7/16/24 staff was called to Tenant #3's apartment. He had gotten up, lost his balance and fell. There were three skin tears noted, two on his legs and one on his chest. Tenant #3's right knuckles were bruised and a hematoma was noted to the right knee/shin. Tenant #3 initially had heat on it but switched to ice. His family requested physical therapy (PT). - On 7/17/24 Tenant #3 was encouraged to go to the fitness room. He had a lot of falls recently and had been staying in his apartment. - On 7/19/24 Tenant #3 complained of pain in the right lower extremity (RLE) related to a hematoma and edema. It was noted Tenant #3 had an open blister. A fax was sent to the PCP requesting orders for Tramadol and wound care. - On 7/20/24 Tramadol HCL 50 milligram (mg) one tablet was administered for pain and was ineffective. - On 7/20/24 acetaminophen 500 mg tablet (two tablets) for pain were administered and were ineffective. - On 7/22/24 Tramadol HCL 50 mg one tablet was administered for pain and was ineffective. It was noted Tenant #3's pain level was very high especially when walking. - On 7/23/24 Tramadol HCL 50 mg one tablet was administered for pain and was ineffective. - On 7/23/24 an assessment was completed related to increased weakness and many falls. After one fall Tenant #3 sustained a hematoma to	A 350		

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A 350	Continued From page 37	A 350		

his right knee that caused him pain. It had reduced the amount of time Tenant #3 spent outside of his apartment.
- On 7/24/24 Tramadol HCL 50 mg one tablet was administered for pain and was ineffective. The follow up pain scale was a 10.
- On 8/5/24 acetaminophen 500 mg tablet (two tablets) for pain were administered for extreme pain when walking on the right leg.
- On 8/5/24 Tramadol HCL 50 mg one tablet was administered for pain. It was noted Tenant #3 was in extreme pain when walking on the right leg.
- On 8/7/24 Tenant #3 was seen by the wound clinic and the wound was debrided. Orders were received to leave dressing intact unless drainage came through. It was noted drainage through the dressing occurred. The dressing was removed, packed with saline soaked roll gauze, covered with an ABD pad and covered with roll gauze.
- On 8/16/24 the treatment was not completed as Tenant #3 went to the wound clinic and had a wound vac.
- On 8/22/24 hospice staff stopped by and requested information on Tenant #3. Hospice was going to speak with Tenant #3 and his family.
- On 8/22/24 a new wheelchair and cushion were received.

An After Visit Summary from the ED dated 7/30/24 indicated Tenant #3 was seen for cellulitis of the right lower leg and hematoma of the right lower leg. An order was received for cephalexin 500 mg, one capsule by mouth three times per day for seven days. It also indicated to follow up with a wound care provider.

Review of wound clinic orders indicated the following:
- On 8/7/24 it was noted there was an

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A 350	Continued From page 38 appointment on 8/8/24 for general surgery and to obtain a wound vac to be placed at an appointment on 8/9/24. The wound treatment indicated the wound location was the right knee, the primary dressing was to pack loosely with saline moistened 2" conform, secondary dressing was an ABD pad 5 x 9, place over wound area as needed and secure with Kerlix (4 inch) as needed. . - On 8/9/24 it was noted to assist with pain management take Tylenol or ibuprofen one hour prior to wound care appointment and return in one week. It indicated Tenant #3 could shower with protection but not to get the dressing wet. A wound vac would be obtained for the next appointment. Orders included edema stocking once per day. - On 8/16/24 it was noted to assist with pain management take Tylenol or ibuprofen one hour prior to wound care appointment and return in one week. It indicated Tenant #3 could shower with protection but not to get the dressing wet. It noted a wound vac to wound continuously at 125 mm/hg pressure (negative pressure wound therapy). He was to avoid standing for long periods of time and elevate the legs for 30 minutes, two to three times daily. He was to wear stockings once per day for edema. - On 8/21/24 it was noted to assist with pain management take Tylenol or ibuprofen one hour prior to wound care appointment. It indicated Tenant #3 could shower with protection but not to get the dressing wet. Tenant #3's family would change the vac dressing on Saturday or Sunday that weekend. It noted a wound vac to wound continuously at 125 mm/hg pressure (negative pressure wound therapy). He was to avoid standing for long periods of time and elevate the legs for 30 minutes, two to three times daily. For edema he was to wear stocking twice per week.	A 350		

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A 350	Continued From page 39 Tenant #3 had service plans dated 2/16/24 and 7/23/24 and 8/19/24. The service plan dated 7/23/24 did not reflect any issues with the right knee or pain. The service plan updated on 8/19/24 did not reflect the wound, extreme pain, wound treatment, wound clinic involvement or the wound vac. It also did not reflect the other instructions noted above related to elevation of legs, the wheelchair and cushion, edema stockings and instructions needed related to bathing with the wound vac. The service plan was not updated as needed and did not reflect his needs related to the on-going wound and treatment. 4. Review of Tenant #4's file on 8/28/24 revealed diagnoses included mild cognitive impairment of unknown etiology, dementia without behavioral disturbance and Alzheimer's disease. Tenant #4 was staged at a three on the Global Deterioration Scale (GDS) (mild cognitive decline) on 2/6/24 and a four (moderate cognitive decline) on the GDS on 8/23/24. Continued record review revealed Progress Notes indicating the following: - On 6/29/24 (late entry) staff reported Tenant #4 had said she was going to walk outside around the building. Her family member called and asked to let her and they would be coming for lunch. When staff went to her apartment she was not there. The staff looked throughout the building and was not able to locate her. The staff notified all care staff to help in the search. At that time Tenant #4 was observed entering the memory care (attached unit) doors. Tenant #4 had walked to the west but she was unsure where she was or how to get back and she knocked on someone's door. Tenant #4 mentioned trying to find the	A 350		

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A 350	Continued From page 40 Program (called by name) and she was given a ride back to the building. Tenant #4's family member was notified of the situation and safety checks were increased to hourly. - On 7/15/24 it was noted safety checks resumed to every two hours. The tenant's service plans were dated 2/6/24 and 8/23/23. The service plan was not updated to reflect the incident noted above or the temporary increased safety checks. 5. Review of Tenant #5's file on 8/29/24 revealed diagnoses included major depressive disorder (recurrent, moderate) and anxiety disorder. The Adult Services Monitoring Entrance Form completed by the Program identified Tenant #5 as a tenant who had suicidal ideations. Progress Notes indicated the following: - On 6/21/24 a fax was sent to the PCP requesting an order for psych evaluation and treatment. Tenant #5 had agreed to see a psychologist to assist with coping with a family member's death. - On 8/11/24 (late entry) staff reported Tenant #5 was very tearful and made comments that she wished she was dead so she could be with a family member A fax was sent to the PCP dated 6/21/24 indicating Tenant #5 was depressed and said she was having a difficult time coping with the loss of a family member. An order was received for a psych evaluation and treatment. The tenant's service plan dated 6/24/24 reflected Tenant #5 received mental health services through the PCP. The service plan was not updated as needed to reflect the order for the psych evaluation and treatment, her difficulty	A 350		

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A 350	Continued From page 41 coping with a family member's death and the comments she made related to not wanting to be alive or any interventions related to her mental health and safety. 6. Review of Tenant C1's file on 8/26/24 revealed Progress Notes indicating the following: - On 2/4/24 when ambulating back to her chair from the bathroom, Tenant C1's knee gave out. Staff lowered her to the floor. She was assisted up with the assistance of two staff. No injuries were noted. - On 2/12/24 it was noted that on 2/9/24 Tenant C1 was very weak and difficult to transfer. She did not let staff complete perineal cares. - On 2/13/24 (late entry) first shift staff reported Tenant C1 was a hard transfer all shift. She was not able to lift any of her weight and relied on staff 100%. - On 2/14/24 first shift reported Tenant C1 was a difficult transfer and required the assistance of two people. - On 2/20/24 staff attempted to transfer Tenant C1 into the vehicle for her appointment. Tenant C1 threw her body to the side and landed on the lap of the staff (who was positioned near the ground). Staff called for help and Tenant C1 was assisted up and into the vehicle with assistance of three people. When transferring in the vehicle to come back, Tenant C1 required the assistance of two people. Staff reported she was a heavy transfer and was unable to lift her feet with cueing. - On 2/21/24 first shift staff reported Tenant C1 required the assistance of two staff all shift. She did not assist to push herself up from the wheelchair, recliner or toilet. She told staff to pull her up and refused to accept verbal guidance from the staff. - On 3/6/24 Tenant C1 complained of shortness	A 350		

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A 350	Continued From page 42	A 350		

of breath. Expiratory wheezes were heard in bilateral upper lobes and it was diminished in the bilateral bases. Tenant C1 requested to the ED via ambulance.

- On 3/6/24 Tenant C1 was admitted to the hospital for respiratory syncytial virus and acute respiratory failure with hypoxia.
- On 3/12/24 a call was received from the hospital and Tenant C1 would be discharged to skilled care.
- On 4/15/24 second shift staff reported Tenant C1 was assisted with two people and a gait belt to get off of the toilet. Tenant C1 continued to require the assistance of two people for the rest of the shift.
- On 4/15/24 third shift reported Tenant C1 was very difficult to transfer off of the toilet. It took two people.
- On 4/17/24 third shift staff reported Tenant C1 was a very hard transfer. The staff reported she refused to wear a gait belt.
- On 4/17/14 first shift staff reported Tenant C1 was a very hard transfer from the toilet. She required the assistance of two to three people. Orders were received for PT/OT. A toileting riser with handles was ordered.
- On 4/18/24 staff reported when transferring Tenant C1 from her wheelchair to the toilet, she said she could not make it and fell to the ground.
- On 4/19/24 it was noted Tenant C1 went out via ambulance on 3/6/24 and was admitted to the hospital. She was discharged to skilled care. She was assessed on 4/12/24 and required the assistance of one for transfers and ambulation. She was discharged back to the Program on 4/15/24 and upon arrival required the routine assistance of two people and at times required the assistance of more than two people. A referral was received for PT/OT. Tenant C1 was not appropriate for assisted living and it was noted

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A 350	Continued From page 43 Tenant C1 would be given 30 days to work with therapy to see if improvements could be made with ambulation and transfers. - On 4/20/24 staff assisted Tenant C1 to the bathroom. She ambulated back from the bathroom but made it just inside the bedroom door and was no longer able to walk and was lowered to the ground. It took the assistance of three staff and a gait belt to assist her up off of the floor. - On 4/21/24 third shift staff reported Tenant C1 transferred with the assistance of two staff all shift and she refused to stand up when getting off of the toilet. - On 4/21/24 staff reported Tenant C1 had very poor heavy transfers today. Tenant C1 required the assistance of two staff with all transfers. Continued record review revealed a notice was given (dated 8/7/23 error) that indicated a 30 day notice was given with the effective date of 5/23/24 related to exceeding level of care due to transfers that required the assistance of two or more staff. Further record review revealed service plans were dated 10/3/23 and 4/19/24. The service plan dated 10/3/23 reflected she required the assistance of one person with a walker. The service plan dated 4/19/24 reflected Tenant C1 required the assistance of two people, a gait belt and walker for transfers. The service plan was not updated following her hospitalization, skilled stay and return to the Program. 7. Review of Tenant C2's file on 8/26/24 and 8/27/24 revealed Progress Notes indicating the following: - On 2/5/24 staff reported Tenant C2 would stand up from his wheelchair when transferring to his bed. He would not pivot his feet, but threw	A 350		

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A 350	Continued From page 44 himself onto the bed. It caused the staff to fall. - On 2/12/24 staff reported on 2/9/24 that Tenant C2 had hard transfers and required the assistance of two people. - On 2/13/24 it was noted Tenant C2 required the assistance of two staff for transfers all shift and was not standing well. He was unable to take steps to pivot to his wheelchair. He was throwing his body for transfers. - On 2/14/24 first shift staff reported Tenant C2 required the assistance of two people for transfers. He was barely bearing any weight, did not take steps to pivot and tried to throw himself into the recliner and wheelchair. - On 2/21/24 first shift staff reported Tenant C2 required the assistance of two to three people all shift. He would not follow verbal cues and threw himself back into the chair. - On 3/27/24 first shift reported Tenant C2 had a poor transfer. Staff attempted with one person but his knees gave out. Staff was able to get him back into the wheelchair to call for assistance. He was then transferred with the assistance of two people. - On 4/2/24 staff reported Tenant C2 continued to transfer with not less than the assistance of two people. He struggled to move his feet to pivot when going to and from the wheelchair to the recliner - On 4/19/24 it was noted Tenant C2 was currently working with PT but required the assistance of two or more people for transfers with a gait belt and walker. Tenant C2 was not appropriate for assisted living but it would be re-evaluated when he was discharged from PT. - On 4/22/24 staff reported they transferred Tenant C2 from the bed with the assistance of two people. He stood up with the assistance of two people and started to lean to the side but staff could not correct it. Tenant C2 fell to the	A 350		

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A 350	Continued From page 45 floor. He was not able to move his legs during the transfer and was not able to move his legs when he was assisted up from the ground. He required the assistance of four people to get him up off of the floor. - On 4/22/24 staff reported Tenant C2 had required the assistance (heavy) of two people all shift. - On 4/27/24 staff reported Tenant C2 had a fall in front of the toilet. He laid on the floor in front of the toilet with his feet towards the wall and his head towards the door. He was assisted to the toilet by two staff when he lost his balance and fell. - On 5/3/24 staff reported Tenant C2 was a difficult transfer and he could not stand or bear weight. He required max assistance of two people with the transfer. Continued record review revealed a notice was given (dated 8/7/23 error) that indicated a 30 day notice was given with the effective date of 5/23/24 related to exceeding level of care due to transfers that required the assistance of two or more staff. Further record review revealed service plans were dated 10/3/23 and 4/19/24. The service plan dated 10/3/23 reflected he required the assistance of one to two people with a walker. It indicated he could be transferred with one person and a gait belt and walker. He required occasional assistance of two people for transfers. The service plan dated 4/19/24 reflected Tenant C2 required the assistance of two people, a gait belt and walker for transfers and at times required more than an assist of two with transfers. The service plan was not updated as needed when Tenant C2 started to require the assistance of two people or more to transfer beginning in February.	A 350		

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A 350	Continued From page 46 8. When interviewed on 9/5/24 at 1:44 p.m. the Registered Nurse indicated all service plans requested 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. 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 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review of Tenant C1's file on 8/26/24 and 8/27/24 revealed Tenant C1 was admitted on 8/1/23. The service plan was updated on 10/3/23; however, the service plan was not updated within 30 days of taking occupancy. 2. Review of Tenant C2's file on 8/26/24 and 8/27/23 revealed Tenant C2 was admitted on on 8/1/23. The service plan was updated on 10/3/23; however, was not updated 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	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	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN ASSISTED LI\	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 360	Continued From page 47 were provided for tenants reviewed.	A 360		
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 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 2 of 3 current tenants reviewed applicable for a 90 day nurse review (Tenant #3 and Tenant #4) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review on of Tenant #3's file 8/28/24 revealed Tenant #3 received personal or health related care. Evaluations were completed on 2/16/24 for an annual review and to bring the chart back into compliance. Evaluations were completed on 7/23/24 for a significant change. There were no nurse reviews completed between 2/16/24 and 7/23/24. Nurse reviews were not completed every 90 days. 2. Review of Tenant #4's file on 8/28/24 revealed	A 430	1) Nurse worked with a nurse consultant. Nurse consultant helped structure a calendar to keep evaluations in compliance including 90 day 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.	

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
	S0385	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN ASSISTED LI\	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 430	Continued From page 48 Tenant #4 received personal or health related care. Evaluations were completed on 2/6/24 (quarterly review) and on 8/23/24 (quarterly review). The nurse review on 8/23/24 reflected it was completed to bring the chart back into compliance. There were no nurse reviews completed between 2/6/24 and 8/23/24. Nurse reviews were not completed every 90 days. 3. Review of Tenant C1's file on 8/26/24 revealed Tenant C1 was admitted on 8/1/23 and was discharged on 5/21/24. The nurse review dated 10/3/23 indicated Tenant C1 received assistance with bathing, dressing, transfers with the assistance of one person, and needed the assistance of one person to the toilet. She was independent with medication administration. Evaluations were completed on 10/3/23 (a 30 day review) and evaluations were completed on 4/19/24 related to a significant change. There were no 90 day reviews completed during the time Tenant C1 resided at the Program (8/1/23 to 5/21/24). 4. Review of Tenant C2's file on 8/26/24 and 8/27/24 revealed Tenant C2 was admitted on 8/1/23 and was discharged on 5/21/24. The nurse review dated 10/3/23 indicated Tenant C2 received assistance with personal cares and he managed his own medications. Evaluations were completed on 10/3/23 (a 30 day review) and evaluations were completed on 4/19/24. There were no 90 day reviews completed during the time Tenant C1 resided at the Program (8/1/23 to 5/21/24). 5. When interviewed on 9/5/24 at 1:44 p.m. the Registered Nurse confirmed all 90 day nurse reviews were provided for the tenants reviewed.	A 430	EP Jennifer Stanley 11-26-24 IRN 11/26/2024 IRN 11/26/24	