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 _____	C 02/03/2025

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

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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 impairment: 36 Number of tenants with cognitive impairment: 1 Total census: 37 The following regulatory insufficiencies were cited related to the investigation of Complaint #122036-C:	A 000	The Plan of Correction is attached	
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 the established policy and procedure related to discharge. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Review of Tenant C1's file on 1/30/25 and 2/3/25 revealed Progress Notes indicating the following: - On 7/1/24 a call was placed to hospice regarding concerns related to level of care needs. Home health aide visits were added weekly. Tenant C1 had increased urinary incontinence, and confusion. Staff assisted with ambulation and transfers per Tenant C1's request. Family requested a urinalysis (UA).	A 150		

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- On 7/2/24 a meeting was held with Tenant C1, three family members, the nurse and social worker from hospice, the Director of Nursing (DON), and the former Assisted Living Director (ALD). A discussion was held regarding level of care needs and extended care. Family was educated on increased needs of Tenant C1 and possible plans for a future transition to long term care. Family reported they wanted more time to make decisions. An order for a UA was obtained.
- On 7/2/24 new orders were received from hospice for a fentanyl patch (change every 72 hours), Hydrocodone twice daily and Dilaudid at bedtime were discontinued.
- On 7/3/24 a change of condition was completed. Tenant C1 had confusion compared to her baseline, and she required more assistance with incontinence and dressing. She had a small open area to the left buttock and coccyx. She had recently started on a Fentanyl patch every 72 hours. UA results were pending and she had recent weight loss.
- On 7/5/24 verbal orders were received to start Levaquin 500 mg daily for five days for a urinary tract infection (UTI).
- On 7/8/24 over the weekend staff reported Tenant C1 had increased confusion and required additional assistance. Tenant C1 was at the front desk, yelled for help and said she was lost. Staff oriented Tenant C1 and she rested in the chair at the front lounge. After a time period, Tenant C1 was not able to get herself out of the chair and staff assisted with it. As she walked down the hall it was noted she was incontinent and had saturated her clothing. She was not able to assist with changing her clothes or with her perineal care. On 7/6/24 it was noted Tenant C1 went outside to the front entrance seating area. After a time period she was not sure where she was and was not able to stand alone. She used her

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pendant for assistance but staff was not aware she was outside. She was located at the entrance and was assisted from the chair to her apartment. She was not sure where her apartment was located. Tenant C1 had two hour checks put in place.

- On 7/9/24 a meeting was held with Tenant C1's daughter. the DON and former ALD. It was discussed there were safety concerns related to Tenant C1 going outside and not remembering where she was. It was explained by the DON that Tenant C1 exceeded the level of care and would need to transition to a higher level of care when a room opened up at the health center (the long term care facility). The daughter wondered if the increased confusion was related to the Fentanyl patch. The DON explained they would get pain management updated but that family should start planning for her to move.
- On 7/9/24 a new verbal order was received to discontinue the Fentanyl patch, and start Dilaudid 2 mg, four times daily and every two hours as needed (PRN). An order was also placed for a wanderguard.
- On 7/11/24 the former ALD and DON received a call from the social worker with hospice. The social worker had spoken with Tenant C1's daughter regarding placement to long term care. She reported not being aware there was a plan in place to transfer her mother to the health center. It was explained it occurred at the meeting earlier that week. Tenant C1's daughter denied the DON or former ALD had spoken with her regarding any changes. The Program placed a call to the daughter with no answer and a message was left. The Program called the tenant's son and discussed the plans for transition to the health center next week. He reported knowing the transfer would occur as his sister had told him earlier in the week. He also understood his

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mother exceeded the level of care and was a safety risk with recent confusion. He agreed she should move to the health center and would speak with his sister.

- On 7/11/24 the former ALD and DON received a return call from Tenant C1's daughter. She wanted to transfer Tenant C1 to a new facility, and not the long term care facility included in the continuing care community. The social worker from hospice called and told the DON that she spoke with Tenant C1's family and they had found placement at a new facility.
- On 7/11/24 when the nurse went to evaluate her wounds, the tenant received a call from a call from 911. Dispatch reported Tenant C1 had called 911 and said she was "illegal." She reported she needed to leave as was in another person's condominium. She said she needed to speak with police as she did not belong here, and was not wanted there. The RN explained who she was and where she worked and that the person who had called 911 was a tenant dealing with confusion. Hospice was notified of the increased confusion.
- On 7/12/24 Tenant C1's family reported a plan to admit her to another facility on 7/15/24.
- On 7/14/24 staff reported Tenant C1 had a fall when ambulating with her walker near the kitchen. She had a large laceration to the left cheek and it was bleeding. Hospice on-call and family were notified. Family reported to give pain medication, apply a bandage and wrap tight with a scarf. Family declined an emergency department (ED) visit related to the fall with injury.
- On 7/14/24 it was noted the former ALD spoke with the hospice nurse. She reported the laceration was covered with an ABD pad and wrapped with gauze at that time. She said Tenant C1 unwrapped the dressing and was reminded to leave it in place. Hospice called family and

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reported concerns and need for family to come and stay at the Program. It was reported a family member would be coming in. Overnight assistance was needed and it was not known how long family would be staying. The hospice nurse said staff should provide Dilaudid every two hours as needed to reduce pain. Hospice left extra supplies to wrap the laceration. Staff would provide increased support when family was not present.

- On 7/15/24 staff reported Tenant C1 had been bed bound all night. Staff provided one to one care in the night hours and the day today. Family was not able to stay overnight and another family member arrived at 10:45 a.m. that morning. Staff assisted with checking and changing Tenant C1's brief every two hours and as needed. Staff administered medications and she was kept comfortable with PRN (as needed) medications. Repositioning was completed with checks. Tenant C1 would be transported via non-emergent ambulance at 1:00 p.m.
- On 7/15/24 it was noted Tenant C1 was not able to take oral medications during morning medication pass. Hospice was notified and oral medications were discontinued. New orders were received for a catheter for comfort, Fentanyl patch, hyoscyamine sulfate SL 0.125 mg, one tablet every two hours PRN for secretions, morphine 20 mg/milliliters (ml), 0.25 ml every two hours PRN for pain, and lorazepam 2 mg/ml 0.5 ml every four hours PRN for restlessness/anxiety.
- On 7/15/24 Tenant C1 was assisted to a new facility via non-emergency ambulance.

2. Record review revealed the Program's policy and procedure related to discharge was located within the Occupancy Agreement. The policy and procedure (under Termination Procedures) indicated a significant change in the tenant's

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condition might result in the need for the provision of services that exceeded the type or level of services permitted by the regulations or the Occupancy Agreement. "In those circumstances, the Program will provide written notice to the Tenant of the need for discharge and the reason for discharge." The Program would initiate procedures for a safe and orderly transfer if one or more of the conditions (level of care criteria) were met.

A written notice related to the need for discharge and the reason for discharge, as required by the Program's policy could not be located in Tenant C1's file,

3. When interviewed on 2/3/25 at 3:00 p.m. the DON said it started with a hospice telephone call indicating there were changes noticed with increased weakness, a fall, requiring one to two staff to stand up and incontinency. During the first meeting with Tenant C1's family on 7/9/24, hospice was present and family was told what they were seeing. She said one of the family members was not very happy. Level of care was discussed and hospice agreed with the Program staff. It was decided to get a UA and start a Fentanyl patch. Tenant C1 continued to decline after the meeting. The DON, the former ALD and one of Tenant C1's family members discussed she needed a higher level of care. There was no written notice given. A telephone call was received from the hospice social worker regarding Tenant C1's transfer to another facility. She declined very quickly, fell and was bed bound. Her care needs were met until she transferred.

On 2/3/24 comments were voiced by the Executive Director prior to the exit meeting

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A 150	Continued From page 6 regarding Tenant C1's transfer. He stated the program was a part of a continuing care retirement community (placement was available at a higher level of care), there were two criteria in the occupancy agreement that allowed for less than 30 days notice to be given, and the quick timeframe of events related to Tenant C1's transfer and family notification to the Program of her new facility placement. In summary, Tenant C1 was identified as approaching the level of care requirements and a meeting was held on 7/2/24. Per interview and record review Tenant C1 continued to have changes noted and on 7/9/24 Tenant C1's family was informed she exceeded the level of care and needed to move to a higher level of care. Per the Program's policy regarding discharge, a written notice (no specific time in the policy) would be provided regarding the need and reason for transfer. A written notice was not provided to Tenant C1 or her Power of Attorney regarding the involuntary transfer. The Program did not follow its own policy and procedure related to discharge. .	A 150		
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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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 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow:

1. Review of Tenant C1's file on 1/30/25 and 2/3/25 revealed Progress Notes indicating the following:
- On 7/1/24 a call was placed to hospice regarding concerns related to level of care needs. Home health aide visits were added weekly. Tenant C1 had increased urinary incontinence, and confusion. Staff assisted with ambulation and transfers per Tenant C1's request. Family requested a urinalysis (UA).
- On 7/2/24 a meeting was held with Tenant C1, three family members, the nurse and social worker from hospice, the Director of Nursing (DON), and the former Assisted Living Director (ALD). A discussion was held regarding level of care needs and extended care. Family was educated on increased needs of Tenant C1 and possible plans for a future transition to long term care. Family reported they wanted more time to make decisions. An order for a UA was obtained.
- On 7/2/24 new orders were received from hospice for a fentanyl patch (change every 72 hours). Hydrocodone twice daily and Dilaudid at bedtime were discontinued.

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- On 7/3/24 a change of condition was completed. Tenant C1 had confusion compared to her baseline, and she required more assistance with incontinence and dressing. She had a small open area to the left buttock and coccyx. She had recently started on a Fentanyl patch every 72 hours. UA results were pending and she had recent weight loss.
- On 7/5/24 verbal orders were received to start Levaquin 500 mg daily for five days for a urinary tract infection (UTI).
- On 7/8/24 the nurse evaluated an open area to the left buttock and coccyx. It was cleansed, dried and barrier cream applied. There were three pinpoint open areas noted to the left inner buttock. The areas were cleansed, dried and covered with barrier cream. Hospice was notified of the need for new treatment orders. It was later noted hospice was going to put in an order for Mepilex to the left inner cheek and coccyx area.
- On 7/8/24 over the weekend staff reported Tenant C1 had increased confusion and required additional assistance. Tenant C1 was at the front desk, yelled for help and said she was lost. Staff oriented Tenant C1 and she rested in the chair at the front lounge. After a time period, Tenant C1 was not able to get herself out of the chair and staff assisted with it. As she walked down the hall it was noted she was incontinent and had saturated her clothing. She was not able to assist with changing her clothes or with her perineal care. On 7/6/24 it was noted Tenant C1 went outside to the front entrance seating area. After a time period she was not sure where she was and was not able to stand alone. She used her pendant for assistance but staff was not aware she was outside. She was located at the entrance and was assisted from the chair to her apartment. She was not sure where her apartment was located. Tenant C1 had two hour

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checks put in place.
- On 7/8/24 Tenant C1's right lower extremity had a dime size open area. There was a small amount of weeping (clear drainage) noted.
- On 7/9/24 a new order was received for the right lower extremity wound dressing. It was ordered to cleanse the area with saline, let dry, apply bacitracin ointment to the wound base, cover with an ABD pad wrap with gauze and secure with tape. It was ordered to be changed daily and as needed for wound drainage.
- On 7/9/24 a meeting was held with Tenant C1's family, the DON and former ALD. It was discussed there were safety concerns related to Tenant C1 going outside and not remembering where she was. It was explained by the DON that Tenant C1 exceeded the level of care and would need to transition to a higher level of care when a room opened up at the health center. Family reported the increased confusion was related to the Fentanyl patch. The DON explained they would get pain management updated but that family should start planning for her to move.
- On 7/9/24 a new verbal order was received to discontinue the Fentanyl patch, and start Dilaudid 2 mg, four times daily and every two hours as needed (PRN). An order was also placed for a wanderguard.
- On 7/9/24 the nurse observed an open area to coccyx. The wound site remained unchanged. The area to the left inner buttock was open with two small sites. There was a new area to the right inner buttock. One open area was the size of a pencil eraser. It was covered with Mepilex at that time.
- On 7/10/24 the Levaquin was completed for the UTI.
- On 7/11/24 the former ALD and DON received a call from the social worker with hospice. The social worker had spoken with Tenant C1's

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daughter regarding placement to long term care. She reported not being aware there was a plan in place to transfer her mother. It was explained it occurred at the meeting earlier that week. Tenant C1's daughter denied the DON or former ALD had spoken with her regarding any changes. The Program placed a call to the daughter with no answer and a message was left. The Program called the tenant's son and discussed the plans for transition to the health center next week. He reported knowing the transfer would occur as his sister had told him earlier in the week. He also understood his mother exceeded the level of care and was a safety risk with recent confusion. He agreed she should move to the health center and would speak with his sister.

- On 7/11/24 the former ALD and DON received a return call from Tenant C1's daughter. She wanted to transfer Tenant C1 to a new facility, and not the long term care facility included in the continuing care community. The social worker from hospice called and told the DON that she spoke with Tenant C1's family and they had found placement at a new facility.
- On 7/11/24 per the nurse evaluation all wound areas were dressed per orders. Tenant C1's bilateral lower extremities had 1+ edema noted.
- On 7/11/24 when the nurse went to evaluate her wounds, there was a call from 911. Dispatch reported Tenant C1 had called 911 and said she was "illegal." It was explained she had called related to confusion. Tenant C1 reported she needed to leave as was in another person's condominium. She said she needed to speak with police as she did not belong here. Hospice was notified of the increased confusion.
- On 7/11/24 the nurse checked on Tenant C1 after supper. Staff assisted Tenant C1 with holding the phone so she could visit with family. She told her family it was another person's

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condominium and she was going to have to call the police. Family asked why staff had told her about the move and it was explained staff had not told her about the move. Family then asked how she knew of the move and was told it might be a discussion for family as they were only people who knew about the move.

- On 7/12/24 Tenant C1's family reported a plan to admit her to another facility on 7/15/24.
- On 7/14/24 staff reported Tenant C1 had a fall when ambulating with her walker near the kitchen. She had a large laceration to the left cheek and it was bleeding. Hospice on-call and family were notified. Family reported to give pain medication, apply a bandage and wrap tight with a scarf. Family declined an emergency department (ED) visit related to the fall with injury.
- On 7/14/24 it was noted the former ALD spoke with the hospice nurse. She reported the laceration was covered with an ABD pad and wrapped with gauze at that time. She said Tenant C1 unwrapped the dressing and was reminded to leave it in place. Hospice called family and reported concerns and need for family to come and stay at the Program. It was reported a family member would be coming in. Overnight assistance was needed and it was not known how long family would be staying. The hospice nurse said staff should provide Dilaudid every two hours as needed to reduce pain. Hospice left extra supplies to wrap the laceration. Staff would provide increased support when family was not present.
- On 7/15/24 staff reported Tenant C1 had been bed bound all night. Staff provided one to one care in the night hours and the day today. Family was not able to stay overnight and another family member arrived at 10:45 a.m. that morning. Staff assisted with checking and changing Tenant C1's brief every two hours and as needed. Staff

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administered medications and she was kept comfortable with PRN (as needed) medications. Repositioning was completed with checks. Tenant C1 would be transported via non-emergent ambulance at 1:00 p.m.
- On 7/15/24 it was noted Tenant C1 was not able to take oral medications during morning medication pass. Hospice was notified and oral medications were discontinued. New orders were received for a catheter for comfort, Fentanyl patch, hyoscyamine sulfate SL 0.125 mg, one tablet every two hours PRN for secretions, morphine 20 mg/milliliters (ml), 0.25 ml every two hours PRN for pain, and lorazepam 2 mg/ml 0.5 ml every four hours PRN for restlessness/anxiety.
- On 7/15/24 Tenant C1 was assisted to a new facility via non-emergency ambulance.

2. Further review revealed cognitive, health and functional evaluations were completed on 7/3/24 with a change in condition. Evaluations were not completed after 7/3/24 up to the time of discharge on 7/15/24 despite frequent changes including: new affected skin areas that required treatment, increased confusion and safety concerns, an order for a wanderguard, increased assistance with activities of daily living, changes with medications, a fall with large laceration, becoming bed bound and requiring one to one care, repositioning, not being able to take oral medications and being checked and changed related to incontinence care. The evaluation completed on 7/3/24 indicated she had a wound to the face and treatment was ordered. It also indicated there were new areas to the coccyx and left inner buttock. There were no further evaluations documented of the skin cancer lesion on Tenant C1's face.

3. When interviewed on 2/3/25 at 3:00 p.m. the

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A 145	Continued From page 13 DON confirmed all evaluations were provided for the 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed to develop service plans that reflected the service needs of the tenants. This pertained to 2 of 2 current tenants reviewed (Tenant #1 and Tenant #2) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. On 2/3/25 review of Tenant #1's file revealed Progress Notes indicating the following: - On 12/26/24 Tenant #1 complained of stomach muscle pain for three days related to vomiting on 12/20/24. Staff reported Tenant #1 complained of stomach pain, chest pain and throat tightness. She requested to be sent out to the hospital for evaluation. - On 12/26/24 Tenant #1 was transported to the emergency department (ED) and was started on	A 350		

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an antibiotic and would likely be staying overnight.
- On 12/27/24 Tenant #1 was admitted for pneumonia and received intravenous (IV) Rocephin. She was on 2 liters of oxygen overnight but now on room air at 93%.
- On 12/28/24 a significant change was completed related to Tenant #1's hospitalization. She was admitted to the hospital for aspiration pneumonia from 12/26/24 to 12/30/24. The hospital recommended soft and bite size diet. It was discussed with Tenant #1 and she would continue to make independent meal choices with the menu. Speech therapy (ST) was to evaluate and treat.
- On 12/30/24 Tenant #1 returned from the hospital.
- On 12/31/24 a signed order was received related to speech therapy and the hospital recommendations of soft and bite size diet. Tenant #1 was independent with meal and menu choices.
- On 1/3/25 (late entry) it was noted ST recommendations indicated a regular/easy to chew diet and to alternate solid and liquid bites. Tenant #1 was able to make appropriate decisions.
- On 1/16/25 it was noted Tenant #1 was working with ST and she was upgraded to a regular diet and pharyngeal strengthening would be reviewed.
- On 1/29/25 Tenant #1 complained of a dry mouth. An order was received for Biotene Dry Mouth Moisturizing Spray as needed. It could be left at bedside and she administered unsupervised.
- On 1/30/25 ST continued with pharyngeal strengthening.

Speech Therapy Treatment Encounter Note(s) indicated the following:

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- On 1/16/25 Tenant #1 reported more difficulty with swallowing medications. It was recommended to swallow pills with applesauce.
- On 1/22/25 the recommendation was reviewed regarding taking medications with applesauce. It was communicated to the Assisted Living Director, who verbalized understanding.
- On 1/31/25 she was presented with regular textures and thin liquids. She benefited from max cues to alternate between solids and liquids. It was recommended to continue with current diet recommendations.

Tenant #1's service plan dated 12/30/24 indicated she was hospitalized for aspiration pneumonia from 12/26/24 to 12/30/24. The service plan reflected the hospital recommended soft and bite sized food, ST would evaluate and treat upon re-admission to the Program. Staff was to report any difficulty with swallowing, chewing, aspiration, low oxygen and coughing after swallowing. The service plan also reflected staff administered her medications and stored them in a locked area. The service plan was not updated with ST recommendations as indicated above including her current diet recommendations, recommendations with taking medications in applesauce and that she kept the dry mouth spray at bedside and administered independently.

2. Review of Tenant #2's file on 2/3/25 revealed Progress Notes indicating the following:
- On 12/31/24 new orders were received for anti-embolism hose (on in the morning and off in the evening), Duo Neb scheduled twice daily, reminders for his continuous positive airway pressure (CPAP) machine on at bedtime, scheduled Miralax 17 grams by mouth daily and scheduled Tylenol 650 milligram (mg) twice daily.
- On 1/3/25 an order was received to change

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blood glucose monitoring to three times per day before meals.
- On 1/16/25 Tenant #2 was sent to the hospital on 1/15/25 as he could not catch his breath. The hospital indicated he received IV Lasix yesterday and overnight to help with breathing/fluid. He tested positive for coronavirus NL63.
- On 1/17/25 it was noted Tenant #2's diagnosis was congestive heart failure and he was on droplet precautions for coronavirus NL63.
- On 1/17/25 signed orders were received to change torsemide to 40 mg twice daily and the hospital recommended a carbohydrate count diet. The primary care provider (PCP) gave an order for general diet and Tenant #2 was educated on importance of choosing low carbohydrate items.
- On 1/27/25 Tenant #2 was admitted to the hospital on 1/26/25.
- On 1/28/25 returned from the hospital. He was admitted for chronic obstructive pulmonary disease (COPD) exacerbation.

An Order Summary Report indicated Tenant #2 had orders including blood glucose checks three times per day before meals and nitroglycerin 0.4 mg tablet, one tablet sublingual (SL), every five minutes as needed for chest pain, after 3 administrations without relief, call 911.

Tenant #2's service plan was updated on 1/17/25 and 1/28/25 post hospitalizations. The service plan reflected staff administered Tenant #2's medications; however, did not reflect staff assisted with blood glucose monitoring three times daily. The service plan also did not reflect Tenant #2 was prescribed nitroglycerin and the storage and administration of the medication. The service plan reflected he was independent with three meals per day but did not reflect Tenant #2 was encouraged to choose low carbohydrate

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A 350	Continued From page 17 foods. 3. Review of Tenant C1's file on 1/30/25 and 2/3/25 revealed Progress Notes indicating the following: - On 7/1/24 a call was placed to hospice regarding concerns related to level of care needs. Home health aide visits were added weekly. Tenant C1 had increased urinary incontinence, and confusion. Staff assisted with ambulation and transfers per Tenant C1's request. Family requested a urinalysis (UA). - On 7/2/24 new orders were received from hospice for a fentanyl patch (change every 72 hours). Hydrocodone twice daily and Dilaudid at bedtime were discontinued. - On 7/3/24 a change of condition was completed. Tenant C1 had confusion compared to her baseline, and she required more assistance with incontinence and dressing. She had a small open area to the left buttock and coccyx. She had recently started on a Fentanyl patch every 72 hours. - On 7/5/24 verbal orders were received to start Levaquin 500 mg daily for five days for a urinary tract infection (UTI). - On 7/8/24 the nurse evaluated an open area to the left buttock and coccyx. It was cleansed, dried and barrier cream applied. There were three pinpoint open areas noted to the left inner buttock. The areas were cleansed, dried and covered with barrier cream. Hospice was notified of the need for new treatment orders. It was later noted hospice was going to put in an order for Mepilex to the left inner cheek and coccyx area. - On 7/8/24 over the weekend staff reported Tenant C1 had increased confusion and required additional assistance. Tenant C1 was at the front desk, yelled for help and said she was lost. Staff oriented Tenant C1 and she rested in the chair at	A 350		

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the front lounge. After a time period, Tenant C1 was not able to get herself out of the chair and staff assisted with it. As she walked down the hall it was noted she was incontinent and had saturated her clothing. She was not able to assist with changing her clothes or with her perineal care. On 7/6/24 it was noted Tenant C1 went outside to the front entrance seating area. After a time period she was not sure where she was and was not able to stand alone. She used her pendant for assistance but staff was not aware she was outside. She was located at the entrance and was assisted from the chair to her apartment. She was not sure where her apartment was located. Tenant C1 had two hour checks put in place.

- On 7/8/24 Tenant C1's right lower extremity had a dime size open area. There was a small amount of weeping (clear drainage) noted.
- On 7/9/24 a new order was received for the right lower extremity wound dressing.
- On 7/9/24 a new verbal order was received to discontinue the Fentanyl patch, and start Dilaudid 2 mg, four times daily and every two hours as needed (PRN). An order was also placed for a wanderguard.
- On 7/9/24 the nurse observed the open area to coccyx. The wound site remained unchanged. The area to the left inner buttock was open with two small sites. There was a new area to the right inner buttock. One open area was the size of a pencil eraser. It was covered with Mepilex at that time.
- On 7/10/24 the Levaquin was completed for the UTI.
- On 7/11/24 per the nurse evaluation all wound areas were dressed per orders. Tenant C1's bilateral lower extremities had 1+ edema noted.
- On 7/11/24 when the nurse went to evaluate her wounds, there was a call from 911. Dispatch

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reported Tenant C1 had called 911 and said she was "illegal." It was explained she had called related to confusion. Tenant C1 reported she needed to leave as she was in another person's condominium. She said she needed to speak with police as she did not belong here. Hospice was notified of the increased confusion.

- On 7/14/24 staff reported Tenant C1 had a fall when ambulating with her walker near the kitchen. She had a large laceration to the left cheek and it was bleeding. Hospice on-call and family were notified. Family reported to give pain medication, apply a bandage and wrap tight with a scarf. Family declined an emergency department (ED) visit related to the fall with injury.
- On 7/14/24 it was noted the former ALD spoke with the hospice nurse. She reported the laceration was covered with an ABD pad and wrapped with gauze at that time. She said Tenant C1 unwrapped the dressing and was reminded to leave it in place. Hospice called family and reported concerns and need for family to come and stay at the Program. It was reported a family member would be coming in. Overnight assistance was needed and it was not known how long family would be staying. The hospice nurse said staff should provide Dilaudid every two hours as needed to reduce pain. Hospice left extra supplies to wrap the laceration. Staff would provide increased support when family was not present.
- On 7/15/24 staff reported Tenant C1 had been bed bound all night. Staff provided one to one care in the night hours and the day today. Family was not able to stay overnight and another family member arrived at 10:45 a.m. that morning. Staff assisted with checking and changing Tenant C1's brief every two hours and as needed. Staff administered medications and she was kept comfortable with PRN (as needed) medications.

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Repositioning was completed with checks. Tenant C1 would be transported via non-emergent ambulance at 1:00 p.m.
- On 7/15/24 it was noted Tenant C1 was not able to take oral medications during morning medication pass. Hospice was notified and oral medications were discontinued. New orders were received.
- On 7/15/24 Tenant C1 was assisted to a new facility via non-emergency ambulance.

Further record review revealed Tenant C1's service plan was updated on 7/3/24 with a change in condition. The service plan was not updated after 7/3/24 up to the time of discharge on 7/15/24 despite frequent changes including new affected skin areas that required treatment, increased confusion and safety concerns, an order for a wanderguard, increased assistance with activities of daily living and changes with medications.

4. Review of Tenant C2's file on 1/30/25 and 2/3/25 revealed Progress Notes indicating the following:
- On 5/10/24 Tenant C2 complained of burning with urination. She was not very motivated and slept a lot throughout the day. A verbal order was received to obtain a UA with culture and sensitivity (C/S).
- On 5/13/24 the UA with C/S was sent to the primary care provider (PCP) for review.
- On 5/13/24 a new order was received for Augmentin 875 mg twice daily for seven days for a UTI. It was noted as a chronic condition and that it was already reflected on her service plan. It indicated she had UTIs often and it was a chronic condition.
- On 5/21/24 the antibiotic was completed that day. She was without fever and overall was

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A 350	Continued From page 21 feeling better. The UTI was resolved. - On 6/9/24 staff reported Tenant C2 was sent out to the hospital as she went unresponsive while on the toilet. - On 6/10/24 the nurse in the ICU at the hospital indicated Tenant C2 remained confused and fatigued. She was being treated for a UTI via IV antibiotic therapy. They were waiting on the culture for sepsis. - On 6/26/24 Tenant C2 was admitted to the health center (long term care facility) and would not be returning to the assisted living. Tenant C2's service plan dated 5/1/24 did not reflect the history of UTIs. 5. When interviewed on 2/3/25 at 3:00 p.m. the DON confirmed all service plans were provided for the tenants reviewed.	A 350		

TERRACE GLEN VILLAGE makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this plan of correction is an admission otherwise. TERRACE GLEN VILLAGE is submitting this plan of correction in compliance with its regulatory obligations and does not waive any objections it may have regarding the merit or form of any allegations contained herein. This plan of correction constitutes TERRACE GLEN VILLAGE's credible allegation of compliance for the deficiencies noted.

A-150

Corrective Action for Affected Residents: On 2/4/25, the Executive Director, Assisted Living Director, and Director of Nursing met to review the occupancy agreement and discharge policies and procedures related to Tenant C1. It was identified that while verbal communication occurred with Tenant C1's family regarding the need for discharge due to exceeding level of care, the required written notice was not provided as outlined in the Program's policy. A new form has been created to present to tenants and/or their Power of Attorney at the time the facility feels a higher level of care is needed for future discharge to ensure proper written documentation.

Identifying other Residents having the Potential to be Affected: On 2/5/24 the Assisted Living Director and Director of Nursing conducted a review of all discharges that occurred in the past 90 days to determine if written notices were provided as required by the Program’s policy. There were no identified deficiencies or concerns with this audit. Additionally, all current tenants were assessed to identify any who may be approaching level of care will include proper documentation requirements, timeframes, and the use of new discharge notification form.

Measures put into place or Systemic Changes: On 2/4/25, a new standardized discharge notification form was created and implemented to ensure written notice is provided to tenants and/or their Power of Attorney when discharge is necessary due to exceeding level of care or other reasons outlined in the Occupancy Agreement. The form includes documentation of the specific reason for discharge, and date of notice.

Plan to Monitor Performance: The Assisted Living Director or Designee will audit 100% of all discharges weekly for 4 weeks to ensure compliance with the Program's discharge policy, including verification that written notices are provided and properly documented. After 4 weeks, if 100% compliance is achieved, audits will be conducted monthly for 3 months and then randomly thereafter.

Results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and recommendations. If any instances of non-compliance are identified, immediate corrective action will be taken, including additional staff education and process improvements as needed.

AL Director or Designee will report monitoring plan results to the QAPI Committee. The QAPI Committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.

A-145

Corrective Action for Affected Residents: On 02/05/2025, a comprehensive review of Tenant C1's record was completed. Although Tenant C1 has been discharged from the facility, the review identified that evaluations were not completed after 7/3/24 despite significant changes in condition up to discharge on 7/15/24. The AL Director has been educated on the requirement to complete evaluations with each significant change in a tenant's condition.

Identifying other Residents having the Potential to be Affected: On 3/5/25 the AL Director/designee conducted a comprehensive review of all current tenant records to identify any other tenants who may have experienced significant changes without proper evaluation documentation. Any identified deficiencies were immediately addressed with appropriate evaluations completed.

Measures put into place or Systemic Changes:

1. On 02/05/2025, education was provided to the AL Director on the policy of evaluation of tenants, specifically emphasizing the requirement to complete evaluations with each significant change in condition.

2. On 3/5/25 all Nurse Managers were educated on the requirement to notify the AL Director or designee within 24 hours when a tenant experiences a significant change in condition to ensure timely completion of required evaluations.

Plan to Monitor Performance:

1. The AL Director/designee will conduct weekly audits x 8 weeks. After 8 weeks if we continue to be in compliance, we will perform random audits thereafter.

2. Audit results will be compiled and presented at the monthly QAPI meetings for review and discussion. If compliance falls below 90%, additional education and interventions will be implemented.

3. The AL Director or designee will report on monitoring plan results to the Quality Assurance Performance Improvement Committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.

A-350

Corrective Action for Affected Residents: On 02/05/2025, the service plans for Tenant #1 and Tenant #2 were reviewed and updated to include all current recommendations and services. For Tenant #1, the service plan now includes speech therapy recommendations for regular/easy to chew diet, alternating solid and liquid bites, taking medications with applesauce, and independent administration of Biotene Dry Mouth Moisturizing Spray kept at bedside. For Tenant #2, the service plan now includes staff assistance with blood glucose monitoring three times daily before meals, nitroglycerin administration protocol including storage and administration, and encouragement to choose low carbohydrate food items.

Identifying other Residents having the Potential to be Affected: On 02/05/2025, the AL Director and DON conducted a comprehensive review of all current tenant service plans to identify any other tenants with similar issues. This review focused specifically on ensuring service plans accurately reflected all current orders, therapy recommendations, skin issues, infections/antibiotics, blood sugar monitoring/insulin administration, and nitroglycerin orders. Any identified discrepancies were corrected immediately.

Measures put into place or Systemic Changes: On 02/04/2025, the DON provided in-service education to the AL Director on the service plan policy, emphasizing the requirement to update service plans whenever changes are needed and to ensure they accurately reflect all tenant service needs.

On 02/04/2025, the DON, AL Director, and Therapy department met to establish a better process for communicating therapy recommendations to ensure they are promptly incorporated into tenant service plans.

On 02/05/2025, a new standardized form was created for the therapy department to utilize when reporting new recommendations. This form includes a section requiring the AL Director to document when the service plan was updated with the new recommendations.

On 02/05/2025, a comprehensive audit was completed on all tenant service plans to ensure they accurately reflected all nitroglycerin orders, infections/antibiotics, skin issues, and blood sugars/insulin administration.

Plan to Monitor Performance: The AL Director or Designee will randomly audit weekly x 4 weeks then random audits thereafter to ensure service plans are updated as needed and accurately reflect all tenant service needs.

The DON will review all audit results weekly for 4 weeks, then random audits thereafter to identify any trends or ongoing concerns. Any identified issues will be addressed immediately through additional staff education and process improvements.

The AL Director will report monitoring plan results to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI Committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.