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
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs 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: 41 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 41 The following regulatory insufficiencies were cited during 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 policy and procedure related to treatments for 1 of 1 tenants reviewed with a head laceration (Tenant #3). Findings follow: 1. On 2/1/24 review of Tenant #3's file revealed an Incident Report dated 1/10/24 at 6:00 p.m. indicating Tenant #3 used a pendant to call for staff assistance. Staff responded and observed the tenant on the floor in her bathroom. Tenant #3 reported she hit her head and had bleeding from the right side of her head. Staff called for another staff to assist and an ambulance was called. Staff took Tenant #3's vital signs. She was not moved due to head trauma. Tenant #3 reported she lost	A 150	The Plan of Correction is attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 1	A 150		

her balance when she was walking to the bathroom and pulling down her pants. Tenant #3's walker was in the living room. The report documented the tenant was taken to the emergency department (ED) where four staples where placed in a head laceration. The resolution/outcome section of the incident report completed by the Assisted Living (AL) Director indicated the staples were removed on 1/15/24. Her skin was intact with no drainage or bleeding noted.

2. When interviewed on 2/1/24 at 1:40 p.m. the AL Director indicated there was no After Visit Summary (AVS) for the ED visit and she removed Tenant #3's staples after five days as indicated on the incident report.

3. When Tenant #3's file was requested on 2/1/24, the AVS from the ED was not initially available. The Program obtained the AVS on 2/1/24. The AVS indicated Tenant #3 was seen on 1/10/24 for a scalp laceration. Orders included to follow up with her primary care provider (PCP) in two days (around 1/12/24) and to have staples removed in five days. The orders were not noted and were not obtained by the Program until 2/1/24.

4. Record review on 2/1/24 of the Program's Medications policy and procedure indicated medications and treatments would be administered as prescribed.

5. When interviewed on 2/1/24 at 3:50 p.m. the AL Director said Tenant #3 asked staff to ask the AL Director to remove her staples. She told her no at first but then the PCP's office said it was okay. The AL Director removed the staples on 1/15/24. She did not receive an written order to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 2 remove them.	A 150		
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 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 provide nurse delegated training on all tasks including insulin pen administration. This pertained to 1 of 4 staff reviewed who assisted with insulin pen administration (Staff A). Findings follow: 1. When interviewed on 1/31/24 at 1:38 p.m. Staff A said she administered medications and assisted with blood glucose monitoring via a continuous glucometer or finger sticks as needed. Staff A said she also assisted with insulin pens by dialing up the insulin. Generally the tenant injected the insulin however at times Tenant #4 needed assistance to depress the plunger on the insulin pen. 2. Review of Staff A's training documents on 1/31/24 revealed Staff A was hired on 8/1/23. A Certificate of Completion for a medication	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 355	Continued From page 3 manager course was dated 9/25/23. Staff A had documented nurse delegated training; however, the training did not include training on insulin pen administration or insulin pen preparation. 3. When interviewed on 2/1/24 at 3:50 p.m. the Assisted Living Director confirmed all nurse delegated training was provided for the staff reviewed.	A 355		
A 106	231C.5 1 Occupancy Agreement 231C.5 Written occupancy agreement required. 1. An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain a signed occupancy agreement prior to taking occupancy for 1 of 1 tenants reviewed admitted in the prior six months (Tenant #3). Findings follow:	A 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 106	Continued From page 4 1. On 2/1/24 review of Tenant #3's file revealed an admission date of 8/29/23. The Assisted Living Occupancy Agreement was signed by Tenant #3 on 9/1/24 and was signed by a Program representative on 8/31/23. Continued record review revealed a Progress Note dated 8/29/23 indicated Tenant #3 moved to the assisted living from independent living with her spouse. Pre-admission evaluations were completed. Further record review revealed the preliminary evaluations were dated 8/29/23 and the service plan was signed by Tenant #3 on 8/29/23. The occupancy agreement was not signed by Tenant #3 or Tenant #3's legal representative prior to taking occupancy. 2. When interviewed on 2/1/24 at 3:50 p.m. the Assisted Living Director confirmed all evaluations and service plans were provided for the tenant reviewed.	A 106		
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	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 5 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 for 2 of 4 current tenants reviewed (Tenant #3 and Tenant #4). Finding follow: 1. On 2/1/24 review of Tenant #3's file revealed incident reports indicating the following: a. An incident report dated 12/11/23 at 7:20 a.m. indicated Tenant #3 pushed her pendant to call for assistance. When staff responded Tenant #3 was observed on the bathroom floor on her right side. She said she fell and hit her head on the wall. Tenant #3 had a bump on the right side of her head and complained of left arm pain. Shewas taken to the emergency department (ED). b. An incident report dated 1/10/24 at 6:00 p.m. indicated Tenant #3 pushed her pendant to call for staff assistance. Staff responded and observed Tenant #3 on the floor in her bathroom. Tenant #3 reported she hit her head and had bleeding from the right side of her head. It indicated Tenant #3 was taken to the ED where staples were placed due to a head laceration. The resolution/outcome section of the incident report completed by the Assisted Living (AL) Director indicated the staples were removed on 1/15/24. Her skin was intact with no drainage or bleeding noted. Tenant #3's Progress Notes indicated the	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 6	A 145		

following:
a. On 12/13/23 (late entry) Tenant #3 had swelling in the right hand. It was very swollen and she complained of pain in the right elbow. Tenant #3's family took her to have x-rays taken and it was noted Tenant #3 had a hairline fracture to the right elbow. She was wearing a sling at rest and she was not to use it when ambulating. Tenant #3 was aware she needed to apply less pressure to the right arm when walking with the walker.
b. On 12/18/23 a new order was received for physical therapy (PT)/occupational therapy (OT) to evaluate and treat.
c. On 1/18/24 it was noted Tenant #3 worked with PT/OT on balance and using her walker in her room with constraints related to space. It was noted the pain in her arm continued. Staff would give reminders when she was seen not using her walker.

Continued record review revealed evaluations were completed on 9/28/23 (30 days evaluations) and on 1/2/24 (90 day evaluations). Evaluations were not completed as needed related to Tenant #3's two falls with injuries, including a hairline fracture and scalp laceration, orders for PT/OT and the use of a sling and continued arm pain.

2. On 2/1/24 review on 2/1/24 of Tenant #4's file revealed Progress Notes indicating the following:
a. On 12/15/23 Tenant #4 reported to staff he had increased urge incontinence when he attempted to get to the bathroom. A new order was received for a urinalysis (UA) with culture and sensitivity.
b. On 12/22/23 it was noted the results of the UA with culture and sensitivity were received and did not indicate an infection. Staff were to prompt Tenant #4 at med pass times to use the bathroom and change his undergarment if needed. Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 7 reported Tenant #4 was not using the bathroom as much and did know always know his undergarment was wet. Continued record review revealed a lab document indicated the PCP stated there was no evidence of a urinary tract infection and asked if he was still having a lot of urinary incontinence issues. The returned response indicated Tenant #4 needed to use the toilet more than he was and staff would start prompting him every three to four hours and would change his protective undergarment too. Further record review revealed the most recent evaluations were dated 11/15/23 and 11/17/23 (90 day evaluations). Evaluations were not completed with new orders for UA and culture and sensitivity, increased urinary incontinence, staff reports of not always knowing he had been incontinent of urine and increased services provided related to toileting and incontinence. 3. When interviewed on 2/1/24 at 3:50 p.m. the Assisted Living Director confirmed all evaluations requested were provided for tenants reviewed.	A 145		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed for 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file on 2/1/24 revealed an Order Summary Report dated 11/15/23 indicating to complete monthly vitals and weights on the 17th and to notify the primary care provider (PCP) of vitals outside of the established parameters. The document also indicated orders for anti-embolism hose, on in the morning and off at bedtime. Continued record review revealed November and December 2023 medication administration records (MARs) and January 2024 MARs at bedtime reflected entries related to his ant-embolism hose not being on when staff went to remove them. Tenant #1's service plan reflected he wore anti-embolism hose but did not reflect the issue related to Tenant #1 not having them on at times at bedtime when staff attempted to remove the hose. 2. Review on 2/1/24 of Tenant #2's file revealed Progress Notes indicated the following: a. On 1/3/24 staff found Tenant #2 on the toilet and he had black tarry stools and was bleeding profusely from hemorrhoids. Tenant #2 was weak, his eyes became glassy and he did not respond to verbal communication. Staff called 911 and he was transported to the hospital. b. On 1/4/24 Tenant #2's family called and reported he had a major bleed and was given	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 9	A 350		

only a few days. Tenant #2 would be admitted to hospice services.

c. On 1/5/24 Tenant #2 returned to the Program with hospice services. He was bed bound and staff would provide comfort cares.

d. On 1/24/24 the hospice aide was at the Program to complete daily cares and bath with Tenant #2. It was scheduled two times per week. Program staff completed all daily cares as needed, including emptying his catheter. He was repositioned every two hours while awake. Tenant #2 used a bed pan and brief for bowel movement needs. Tenant #2 was on continuous oxygen at 2 liters per nasal cannula. Comfort medications were ordered. Tenant #2 had no pain reported except at times of repositioning. A waiver was requested related to end of life cares.

Tenant #2's service plan reflected he was bed bound and had comfort medications only as ordered. The service plan reflected all activities of daily living were to be completed at bedside. The service plan did not reflect repositioning and at times pain reported with repositioning.

3. On 2/1/24 review of Tenant #3's file revealed incident reports indicated the following:

a. An incident report dated 12/11/23 at 7:20 a.m. indicated Tenant #3 pushed her pendant to call for assistance. When staff responded Tenant #3 was observed on the bathroom floor on her right side. She said she fell and hit her head on the wall. Tenant #3 had a bump on the right side of her head and complained of left arm pain. She was taken to the emergency department (ED).

b. An incident report dated 1/10/24 at 6:00 p.m. indicated Tenant #3 pushed her pendant to call for staff assistance. Staff responded and observed Tenant #3 on the floor in her bathroom. Tenant #3 reported she hit her head and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 10	A 350		

bleeding from the right side of her head. It indicated Tenant #3 was taken to the ED where staples were placed due to a head laceration.

Tenant #3's Progress Notes indicated the following:
a. On 12/13/23 (late entry) Tenant #3 had swelling in the right hand. It was very swollen and she complained of pain in the right elbow. Tenant #3's family took her to have x-rays taken and it was noted Tenant #3 had a hairline fracture to the right elbow. She was wearing a sling at rest and she was not to use it when ambulating. Tenant #3 was aware she needed to apply less pressure to the right arm when walking with the walker.
b. On 12/18/23 a new order was received for physical therapy (PT)/occupational therapy (OT) to evaluate and treat.
c. On 1/18/24 it was noted Tenant #3 worked with PT/OT on balance and using her walker in her room with constraints related to space. It was noted the pain in her arm continued. Staff would give reminders when she was seen not using her walker.

Continued record review revealed the service plan was updated on 12/21/23 to reflect PT. The service plan was not updated as needed related to Tenant #3's two falls with injuries, including a hairline fracture and scalp laceration, the use of a sling and arm pain.

4. On 2/1/24 review on 2/1/24 of Tenant #4's file revealed Progress Notes indicating the following:
a. On 12/15/23 Tenant #4 reported to staff he had increased urge incontinence when he attempted to get to the bathroom. A new order was received for a urinalysis (UA) with culture and sensitivity.
b. On 12/22/23 it was noted the results of the UA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0386	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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 11	A 350		

with culture and sensitivity were received and did not indicate an infection. Staff were to prompt Tenant #4 at med pass times to use the bathroom and change his undergarment if needed. Staff reported Tenant #4 was not using the bathroom as much and he did know always know his undergarment was wet.

Continued record review revealed a lab document indicated the PCP indicated there was no evidence of a urinary tract infection and asked if he was still having a lot of urinary incontinence issues. The returned response indicated Tenant #4 needed to use the toilet more than he was and staff would start prompting him every three to four hours and change his protective undergarment too.

Tenant #4's service plan was not updated regarding increased urinary incontinence, staff reports of him not always knowing he had been incontinent of urine and increased services provided related to toileting and incontinence.

5. When interviewed on 2/1/24 at 3:50 p.m. the Assisted Living Director confirmed all service plans for the tenants reviewed were provided.

481-67.2(3) Program and Policies

1. The program will correct this insufficiency as follows:
   The AL Director was educated on medication policy and procedure on 4.4.24.

2. The measures taken to ensure the problem does not recur are as follows:
   AL Director/Designee will perform weekly audits to ensure when a tenant goes out to the doctor or hospital that they return with discharge orders/after visit summary. This will be brought to QAPI monthly.

   We have added physician appointments/hospitalizations to our risk meeting template and will discuss weekly at our Risk meeting.

3. The program plans to monitor performance to ensure compliance by:
   AL Director/Designee will perform weekly audits to ensure when a tenant goes out to the doctor or hospital that they return with discharge orders/after visit summary. This will be brought to QAPI monthly and Risk.

   We have added physician appointments/hospitalizations to our Risk meeting template and will discuss weekly.

4. The regulatory insufficiency was corrected on 4.4.24.

48-67.9(4)d Staffing

1. The program will correct the regulatory insufficiency as follows:

   The AL program created a new delegation form that has insulin administration and insulin preparation on it.

   All AL medication managers have been redelegated on insulin administration/preparation as of 2.15.24.

2. The following measures have been taken to ensure the problem does not recur:
   AL Director/Designee will audit all new hires monthly to ensure proper delegations are being completed, including insulin administration/preparation.

3. The program will monitor performance to ensure compliance by:
   AL Director/Designee will audit all new hires monthly to ensure proper delegations are being completed, including insulin administration/preparation. This will be brought to our monthly QAPI meeting to discuss.

4. The regulatory insufficicency was corrected on 2.12.24.

231C.5 1 Occupancy Agreement

1. The program will correct this insufficiency as follows:
   Marketing Director educated on AL regulations of 69.26(2) Occupancy agreement on 2.5.24.

2. The measures taken to ensure the problem does not recur are as follows:
   The Marketing Director/Designee will perform monthly audits on all new admissions from month prior to ensure occupancy agreements are signed prior to occupancy of their unit.

3. The program plans to monitor performance to ensure compliance by:

   The Marketing Director/Designee will perform monthly audits on all new admissions from month prior to ensure occupancy agreements are signed prior to occupancy of their unit. This will be brought to our monthly QAPI meeting to discuss.

4. The regulatory insufficiency was corrected on 2.5.24.

481-69.22(3) Evaluation of Tenant

1. The program will correct the regulatory insufficiency as follows:

   The AL Director was educated on what would require new assessments, nurse review, and/or significant changes on 4.4.24.

2. The following measures have been taken to ensure the problem does not recur:
   The AL Director or Designee will perform random weekly audits to ensure that changes of conditions are getting new assessments and/or significant changes, if appropriate, and added to service plans. We will also correlate this in our weekly risk meeting.

3. The program will monitor performance to ensure compliance by:
   The AL Director or Designee will perform random weekly audits to ensure that changes of conditions are getting new assessments and/or significant changes, if appropriate, and added to service plans. These Audits will be brought to our monthly QAPI meeting. We will also correlate this in our weekly risk meeting.

4. The regulatory insufficiency was corrected on 4.4.24.

481-69.26(1) Service Plans

1. The program will correct the regulatory insufficiency as follows:
   The AL Director was educated on Service Plan Policy and what should be placed on a service plan, on 4.4.24.

2. The following measures have been taken to ensure the problem does not recur:
   AL Director/Designee will perform random weekly audits to ensure service plans are updated per Terrace Glen Village's policy.

   We will continue to discuss service plan changes at our weekly risk meeting.

3. The program will monitor performance to ensure compliance by:
   AL Director/Designee will perform random weekly audits to ensure service plans are updated per Terrace Glen Village's policy. These audits will be brought to our monthly QAPI meetings to discuss.

   We will continue to discuss service plan changes at our weekly risk meeting.

4. The regulatory insufficiency was corrected on 4.4.24.

√ 6/27/24