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
	S0388	A. BUILDING: _____ B. WING _____	C 10/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

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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: 63 Number of tenants with cognitive disorder: 4 Total census of Assisted Living Program: 67 There were no regulatory insufficiencies cited during the onsite infection control survey. The following regulatory insufficiencies were cited during the investigation of Complaint #97720-C and the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications as prescribed for 4 of 6 tenants reviewed (Tenants #1, #2, #3 and #4). Findings include:	A 285	Employees providing medication services are scheduled to receive education on 1/26/2022 regarding proper medication handling procedures and documentation of refused or held medications.. Employees will also have medication administration audited and documented for their delegation file by the clinical services coordinator. Going forward medication administration audits will take place quarterly x2 as needed thereafter. Employees noting orders are scheduled to receive education on 1/26/2022 regarding double noting of orders. Orders will also be checked to the MAR by the clinical services coordinator. Audits of a sample of MARs will take place monthly by the clinical services coordinator for proper documentation and noting of orders. Completion date: 1/26/2022	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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1. On 9/23/21 review of Tenant #1's file revealed a diagnoses of type 2 diabetes mellitus (DM). The service plan dated 8-6-21 reflected staff drew up Tenant #1's insulin and she self-administered. Tenant #1 completed blood glucose checks four times per day.

A Medication Error report dated 7-25-21 indicated Tenant #1 reported she had not been given her lunch time insulin.

Continued record review revealed a Physician's Order Sheet reflected the following orders:
- Basaglar injection 100 unit, inject 16 units subcutaneous (SQ) at bedtime
- Humalog Kwik injection 100/unit, inject 4 units SQ, three times per day with meals
- Humalog Kwik injection, inject per sliding scale three times per day (sliding scale 201-250 4 units, 251 to 300 8 units, 301 to 350 12 units and 351 to 500 14 units).

The tenant's monthly blood glucose records and medication administration records (MARs) for July through September (1-23) 2021 revealed the Program failed to document the following as administered/completed:
- July 2021 blood glucose readings four times per day: the bedtime blood glucose reading was only recorded 4 times for the entire month. There were 3 blood glucose readings at breakfast, three blood glucose readings at lunch and 7 blood glucose readings at supper not recorded.
- July 2021 Basaglar insulin 16 units SQ at bedtime: 10 times it was not documented as administered.
- July 2021 Humalog insulin 4 units SQ three times daily: 3 times at 8:00 a.m. 5 times at 12:00 p.m. and 12 times at 5:00 p.m. not documented

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as administered.
- July 2021 Humalog insulin, sliding scale, three times daily: on 7-4-21 at lunch Tenant #1's blood glucose reading was 257 (sliding scale prescribed was 8 units) and 4 units were documented as given. On 7-14-21 at supper Tenant #1's blood glucose reading was 209 (sliding scale prescribed was 4 units) and none were documented as administered.
- August 2021 blood glucose readings four times per day: the bedtime blood glucose reading was not recorded for the entire month. There were 2 blood glucose readings at lunch not recorded and 13 readings at supper not recorded.
- August 2021 Basaglar insulin 16 units SQ at bedtime: 13 times it was not documented as administered.
- August 2021 Humalog insulin 4 units SQ three times daily: there were 3 times at 12:00 p.m. and 11 times at 5:00 p.m. it was not documented as administered.
- August 2021 Humalog insulin, sliding scale, three times daily: there was an entry on 8-17-21 at 5:00 p.m. that reflected Tenant #1's blood glucose reading was 294 (sliding scale prescribed was 8 units) and 4 units were documented as administered. On 8-27-21 at 12:00 p.m. Tenant #1's blood glucose reading was 260 (sliding scale prescribed was 8 units) and there were no sliding scale units recorded as administered.
- September 2021 (1-23) blood glucose readings four times per day: the bedtime blood glucose readings were recorded one time.
- September 2021 (1-23) Basaglar insulin 16 units SQ at bedtime: there were 8 times it was not documented as administered.
- September 2021 (1-23) Humalog insulin 4 units SQ three times daily: there was 1 time at 12:00 p.m. and 7 times at 5:00 p.m. it was not documented as administered.

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2. When interviewed on 9-29-21 at approximately 10:45 a.m. Tenant #2 stated she was supposed to get a B12 injection on the 20th of each month and it was almost never given on the 20th.

On 9-27-21 review of Tenant #2's file revealed a diagnosis of vitamin B12 deficiency. The service plan dated 7-23-21 reflected Tenant #2 received a B12 injection monthly on the 20th. Tenant #2 was independent with her other medications. A Physician's Order Sheet reflected an order for a Cyancobalam injection 1000 microgram (mcg), 1 milliliter (ml) intramuscular (IM), once per month on the 20th.

Review of the tenant's MARs from December 2020 to September (1-26) 2021 revealed the following injection dates: 12-22-20 (late), 1-22-21 (late), 2-20-21 (as ordered), 3-20-21 (as ordered), 4-25-21 (late), 5-30-21 (late), 6-20-21 (as ordered), 7-20-21 (as ordered), 8-20-21 (as ordered) and 9-20-21 (as ordered).

3. Review of Tenant #3's file on 9-27-21 and 9-28-21 revealed a diagnosis of type 2 DM. The service plan dated 6-30-21 reflected staff assisted with blood glucose readings and administered sliding scale insulin.

A Medication Error report dated 9-17-21 reflected staff went to give Tenant #3 her bedtime dose of insulin, Staff was unable to determine if Tenant #3 received the correct dose since there were 2 tenants who received Basaglar insulin at bedtime. The on-call doctor was notified.

Continued record review of a Physician's Order

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Sheet reflected the following orders:
- Basaglar insulin injection, 100 unit, inject 6 units SQ at bedtime.
- Novolog injection (flexpen), injection SQ per sliding scale three times per day with meals (sliding scale 151-200 1 unit, 201-250 2 units, 251-300 3 units, 301-350 4 units, 351-400 5 units and call the physician). This sliding scale was effective until a new order and change was received dated 9-24-21.
- Blood glucose checks four times daily, including a check at 2:00 a.m.

The tenant's monthly blood glucose records and July through September (1-26) 2021 MARs revealed the Program failed to document the following as administered/completed:
- July blood glucose readings four times per day: two times at lunch and 5 times at 2:00 a.m. that were not recorded.
- July 2021 Basaglar insulin injection, 100 unit, 6 units SQ at bedtime: two times that were not documented as administered.
- July 2021 Novolog injection (flexpen), injection per sliding scale three times per day with meals: on 7-3-21 at 8:00 a.m. Tenant #3 blood glucose reading was 330 (sliding scale 4 units prescribed) and no units were documented as administered. On 7-14-21 at 12:00 p.m. Tenant #3's blood glucose record reading was 399 (5 units and call the doctor was prescribed). The MAR reflected a blood glucose reading of 248 for the same time period and 2 units of insulin were documented as given.
- August 2021 blood glucose readings four times per day: 3 times at 2:00 a.m. that were not recorded.
- August 2021 Novolog injection (flexpen), injection per sliding scale three times per day with meals: on 8-8-21 at 8:00 a.m. Tenant #3's blood

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glucose reading was 207 (sliding scale 2 units prescribed) and 1 unit was documented as given. On 8-10-21 at 12:00 p.m. the blood glucose log reflected a blood glucose reading of 453 (sliding scale up to 400). The MAR reflected a blood glucose reading of 227 (sliding scale 2 units prescribed) and 1 unit was documented as given.
- September 2021 (1-26) Basaglar insulin injection, 100 unit, 6 units SQ at bedtime: one time was not documented as administered.
- September 2021 Novolog injection (flexpen), injection per sliding scale three times per day with meals: on 9-17-21 at 5:00 p.m. Tenant #3's blood glucose reading was 302 (sliding scale 4 units prescribed) and none was documented as administered.

4. Review of Tenant #4's file on 9-28-21 revealed diagnoses including depression and anxiety. The service plan dated 8-5-21 reflected staff administered medications.

Continued record review of a Physician's Order Sheet reflected the following orders:
- Lorazepam tablet 0.5 milligram (mg), 1/2 tablet 0.25 mg by mouth three times a day.
- Haloperidol tablet, 0.5 mg, 1 tablet by mouth every evening.
- Lorazepam concentrate 2 mg/ml, give 0.125 ml (0.25 mg) daily
- Acetaminophen tablet, 500 mg, two tablets by mouth twice daily.
- Tramadol HCL tablet, 50 mg, one tablet by mouth daily.

A Physician Report of Consultation dated 7-20-21 documented the tenant was to receive 0.125 ml (0.25 mg) of liquid Ativan (lorazepam) by mouth at 5:00 a.m. daily.

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A 285	Continued From page 6 Review if theAugust 2021 MARs revealed the Program failed to document the following as administered/completed: - Acetaminophen 500 mg, two tablets twice daily: four times it was not documented as given at 12:00 p.m. and one time at 8:00 p.m. - Haloperidol 0.5 mg tablet, one tablet every evening: one time not documented as given - Lorazepam concentrate 2 mg/ml, give 0.125 ml (0.25 mg) daily: three times not documented as given - Lorazepam tablet, 0.5 mg, 1/2 tablet (0.25 mg) by mouth twice daily: one time at 12:00 p.m. not documented and one entry at 5:00 p.m. not documented as given. - Tramadol HCL tablet, 50 mg, one tablet three times daily: two times at 5:00 p.m. not documented as given. 5. When interviewed on 9-29-21 at approximately 11:20 a.m. and 11:50 a.m. the Clinical Services Coordinator confirmed the above findings.	A 285	Type text here	
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	A 145	All evaluations and significant changes for said residents will be done as required. All Clinical Service Coordinators will audit previous evaluations listed on report will be done by January 26. Clinical Services Coordinators meet daily to ensure proper documentation moving forward.	

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to complete evaluations as needed for 1 of 1 tenants reviewed who had been hospitalized (Tenant #6). Finding follow:

1. Review of Tenant #6's file on 9-28-21 and 9-29-21 revealed a diagnosis of type 2 diabetes mellitus. Progress Notes indicated the following:
-On 9-9-21 a new order was received to start Bactrim DS 160 milligram (mg), twice daily for seven days.
- On 9-12-21 Tenant #6 fell when attempting to get out of a family vehicle and hit her head on the cement. She was escorted back to her apartment by two staff and was noted to be unsteady on her feet.
- On 9-13-21 at 6:49 a.m. Tenant #6 was found on the floor next to her bed. She said she was on the way back from the bathroom and slipped onto the floor.
- On 9-13-21 at 11:30 a.m. the nurse was called to Tenant #6's apartment due to a fall. She was on the floor in the bathroom and said she slipped backwards. It was her third fall in 24 hours.
- On 9-13-21 Tenant #6 left to go to the emergency room with family.
- On 9-14-21 a nurse from the hospital called and said Tenant #6 was being admitted for a urinary tract infection (UTI) and was started on intravenous (IV) antibiotics.
- On 9-25-21 it was noted Tenant #6 returned to the Program post hospital and skilled nursing facility (the tenant was in the SNF from 9/16/21 to 9/25/21). The tenant was admitted with current orders as well as physical therapy (PT), occupational therapy (OT) and speech therapy (ST). Family requested staff encourage water

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A 145	Continued From page 8 intake Further record review revealed a Resident Data Collection Form (head to toe assessment) dated 9-25-21 was completed by a licensed practical nurse. Functional and cognitive evaluations were not completed as needed with significant change and a health evaluation was not completed by a registered nurse. 2. When interviewed on 9-29-21 at 9:40 a.m. the Clinical Services Coordinator confirmed there were no additional evaluations for Tenant #6's return to the Program.	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 ensure service plans were based on evaluations and/or updated as needed to reflect current needs for 4 of 6 tenants reviewed (Tenants #2, #4, #5 and #6). Findings follow: 1. On 9-27-21 review of Tenant #2's file revealed the Routine Nurse Review evaluation dated 7-23-21 reflected the tenant reported eating soft foods and foods that were easy to chew. The	A 350	All significant changes and resident service plans will be updated and done by RN Clinical Service Coordinators as required by January 26. These will be audited to ensure they are meeting the service needs of each resident (#2,#4,#5,#6). Clinical Service Coordinators meet daily to ensure proper documentation moving forward. Type text here	

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tenant said it was difficult for her to chew. The evaluation indicated Tenant #2's appetite was poor. The tenant's service plan dated 7-23-21 did not reflect her difficulty with chewing and selection of soft foods related to this difficulty.

2. Review of Tenant #4's file on 9-28-21 revealed the Routine Nurse Review dated 8-5-21 indicated a hospice aide visited her and she received hospice services. A Hospice Care Plan Review document (visit date of 9-8-21) indicated a nurse visited once per week, social worker once per month, chaplain once per month and home health aide (HHA) three times per week. Further review revealed the service plan dated 8-5-21 Tenant #4 received hospice services; however, did not specify the services provided including the provision of bathing services and HHA visits three times per week.

When interviewed on 9-29-21 at approximately 11:20 a.m. the Clinical Services Coordinator confirmed hospice assisted Tenant #4 with bathing services and morning cares.

3. Review of Tenant #5's file on 9-28-21 revealed a diagnosis of glaucoma. An incident report dated 8-11-21 indicated staff was told Tenant #5 drank hand sanitizer. Staff did not observe her drink it but said she asked for a new bottle of water because the water did not taste good and then handed staff the bottle of hand sanitizer. Staff witnessed Tenant #5 rubbing her tongue with a napkin and said her mouth tasted like soap. Tenant #5 had no recollection of drinking the hand sanitizer, said she liked her water at room temperature and told the nurse to leave her alone so she could eat supper.

A review of Assisted Living Recommendation

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Forms indicated the following:
- On 5-4-21 physical therapy (PT) was initiated and a front wheeled walker was recommended for ambulation.
- On 6-10-21 it was noted occupational therapy (OT) was discontinued.
- On 9-7-21 speech therapy (ST) was discontinued.

Tenant #5 had service plans signed on 5-25-21 and 9-27-21. The service plan dated 9-27-21 reflected Tenant #5 was discharged from OT on 6-10-21. The 5-25-21 service plan did not reflect therapy services. The discontinuation of OT was not reflected until 9-27-21 despite being discontinued on 6-10-21. The service plan also did not reflect the use of an assistive device or the incident that occurred with hand sanitizer as noted above.

4. Review of Tenant #6's file on 9-28-21 and 9-29-21 revealed a diagnoses of diabetes mellitus. Progress Notes indicated the following:
- On 9-9-21 a new order was received to start Bactrim DS 160 milligram (mg), twice daily for seven days.
- On 9-12-21 Tenant #6 fell when attempting to get out of a family vehicle and hit her head on the cement. She was escorted back to her apartment by two staff and was noted to be unsteady on her feet.
- On 9-13-21 at 6:49 a.m. Tenant #6 was found on the floor next to her bed. She said she was on the way back from the bathroom and slipped onto the floor.
- On 9-13-21 at 11:30 a.m. the nurse was called to Tenant #6's apartment due to a fall. She was on the floor in the bathroom and said she slipped backwards. It was her third fall in 24 hours.
- On 9-13-21 Tenant #6 left to go to the

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emergency room with family.
- On 9-14-21 a nurse from the hospital called and said Tenant #6 was being admitted for a urinary tract infection (UTI) and was started on intravenous (IV) antibiotics.
- On 9-25-21 it was noted Tenant #6 returned to the Program post hospital and skilled nursing facility (the tenant was in the SNF from 9/16/21 to 9/25/21). The tenant was admitted with current orders as well as physical therapy (PT), occupational therapy (OT) and speech therapy (ST). Family requested staff encourage water intake

Continued record review revealed a head to toe assessment by a licensed practical nurse was completed when Tenant #6 returned to Program post hospital and SNF stay for sepsis. Cognitive and functional evaluations were not completed. The service plan was updated on 9-25-21; however it was not based on required evaluations. The service plan did not reflect falls, the UTI or the encouragement of water intake.

5. When interviewed on 9-29-21 at approximately 11:20 a.m. and 11:50 a.m. the Clinical Services Coordinator confirmed the above finding.