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
	S0393	A. BUILDING: _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

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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: 34 Number of tenants with cognitive disorder: 2 TOTAL census of Assisted Living Program: 36 An onsite infection control survey was completed and no regulatory insufficiencies were identified. A comment was made to the Program related to the recommended guidance for personal protective equipment for tenants, visitors and staff. A recertification visit conducted to determine compliance with certification for an Assisted Living Program and the investigation of Complaints #96101-C and #93083-C were completed and resulted in the following regulatory insufficiencies:	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 observation, interview and record review the Program failed to follow its policy and procedure related to medications. This pertained to 1 of 4 tenants observed on a medication pass (Tenant #5) and potentially affected all tenants assisted with medication administration (23). Findings follow:	A 150		

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A 150	Continued From page 1 1. When observed on 4-5-21 at approximately at 11:50 a.m. Staff E passed medications to four tenants including Tenant #5. Staff E administered medications to Tenant #5 at the noon medication pass that were not labeled noon medications as the stickers on the bubblepacks reflected morning. 2. Record review of Tenant #5's April 2021 medication administration record (MAR) indicated the following medications were documented as administered at noon on 4-5-21 by Staff E: amantadine capsule 100 milligram (mg) one capsule twice daily, duloxetine capsule 30 mg one capsule daily, levetiracetam tablet 750 mg two tablets twice daily, metoprolol tartate tablet 25 mg one tablet twice daily, pantoprozole tablet 40 mg one tablet before breakfast, Vimpat tablet 200 mg one tablet twice daily and lamotrigine tablet 25 mg two tablets twice daily. 3. Continued record review revealed the Program's policy and procedure for medications reflected when medications were administered by the Program medications would be labeled and maintained in compliance with the label and applicable laws. All current medications and dosage schedules would be recorded on the MAR. When the medications arrived from pharmacy the label was checked against the MAR to ensure correct information was available for administration. The staff would only administer medication ordered by the physician and scheduled by the pharmacy on the MAR. The six rights of medication administered were "always observed" when medications were administer including: right medication, dose, route, time, tenant and documentation. It indicated never to re-label or label any medication and if in doubt about the medication and label to	A 150		

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A 150	Continued From page 2 return it to the pharmacy. 4. When interviewed on 4-6-21 the Director of Health and Wellness revealed the issue with labeling and bubblepacks had been discussed with pharmacy.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate care, treatment and services. This pertained to 1 of 3 discharged tenants (Tenant #1). Findings follow: 1. Record review on 4-5-21 of Tenant #1's file revealed an Incident Report dated 10-2-20 at 10:20 a.m. indicated staff walked into her apartment and she was found on the floor, sitting on the rug with her walker next to her. Her feet were towards the bed. Tenant #1 reported she slipped on the rug and did not hit her head. Tenant #1 was assisted up with a gait belt and staff assisted her back to bed. Tenant #1's family and primary care provider (PCP) were notified. An Incident Report dated 10-2-20 at 10:45 a.m. indicated Tenant #1 was found on the floor in her apartment. She was found in a sitting position and she had tripped on a rug. The report	A 160		

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A 160	Continued From page 3	A 160		

indicated she did not hit her head and sustained four skin tears. An assessment was completed and Tenant #1 was assisted up off the floor. The rugs were removed from her apartment and the skin tears were cleansed and steri strips were applied. Tenant #1's family and PCP were notified.

Continued record review revealed Tenant #1's service plan dated 9-23-20 reflected staff administered Tenant #1's medication and she took an anticoagulant medication. It indicated to notify the nurse of excessive bleeding, increased or new bruising or falls. The service plan also reflected Tenant #1 had a fall history.

Further record review revealed Observation Notes indicated the following:

-On 10-5-20 at 2:45 p.m. (late entry for 11:00 a.m.) it was noted Tenant #1 had "Raccoon eyes" and had her normal vision. She had a bruise on her right upper lateral forehead and one large bruise on her left cheekbone. Her right arm was bruised from 3/4 up her humerus to below her elbow (three inch). Tenant #1 had full range of motion to her joints and denied a headache "now." No bumps or bruises were noted to the back of her head. Tenant #1 had cataract surgery scheduled for later in the week. Tenant #1's family was contacted to recommend that Tenant #1 be seen.

-On 10-5-20 at 1:15 p.m. it was noted Tenant #1's family was emailed regarding her needing to see a doctor before her eye appointment.

-On 10-5-20 at 3:00 p.m. it was noted Tenant #1's friend was contacted to see if she could reach Tenant #1's family to see if someone could take

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A 160	Continued From page 4 Tenant #1 to be seen. -On 10-5-20 at 5:00 p.m. it was noted Tenant #1's family "finally" called back. Tenant #1's family member was out of state and was not able to take her and would to try find someone to take Tenant #1. It was explained that Tenant #1 needed to evaluated by a doctor as soon as possible. -On 10-5-20 at 8:45 p.m. it was noted Tenant #1's family member emailed back and was not able to reach someone else to take Tenant #1. The family member was reminded Tenant #1 needed to be seen related to the falls and to rule out an myocardial infarction or cerebral vascular accident. It was noted Tenant #1 also had bruising on her left elbow and buttocks. Tenant #1's family was provided names of home care help that she could contract with to take Tenant #1 to her appointment and emergency care visit since she had poor memory and could not remember her fall history or why she fell. Tenant #1's family inquired about availability in the memory care unit. It was indicated the unit was full; however, even if Tenant #1 was in the memory care unit Tenant #1 would need to be "accompanied by a responsible adult to all appt due to poor MMSE." -On 10-5-20 at 10:15 p.m. it was noted a significant change assessment was completed for Tenant #1 related to repeated falls and lack of recollection of falls. Tenant #1's mini mental status examination (MMSE) was 20/30 and Global Deterioration Scale (GDS) was a four. Tenant #1 needed to be evaluated for frequent falls while on Coumadin that resulted in bruising to the face, scalp, arms, legs and buttocks. It was discussed with Tenant #1's family to get an	A 160		

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A 160	Continued From page 5	A 160		

assistant to assist with cares, appointments and emergency transfers due to her GDS.

-On 10-6-20 at 4:00 p.m. it was noted Tenant #1's family called to figure out what the Program was doing with Tenant #1. The family member said she would contact Tenant #1's conservator to see if someone from her office could take Tenant #1 to the doctor to be seen for bruising to her eyes and arms. Nursing contacted Tenant #1's conservator and she agreed to accompany Tenant #1 to the hospital. Tenant #1's family (power of attorney) gave permission to have her take Tenant #1 to the hospital. An ambulance was called and arrived at approximately 12:30 p.m. to transport Tenant #1 to the hospital. At 4:00 p.m. nursing contacted the hospital and received an update on Tenant #1. The head computed tomography was normal, there was no urinary tract infection and the international normalized ratio (INR) was 8.3. An x-ray showed a possible classification of the right arm, possible fracture and additional work up was being done regarding it.

-On 10-6-20 at 8:00 p.m. it was noted Tenant #1 was admitted to the hospital with a change in neurological status.

-On 10-12-20 at 10:45 a.m. it was noted nursing contacted the hospital for an update on Tenant #1. Her INR was 1.3, she had a Miami J brace on and t11 fracture.

-On 10-13-20 at 1:00 p.m. it was noted it was discussed with the hospital that Tenant #1 would return to the Program at 11:00 a.m. Then an email was received from Tenant #1's conservator that indicated a 30 day notice was given and Tenant #1 would be transferring to a higher level

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A 160	Continued From page 6 of care. Continued record review revealed email communication dated 10-5-20 at 4:42 p.m. between those involved with Tenant #1's care, including Program staff, revealed Tenant #1's family (POA) indicated Tenant #1 was being taken to emergency room by non-emergency ambulance the evening of 10-5-20 and there was a possibility Tenant #1's cataract surgery would be canceled due to her fall. The Program staff responded to the POA's email on 10-5-20 at 8:13 p.m. and indicated Tenant #1 was not sent out as she could not reach someone (to go with her). The email from Program staff explained security at the hospital would sit with violent patients only. It also indicated Tenant #1's POA needed to think about contracting with someone to assist with Tenant #1's needs in the POA's absence. Memory care did not have beds available and if so she would still need to have someone to be at all of her appointments and emergency transfers. The email indicated Tenant #1's MMSE was too low to leave her unattended in a place not familiar. 2. When interviewed on 4-7-21 at 3:59 p.m. Nurse #1 said she remembered Tenant #1 falling and having bruising. There were issues regarding getting Tenant #1 sent out. Tenant #1's family dynamic was difficult and Tenant #1's financial care person came in and took her to be seen. She said ideally family would be there when a tenant was sent out. When interviewed on 4-7-21 at 4:21 p.m. Nurse #2 said Tenant #1 fell a lot in her apartment and staff would not know she fell until her bruises were observed. If in the dementia unit or if a tenant had a MMSE of less than 25 the tenant	A 160		

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A 160	Continued From page 7 would have a family member go with them. It was a general rule and was not anything in writing. She said if a tenant was unstable, 911 was called and a tenant did not need someone with them. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and the Director of Health and Wellness confirmed there was not a policy that required a tenant to be accompanied when being sent out to the hospital. 3. In summary, Tenant #1, who had moderate cognitive decline, received anticoagulant therapy and had a documented fall history, fell twice on 10-2-20 (approximately 20 minutes apart). Skin tears were noted at the time of one of the falls. On 10-5-20 notes documented additional injuries including bruising to Tenant #1's face, head, arms and buttocks. Notes documented the urgency of Tenant #1 needing to be seen due to the injuries sustained, reason for her falls and to rule out MI or CVA. Notes indicated Tenant #1's family was repeatedly told Tenant #1 needed to have someone accompany her to be seen. Tenant #1's POA indicated in email that Tenant #1 would be sent to the hospital on 10-5-20 and then was told by Program staff the decision was made to not send her out as no one could be reached to accompany her. Tenant #1 was not sent out to the hospital until 10-6-20 at approximately 12:30 p.m. Tenant #1 was admitted to the hospital and had an INR of 8.3 and notes indicated a T11 fracture. Tenant #1 was transferred to a higher level of care. Tenant #1 did not receive services that were adequate and appropriate.	A 160		
A 345	481-67.9(4)b Staffing	A 345		

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A 345	Continued From page 8 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: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse delegated training within 30 days of hire. This pertained to 2 of 6 staff reviewed (Staff A and B). Findings follow: 1. Record review on 4-1-21 of Staff A's training documents indicated Staff A was hired on 1-1-21. Nurse delegations were documented as completed on 2-7-21. 2. Record review on 4-1-21 of Staff B's training documents indicated Staff B was hired on 2-2-21. Nurse delegations were documented as completed on 3-5-21. 3. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed all nurse delegation training documents for the staff listed listed above were provided. Staff A had a delayed start to work from her hire date.	A 345		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the	A 380		

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A 380	Continued From page 9 identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Interview and record review revealed the Program failed to have staff complete dependent adult abuse training within six months of employment. This pertained to 1 of 3 staff reviewed that had been employed six months or greater (Staff D). Findings follow: 1. Record review on 4-1-21 of Staff D's training documents revealed a hire date of 6-23-20. Staff D did not have a completed dependent adult abuse course within six months of employment. A certificate was provided for Staff D's dependent adult abuse training dated 4-1-21. 2. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed no additional dependent adult abuse training was found.	A 380		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 400		

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A 400	Continued From page 10 Program failed to complete background checks prior to employment. This pertained to 1 of 6 staff reviewed (Staff A). Findings follow: 1. Record review on 4-1-21 of Staff A's training documents revealed a hire date of 1-1-21. A criminal history background check and abuse registries background check was not completed at the time of the visit. A background check was completed on 4-1-21 and revealed no results were found. 2. Continued record review revealed time card records indicated Staff A first worked on 1-28-21. 3. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed all background check information was provided for the staff listed above.	A 400		
A 415	481-67.19(3)c Record Checks 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to request the Department of Human Services (DHS) complete an evaluation to	A 415		

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A 415	Continued From page 11	A 415		

determine if employment was prohibited for a person considered for employment. This pertained to 1 of 1 staff reviewed that required a record check evaluation (Staff B). Findings follow:

1. Record review on 4-1-21 of Staff B's training documents revealed Staff B was hired on 2-2-21. A criminal history background check and abuse registries background check was completed on 2-2-21. The check revealed further research was required for the criminal history background check. No results were found on the abuse registries background check. The Iowa Record Check Request Form S dated 2-3-21, indicated a record was found. A Record Check Evaluation was not completed at that time.

Continued record review revealed another criminal history background check and abuse registries background check was completed on 4-5-21. The check revealed further research was required for the criminal history background check. The Iowa Record Check Request Form S dated 4-6-21 indicated a record was found. The Record Check Evaluation was completed and returned with an approval notice dated 4-6-21.

Further record review revealed time records indicated Staff B first worked on 2-3-21, which was prior to the completion of the background check process, including the Record Check Evaluation approval notice.

2. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed all background check information was provided for the staff listed above.

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A 140	Continued From page 12	A 140		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 5 tenants reviewed (Tenants #3 and #4). Findings follow: 1. Record review on 4-5-21 of Tenant #3's file revealed Observation Notes indicated the following: -On 3-25-21 it was noted staff reported an increase of Tenant #3's transfer needs. A transfer study was started for one week. -On 3-31-21 it was noted Tenant #3's family requested an increase in bathing services from two to three times per week to prevent body odor and skin breakdown. Tenant #3's transfer study continued and he required the assistance of one person at all times. Additional interventions included to have Tenant #3 stretching twice per week per activity schedule. Therapy recommended to use a gait belt at all times with transfers. Evaluations were last completed on	A 140		

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A 140	Continued From page 13 2-3-21/2-5-21. A nurse review was completed dated 3-31-21; however, cognitive, health and functional evaluations were not completed as needed with significant change. 2. Record review on 4-6-21 of Tenant #4's file revealed Tenant #4 was admitted on 12-22-20. Observation Notes indicated the following: -On 12-27-20 it was noted Tenant #4's family was made aware Tenant #4 needed increased cares and memory care placement (five days after admission to the Program). Functional and health evaluations were completed on 12-27-20 with a significant change of condition related to increased care needs. A cognitive evaluation was not completed at that time. A cognitive evaluation was not completed as needed with significant change. 3. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed all of the evaluations available for the tenants listed above were provided.	A 140		
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
	S0393	A. BUILDING: _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(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 14 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed, failed to develop service plans to reflect the identified needs of the tenants and failed to develop service plans based on evaluations. This pertained to 3 of 5 tenants reviewed (Tenants #3, #4 and #5). Findings follow: 1. Record review on 4-5-21 of Tenant #3's file revealed Observation Notes indicated the following: -On 1-6-21 it was noted physical therapy/occupational therapy (PT/OT) were working with Tenant #3. -On 2-1-21 it was noted Tenant #3 was discharged from PT on 1-14-21. -On 3-11-21 it was noted Tenant #3 was discharged from OT. -On 3-25-21 it was noted staff reported an increase of Tenant #3's transfer needs. A transfer study was started for one week. -On 3-31-21 it was noted Tenant #3's family requested an increase in bathing services from two to three times per week to prevent body odor and skin breakdown. Tenant #3's transfer study continued and he required the assistance of one person at all times. Additional interventions included to have Tenant #3 stretching twice per week per activity schedule. Therapy recommended to use a gait belt at all times with transfers.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(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 15 Continued record review revealed the service plans dated 12-18-20 and 2-5-21 were not updated and did not reflect the initiation or discharge of PT/OT services. The service plan was updated on 3-31-21 and reflected to transfer with a gait belt and the transfer study. The service plan reflected bathing occurred Monday and Thursday (twice per week) and not three times per week as indicated in the note regarding Tenant #3's family request. The update on the 3-31-21 regarding Tenant #3's transfers with a gait belt and transfer study was completed with an observation note (nurse review); however, the service plan was not based on evaluations, as evaluations were not completed at that time. 2. Record review on 4-6-21 of Tenant #4's file revealed Tenant #4 was admitted on 12-22-20. Observation Notes indicated the following: -On 12-27-20 it was noted Tenant #4's family was made aware Tenant #4 needed cares and memory care placement (five days after admission to the Program). Functional and health evaluations were completed on 12-27-20 with a significant change of condition related to increased care needs. A cognitive evaluation was not completed at that time. A service plan was developed dated 12-27-20 related to the increased care needs; however, the service plan was not based on the cognitive evaluation, as a cognitive evaluation was not completed. 3. Record review on 4-6-21 of Tenant #5's file revealed a diagnosis of Parkinson's disease. Observation Notes indicated the following:	A 350		

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	S0393	A. BUILDING: _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 350	Continued From page 16 -On 1-9-21 it was noted Tenant #5 requested medications not be crushed as she could swallow them. -On 2-5-21 it was noted Tenant #5 was discharged from speech therapy (ST) as Tenant #5 reached all goals. Continued record review revealed Tenant #5's service plan dated 3-5-21 reflected staff administered medications and medications that could be crushed would be in applesauce, yogurt or pudding. The service plan also reflected Tenant #5 received ST five times per week. The service plan was not updated as needed to reflect the preference for medications and discharge from ST. 4. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and the Director of Health and Wellness confirmed all of the service plans available for the tenants listed above were provided.	A 350		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan.	A 355		

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A 355	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a service plan for a tenant prior to taking occupancy. This pertained to 1 of 1 tenant reviewed that was admitted in 2021 (Tenant #2). Findings follow: 1. Record review on 4-5-21 of Tenant #2's file revealed Tenant #2 was admitted on 1-18-21. Observation Notes indicated the following: -On 1-20-21 (two days after admission) it was noted a significant change was observed for increased care needs. It was discussed with Tenant #2's family at admission she would be more appropriate for memory care; however, family wanted to try assisted living. -On 1-26-21 it was noted Tenant #2 voiced a plan to run away, steal a car and kill herself. -On 2-10-21 it was noted a discussion was had with Tenant #2's family about Tenant #2's inability to care for herself or her pet and how she would best fit in the memory care unit. The primary care provider sent a letter regarding Tenant #2's condition and needing a higher level of care. -On 2-11-21 it was noted Tenant #2 moved to the memory care unit on 2-11-21. Continued record review revealed a preliminary service plan was not completed when Tenant #2 moved into the Program. The Program discussed Tenant #2 needed a higher level of care two days after admission and there was not a preliminary service plan to determine if Tenant #2 was an appropriate admission into the	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/08/2021

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A 355	Continued From page 18 Program. 2. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and the Director of Health and Wellness confirmed a preliminary service plan for Tenant #2 was not found.	A 355		

Keystone Place at Forevergreen
Plan of Correction
August 3, 2021

A150- Program Policies and Procedures 481-67.2(3)

Findings:

1. Program failed to follow its policy and procedure related to medications.

Plan of Correction:

1. All tenants receiving medication administration by the Program will have medications administered in accordance with physician or third party health care provider orders.

2. The Program has amended its Medication Needs of Tenants/Medication Management Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 1).

3. All Health and Wellness staff will be retrained with respect to the new Medication Needs of Tenants/Medication Management Policy and Procedure dated August 2, 2021. Retraining will be completed by September 1, 2021.

4. The Program had previously encountered service failures from its preferred pharmacy at the time of the survey. The Community has entered into a new contract with Martin Health Services effective June 1, 2021 as a the Community's preferred pharmacy, and the Community has been able to work successfully with the new preferred pharmacy which will minimize the potential for labeling errors.

5. The Medications Needs of Tenants/Medication Management Policy and Procedure dated August 2, 2021 includes procedures at items (9) and (11) which will add a review of the MAR to medications received by the program to ensure proper labeling including on bubble packs. The Director of Health and Wellness has completed retraining of all registered nurses as to the new procedures.

6. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures.

A 160 – Tenant Rights 481-67.3(2)

Findings:

1. The Program failed to meet tenant rights by failure to provided care, treatment and services which are adequate and appropriate.

Plan of Correction:

1. The Program has revised its Head Injuries Policy and Procedure to include other Injuries and such new policy and procedure is the Falls, Head Injuries and Other Injuries Policy and Procedure (a copy of which is attached as Exhibit 2).

2. The new policy provides the procedure in the event of a likely injury to a cognitively impaired resident in the event his or her family or legal representative is not available.

3. All staff will be trained on the Falls, Head Injuries and Other Injuries Policy and Procedure no later than September 1, 2021.

4. All staff will be retrained on Tenant Rights with examples of situations that could constitute actions to be taken by the Program in the absence of availability of family or other legally responsible parties relating to care, treatment and services.

5. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes review of incident reports and review of appropriate follow up actions.

A 345 – Staffing 481-67.9(4)b

Findings:

1. Program failed to properly complete and document training completed for newly hired staff within 30 days of employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include a checklist for Orientation Training. The Orientation Training includes nurse delegation procedures.

2. The Program has amended its' Staff Training Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 3).

3. The Community has hired a new Director of Operations with substanital experience.

4. The Director of Operations shall conduct audits of the personnel files including verification of training and documentation of training at the intervals set forth on the Staff Training Policy and Procedure and ensure that any training is completely on a timely basis in accordance with regulatory requirements and the policy and procedure.

5. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes item for review of staff files for appropriate documentation.

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A 380 – Staffing 481-67.9(6)

Findings:

1. Program failed to properly complete and document dependent adult abuse training for staff within 6 months of employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include a checklist for Dependent Adult Abuse Training within 6 months of employment and each 3 years thereafter. The Orientation Training includes nurse delegation procedures.

2. The Program has amended its Staff Training Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 3).

3. The Director of Operations shall conduct audits of the personnel files including verification of training and documentation of training at the intervals set forth on the Staff Training Policy and Procedure and ensure that any training is completely on a timely basis in accordance with regulatory requirements and the policy and procedure.

4. A new Director of Operations was hired with experience regarding personnel training and proper documentation of personnel files.

5. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes an item for review of personnel files to ensure appropriate documentation of training.

A 400 – Record Checks 481-67.19(3)

Findings:

1. Program failed to complete background checks with the Iowa Department of Public Safety prior to employment.

2. Program failed to complete evaluation by the Iowa Department of Human Services to determine if employment was prohibited for a person considered for employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include checklist items for background checks with the Iowa Department of Public Safety and record checks with the Iowa Department of Human Services.

2. The Program has amended its Staffing Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 4) to include restrictions (i) on inputting newly hired personnel into the payroll processing system and (ii) placing any newly hired personnel on the schedule for work prior to completion of the Department of Public Safety background check and the Department of Human Services record check to confirm eligibility for employment.

3. At any time the Director of Operations conducts audits of the personnel files, the Director of Operations shall ensure that documentation of record checks is maintained in personnel files.

4. A new Director of Operations was hired with experience regarding personnel record checks and proper documentation of personnel files.

5. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes an item for review of personnel files to ensure appropriate documentation of record checks.

A 415 – Record Checks 481-67.19(3) c

Findings:

1. Program failed to complete its review of background checks with the Iowa Department of Public Safety prior to employment.

2. Program failed to complete its review of evaluation by the Iowa Department of Human Services to determine if employment was prohibited for a person considered for employment.

Plan of Correction:

1. The Program has implemented procedures to ensure that results of DPS and DHS record checks are reviewed by the Director of Operations prior to employment of an individual. The Program has updated its Personnel File Checklist to include checklist items for review of the Iowa Record Check Request Form S relating background checks with the Iowa Department of Public Safety and record checks with the Iowa Department of Human Services.

2. The Program has amended its Staffing Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 4) to include review by the Director of Operations of the results of any record check and includes restrictions (i) on inputting newly hired personnel into the payroll processing system and (ii) placing any newly hired personnel on the schedule for work prior to completion of the Department of Public Safety background check and the Department of Human Services record check to confirm eligibility for employment.

3. At any time the Director of Operations conducts audits of the personnel files, the Director of Operations shall ensure that documentation of record checks and review of record check results is maintained in personnel files.

4. A new Director of Operations was hired with experience regarding personnel record checks and proper documentation of personnel files.

5. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes an item for review of personnel files to ensure appropriate documentation of record checks.

A 140 – Evaluation of Tenant 481-6.22(2)

Findings:

1. Program failed to complete evaluations upon a significant change of tenant's condition.

Plan of Correction:

1. The Program has updated its Evaluation of Residents Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 5). The updated policy includes a list (which is not comprehensive) of changes to a tenant's condition that would be considered a significant change and necessitate an evaluation.

2. The Director of Health and Wellness will ensure that all Health and Wellness staff are retrained in the updated Evaluation of Residents Policy and Procedure by September 1, 2021 and that all Health and Wellness staff understand events which necessitate evaluation and possible updates to resident service plans.

3. All Health and Wellness staff are required to report to the nurse on duty any identified and needed significant changes via an incident report or documentation in the electronic charting system.

4. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes an item for review of incident reports which may necessitation for evaulation of a resident.

A 350 – Service Plans 481-69.26(1)

Findings:

1. Program failed to complete service plans as needed and failed to develop service plans to reflect the identified needs of tenants.

Plan of Correction:

1. The Program has updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 6). The updated policy includes a list (which is not comprehensive) of changes to a tenant's condition

that would be considered a significant change and necessitate an evaluation and service plan change.

2. The Director of Health and Wellness will ensure that all Health and Wellness staff are retrained in the updated Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure by September 1, 2021.

3. All Health and Wellness staff will be retrained by September 1, 2021 on the Community's electronic charting system which includes automated alerts for resident assessments.

4. As a quality assurance measure, the Community has created and is using an excel file, Schedule Assessment Tool, which identifies upcoming assessments to ensure resident service plans are updated timely following evaluations. The Schedule Assessment Tool is reviewed on a weekly basis by the Executive Director and the Director of Operations.

A 355 – Service Plans 481-69.26(1)

Findings:

1. The Program failed to complete a preliminary service plan for a tenant prior to taking occupancy.

Plan of Correction:

1. The Program has updated its Evaluation of Residents Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 5). The updated policy includes procedures for completion of evaluations and creation of a preliminary service plan prior to commencement of residency.

2. The Executive Director, Director of Operations and Director of Health and Wellness have reviewed the updated Evaluation of Residents Policy and Procedure and determined an internal system to ensure a preliminary service plan is created including in situations where a resident desires to enter into a Residence and Services Agreement prior to the date of actual physical occupancy. Prior to September 1, 2021, the Community will create a checklist with pre-requisites for new move-ins into the Community and assigned responsibilities.

3. The Program has updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 6). The updated policy includes a list (which is not comprehensive) of changes to a tenant's condition that would be considered a significant change and necessitate an evaluation and service plan change.

4. The Director of Health and Wellness will ensure that all Health and Wellness staff are retrained in the updated Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure by September 1, 2021.

5. At the time the Director of Operations uploads copies of the resident agreement to the Company's business operating systems, the Director of Operations will ensure the initial service plan is included.