6/26/19 OK 6/24/19

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FORM APPROVED

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
	S0400	A. BUILDING: _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT INDIAN CREEK	325 COLLINS ROAD SE CEDAR RAPIDS, IA 52403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 29 Number of tenants with cognitive disorder: 0 TOTAL census of Assisted Living Program: 29 An initial certification visit conducted to determine compliance with certification for an Assisted Living Program resulted in a regulatory insufficiencies	A 000	Please See Attached Plan POC 6/29/19	6/29/19
A 003	481-67 2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the policy and procedure regarding the completion of incident reports. This pertained to 1 of 3 tenants reviewed (Tenant #1).	A 003		

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A 003	Continued From page 1 Findings follow: Record review on 5-1-19 of Tenant #1's file revealed Tenant #1 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline. Progress Notes dated 4-29-19 reflected over the weekend on Saturday Tenant #1 was up until midnight "roaming the hallways." It was reported she wandered in the late hours. Tenant #1 went out the locked lobby doors and was locked outside. A staff giving a tour to a staff in training observed Tenant #1 looking for a way to get the doors open to get back inside. It was also said that Tenant #1 had gone outside in the dark and rain as she "had things to get done." Tenant #1's family was informed Tenant #1 would be placed into the memory care unit soon due to safety concerns with walking and wandering. Continued record review of incident reports revealed an incident report not completed related to the incident noted above with Tenant #1. Further record review revealed the Program's policy for Incident Reporting reflected all accidents and unusual occurrences within the building or on the premises that affected tenants would be reported as incidents. The person in charge at the time of the incident would prepared and sign the report. When interviewed on 5-2-19 at 9:47 a.m. the Director of Health and Wellness confirmed an incident report not completed related to the incident noted above with Tenant #1.	A 003		

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A 059	Continued From page 2	A 059		
A 059	481-67.9(4)b Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: 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 employment for staff. This pertained to 5 of 6 staff reviewed employed greater than 30 days (Staff B, C, D, E and F). Findings follow: Record review of the ALP Monitoring Entrance Form revealed the Program assisted two tenants with medication administration. When interviewed on 5-2-19 at 9:47 a.m. the Director of Health and Wellness revealed Tenant #1 was the first tenant admitted that staff assisted with medication administration and Tenant #4 was the first tenant that received staff assistance with insulin and blood glucose monitoring. Record review on 5-1-19 of Staff B's training documents revealed a hire date of 2-22-19. The Nurse Delegation Flow sheet reflected training on activities of daily living (ADLs) dated 3-13-19;	A 059		

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A 059	Continued From page 3 however the training did not include nurse delegated training on measuring blood pressure, temperature, pulse and respiration. Record review on 5-1-19 of Staff C's training documents revealed a hire date of 2-4-19. The Nurse Delegation Flowsheet Medications reflected training on medication tasks dated 3-14-19 including: eye drop with dropper, medication management agreement, medication management for bottles and medication management. Continued record review of Tenant #1's medication administration records (MARs) reflected Staff C initialed for the administration of oral medications and eye drops on 3-11-19. The administration of medications by Staff C occurred prior to the training documented on 3-14-19 and greater than 30 days from Staff C's hire date. Record review on 5-1-19 of Staff D's training documents revealed a hire date of 2-4-19. The Nurse Delegation Flowsheet Medications reflected training on medication tasks dated 3-9-19 including: eye drops, eye ointment and on 3-13-19 tasks including medication management agreement, medication management for bottles and medication management. Continued record review of Tenant #1's MARs reflected Staff D initialed on 3-12-19 for the administration of oral medications. The administration of the medications by Staff D occurred prior to the training documented on 3-13-19. Record review of Tenant #4's MARs reflected Staff D signed off completion of blood glucose monitoring on 4-26-19. Training on the glucometer testing was not documented for Staff D. The administration of medications and	A 059		

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A 059	Continued From page 4 assistance with blood glucose monitoring occurred prior to the training on the tasks and greater than 30 days from Staff D's hire date. Record review on 5-1-19 of Staff E's training documents revealed a hire date of 2-4-19. The Nurse Delegation Flow sheet reflected training on ADLs dated 3-13-19, which was greater than 30 days from Staff E's hire date. The training did not include training on measuring blood pressure, temperature, pulse or respiration. Record review on 5-1-19 of Staff F's training documents revealed a hire date of 3-16-19. The Nurse Delegation Flow sheet reflected training on ADLs dated 4-30-19, which was greater than 30 days from Staff F's hire date. When interviewed on 5-2-19 at approximately 10:00 a.m. the Director of Health and Wellness indicated all nurse delegation documents were provided for the staff listed above.	A 059		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse 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.	A 118		

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A 118	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a background check prior to employment. This pertained to 1 of 7 staff reviewed (Staff G). Findings follow: Record review on 5-1-19 of Staff G's training documents indicated a hire date of 2-4-19. A criminal history background check and child and dependent adult abuse record check was completed on 5-1-19, which was after employment. Continued record review revealed Staff G had Certificate of Completion certificates for Dependent Adult Abuse Training and Food Safety dated 2-4-19. The February 2019 Nursing Schedule reflected 2-11-19 as Staff G's first date on the schedule. February, March, April and May Nursing Schedules reflected Staff G worked full time. When interviewed on 5-2-19 at 9:01 a.m. the Executive Director revealed the background check for Staff G could not be found at the time of the onsite visit and a new background check was completed on 5-1-19. Staff G worked full time.	A 118		
A 121	481-67.19(3)c Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse 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	A 121		

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A 121	Continued From page 6 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 record review and interview the Program failed to obtain an evaluation from the department of human service (DHS) to determine if employment was prohibited prior to employment for staff with criminal history record indicated. This pertained to 2 of 3 staff reviewed that had a criminal history background check that required an evaluation (Staff D and Staff E). Findings follow: 1. Record review on 5-1-19 of Staff D's training documents revealed a hire date of 2-4-19. A criminal history background check and child and dependent adult abuse check was completed on 1-11-19 and indicated further research was required for the criminal history background check. The Iowa Record Check Form S indicated a record was found dated 1-14-19. An evaluation by DHS to determine if employment was prohibited was not completed. Continued record review revealed Staff D had Certificate of Completion certificates for Dependent Adult Abuse Training and Food Safety dated 2-4-19. The February 2019 Nursing Schedule reflected 2-11-19 as Staff D's first date on the schedule. February, March, April and May 2019 Nursing Schedules reflected Staff D worked full time.	A 121		

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A 121	Continued From page 7	A 121		

2. Record review on 5-1-19 of Staff E's training documents revealed a hire date of 2-4-19. A criminal history background check and child and dependent adult abuse check was completed on 1-11-19 and indicated further research was required for the criminal history background check. The Iowa Record Check Form S indicated a record was found dated 1-14-19. An evaluation by DHS to determine if employment was prohibited was not completed.

Continued record review revealed Staff E had Certificate of Completion certificates for Dependent Adult Abuse Training and Food Safety dated 2-4-19. The February 2019 Nursing Schedule reflected 2-12-19 as Staff E's first date on the schedule. February, March, April and May 2019 Nursing Schedules reflected Staff E worked full time

Further record review revealed emails dated 2-15-19 from the Business Office Manager to DHS reflected requests for record check evaluations for Staff D and E. The email requests were greater than 30 days from the initial background checks of 1-11-19, which made the initial background checks no longer valid. The email requests for the record check evaluations also occurred after Staff D and Staff E were hired on 2-4-19.

When interviewed on 5-1-19 at approximately 2:25 p.m. and on 5-2-19 at 9:01 a.m. the Executive Director revealed DHS was contacted by the Program regarding the evaluations and DHS reported the evaluations related to the 2-15-19 emails were not received. Staff D and Staff E worked full time. The first day of any

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A 121	Continued From page 8 tenant contact was on 2-18-19, the date the building opened. Prior to that time staff completed orientation and training. There was no additional background check information available for the staff listed above.	A 121		
A 122	481-67.19(3)d Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3)d If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain evaluation from the department of human service (DHS) prior to employment if the record check process for the child abuse registry indicated further research was required. This pertained to 1 of 1 staff reviewed with results to initiate a record check request on the the child abuse registry (Staff D). Findings follow:	A 122		

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A 122	Continued From page 9 Record review on 5-1-19 of Staff D's training documents revealed a hire date of 2-4-19. A criminal history background check and child and dependent adult abuse check was completed on 1-11-19 and indicated to initiate a record check evaluation by DHS for the child abuse registry. Further research as indicated with the initiation of the record check evaluation by DHS was not completed. Continued record review revealed Staff D had Certificate of Completion certificates for Dependent Adult Abuse Training and Food Safety dated 2-4-19. The February 2019 Nursing Schedule reflected 2-11-19 as Staff D's first date on the schedule. February, March, April and May 2019 Nursing Schedules reflected Staff D worked full time. When interviewed on 5-1-19 at approximately 2:25 p.m. and on 5-2-19 at 9:01 a.m. the Executive Director revealed DHS was contacted by the Program regarding the evaluations and DHS reported the evaluation related to the 2-15-19 email was not received. Staff D worked full time. The first day of any tenant contact was on 2-18-19, the date the building opened. Prior to that time staff completed orientation and training. There was no additional background check information available for the staff listed above.	A 122		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of	A 037		

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A 037	Continued From page 10 occupancy. A program shall also 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 or human service professional. A licensed practical nurse may complete the evaluation 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 within 30 days of tenant occupancy. This pertained to 2 of 3 tenants reviewed (Tenants #2 and #3). Findings follow: Record review on 5-1-19 of Tenant #2's file revealed an admission date of 2-18-19. Health, functional and cognitive evaluations were dated 3-25-19 and electronically signed on 3-29-19; which was greater than 30 days from taking occupancy. Record review on 5-1-19 of Tenant #3's file revealed an admission date of 3-8-19. Health, functional and cognitive evaluations were signed and dated on 4-15-19, which was greater than 30 days from taking occupancy. When interviewed on 5-2-19 at 9:47 a.m. the Director of Health and Wellness confirmed there were no additional evaluations completed for the	A 037		

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A 037	Continued From page 11 tenants listed above.	A 037		
A 068	481-69.25(1)f Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: f. Signed authorizations for permission to release medical information, photographs, or other media information as necessary This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain signed authorizations including for release of medical information and media. This pertained to 3 of 3 tenants reviewed. Record review on 5-1-19 of Tenant #1's file revealed an admission date of 3-18-19. The file lacked signed authorizations including for release of medical information and media. Record review on 5-1-19 of Tenant #2's file revealed an admission date of 2-18-19. The file lacked signed authorizations including for release of medical information. The file contained a media release dated 4-11-19. Record review on 5-1-19 of Tenant #3's file revealed an admission date of 3-8-19. The file lacked signed authorizations including for release of medical information and media. When interviewed on 5-2-19 at 1:55 p.m. the Executive Director revealed all releases related to the release of medical information and media for	A 068		

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A 068	Continued From page 12 the tenants listed above were provided.	A 068		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure completion of nurses notes by exception. This pertained to 2 of 3 tenants reviewed (Tenants #2 and #3). Findings follow: 1. Record review on 5-1-19 of Tenant #2's file revealed Incident Reports were completed on 2-18-19, 3-18-19 and 3-26-19 for alleged falls. The incident report on 3-26-19 revealed Tenant #2 sustained a skin tear on the right lower leg and was taken to the emergency room (ER) by car. Continued record review revealed a Progress Note dated 3-20-19 (late entry for 3-18-19) was completed for the fall on 3-18-19. Nurses notes were not completed related to the	A 071		

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A 071	Continued From page 13 falls on 2-18-19 and 3-26-19. The fall on 3-26-19 resulted in an injury and evaluation in the ER. 2. Record review on 5-1-19 of Tenant #3's file revealed a Progress Note dated 3-12-19 indicated two staff reported Tenant #3 had blood noted in his stools. Tenant #3 was on Coumadin and was sent to the emergency department (ED). Continued record review of Medical Record Progress Notes (ED) dated 3-12-19 revealed Warfarin was discontinued and Aspirin 325 milligram was started. Further record review revealed a nurses note was not completed when Tenant #3 returned from the ED with new orders regarding anti-coagulant medication. When interviewed on 5-2-19 at 9:47 a.m. the Director of Health and Wellness confirmed all nurses notes were provided for the tenants listed above.	A 071		
A 085	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by:	A 085		

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	S0400	A. BUILDING: _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT INDIAN CREEK	325 COLLINS ROAD SE CEDAR RAPIDS, IA 52403

(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 085	Continued From page 14 Based on interview and record review the Program failed to update tenants' service plans within 30 days of occupancy. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: Record review on 5-1-19 of Tenant #1's file revealed an admission date of 3-18-19. A service plan was not updated within 30 days of taking occupancy. Service Plan Agreements were provided with effective dates of 5-1-19 and 5-2-19; which was greater than 30 days and the agreements were not signed. Record review on 5-1-19 of Tenant #2's file revealed an admission date of 2-18-19. A service plan was not updated within 30 days of taking occupancy. Service Plan Agreements were provided with effective dates of 5-1-19 and 5-2-19, which was greater than 30 days and the agreements were not signed. Record review on 5-1-19 of Tenant #3's file revealed an admission date of 3-8-19. The service plan was signed and dated on 4-15-19, which was greater than 30 days from taking occupancy. When interviewed on 5-2-19 at approximately 10:00 a.m. the Director of Health and Wellness revealed all service plan documents for the tenants listed above were provided.	A 085		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and	A 089		

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A 089	Continued From page 15 preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to reflect the identified needs of the tenants. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review on 5-1-19 of Tenant #1's file revealed Tenant #1 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline. Progress Notes indicated the following: a. On 4-5-19 a conversation with Tenant #1's family occurred. Tenant #1 took a lot of walks outside and could find her way back. Tenant #1 had a very short term memory and asked the same questions frequently. Tenant #1 became upset when she ordered her food and did not remember ordering. Staff was going to put a card on the dining room table to provide a reminder of the placed order. b. On 4-10-19Tenant #1 had several episodes where she could not remember where to eat and the location of her apartment. c. On 4-29-19 it was noted over the weekend on Saturday Tenant #1 was up until midnight "roaming the hallways." It was reported she was wandering in the late hours. Tenant #1 went out the locked lobby doors and was locked outside. A staff giving a tour to a staff in training observed	A 089		

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A 089	Continued From page 16 Tenant #1 looking for a way to get the doors open to get back inside. It was also said that Tenant #1 had gone outside in the dark and rain as she "had things to get done." Tenant #1's family was informed Tenant #1 would be placed into the memory care unit soon due to safety concerns with walking and wandering. Continued record review of the ALP Monitoring Entrance Form indicated Tenant #1 was identified as a tenant who wandered throughout the Program. Further record review revealed the service plan reflected well-being checks. The service plan did not reflect Tenant #1's behavior and interventions including: walking outside, wandering in the building (including nocturnal) the concern noted with meal ordering, issues with locating her apartment and leaving the building at night. 2. Record review on 5-1-19 of Tenant #2's file revealed Tenant #2 received Hospice services. Progress Notes indicated the following: a. On 3-7-19 Tenant #2 was admitted to Hospice services. b. On 3-8-19 Tenant #2 was "very weepy," was not feeling well, was weak and her appetite had not been good. c. On 3-9-19 (late entry for 3-8-19) Tenant #2 was prescribed Lorazepam when she felt anxious (independent with medication). d. On 3-12-19 Tenant #2 had lost 10 pounds from 2-27-19 to 3-12-19. Tenant #2 felt weak and did not have any energy.	A 089		

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A 089	Continued From page 17	A 089		

e. On 3-27-19 Hospice was responsible for dressing wounds and would be coming daily to dress the wound.

f. On 4-2-19 (late entry for 3-28-19) the Hospice nurse reported they would be providing the dressing changes and supplies. Orders would be for wound care every three days.

Continued review revealed Incident Reports were completed on 2-18-19, 3-18-19 and 3-26-19 for alleged falls. The incident report on 3-26-19 revealed Tenant #2 sustained a skin tear on the right lower leg and was taken to the emergency room by car.

Further record review revealed the service plan reflected Hospice provided all cares including dressing change, pain management and shower assistance. The service plan failed to reflect Tenant #2's falls, information regarding the wound, weight loss, poor appetite, weakness, or anxiety.

3. Record review on 5-1-19 of Tenant #3's file revealed Record review on 5-1-19 of Tenant #3's file revealed a Progress Note dated 3-12-19 indicated two staff reported Tenant #3 had blood noted in his stools. Tenant #3 was on Coumadin and was sent to the emergency department (ED).

Continued record review of Medical Record Progress Notes (ED) dated 3-12-19 revealed Warfarin was discontinued and Aspirin 325 milligram (mg) was started.

Tenant #3's March and April medication administration records (MARs) reflected staff

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A 089	Continued From page 18 administered Erythromycin ointment 5 mg/gram, apply a thin ribbon layer to the right eye twice daily. It also reflected staff administered Refresh Tear Drop 0.5% instill one drop in both eyes four times daily. Further record review revealed the service plan did not reflect Tenant #3 had blood in stools and the prescribed anti-coagulant medication. The service plan also did not reflect staff administration of eye drops or eye ointment. 4. When interviewed on 5-2-19 at approximately 10:00 a.m. the Director of Health and Wellness revealed all service plan documents for the tenants listed above were provided.	A 089		

✓ 6/26/19 OK 6/24/19

Plan of Correction
Grand Living at Indian Creek

A003 -Program Policies and Procedures

Regulatory Insufficiency: The Program failed to follow the policy and procedure related to the completion of incident reports.

Plan of Correction:
The insufficiencies will be corrected as follows:

- With any tenant incident, a report will be completed per policy (Attachment A).

The following measures will be taken to ensure the problem does not recur:

- Review and re-education of *Incident Reporting Policy and Procedure* provided to healthcare staff, including step-by-step instructions of completing the report within EMR (Attachment B) will be provided to all healthcare staff at the June 19, 2019 scheduled Inservice.

The program will monitor performance to ensure compliance as follows:

- Program nurse or designee will monitor completion of incident reports for all reported tenant incidents.

Date insufficiencies corrected by June 29, 2019.

A059 -Staffing

Regulatory Insufficiency: The Program failed to document a review to ensure staff were sufficiently trained within 30 days of employment.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Delegations for Staff B, C, D,E and F and have been completed by the Program Nurse.

The following measures will be taken to ensure the problem does not recur:

- All healthcare staff will be delegated by Program Nurse within 30-days of hire per *Staffing Policy and Procedure* (Attachment C).

The program will monitor performance to ensure compliance as follows:

- Process to be audited periodically and no less than monthly for six months for compliance by Executive Director of designee.

Date insufficiencies corrected by June 29, 2019.

A118- Record Checks

Regulatory Insufficiency: The program failed to complete a background check on employee G prior to employment.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Staff G has had new background check completed.

The following measures will be taken to ensure the problem does not recur:

- A new Interim Business Officer Manger is in place and will be trained and educated on the regulations and guidelines pertaining to timely background checks.

The program will monitor performance to ensure compliance as follows:

- Process to be audited periodically and no less than monthly for six months for compliance by Executive Director of designee.

Date insufficiencies corrected by June 29, 2019

A121- Record Checks

Regulatory Insufficiency- the program failed to obtain an evaluation form the DHS to determine if employment was prohibited prior to employment for staff with criminal history record indicated.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Staff D and E will have background checks and DHS evaluations completed

The following measures will be taken to ensure the problem does not recur:

- A new Interim Business Officer Manger is in place and will be trained and educated on the regulations and guidelines pertaining to timely background checks.

The program will monitor performance to ensure compliance as follows:

- Process to be audited periodically and no less than monthly for six months for compliance by Executive Director of designee.

Date insufficiencies corrected by June 29, 2019

A122- Record Checks

Regulatory Insufficiency- The program failed to obtain evaluation from the DHS prior to employment if the record check process for child abuse registry indicated further research was required.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Staff D will have new background check and DHS evaluation completed

The following measures will be taken to ensure the problem does not recur:

- A new Interim Business Officer Manger is in place and will be trained and educated on the regulations and guidelines pertaining to timely background checks.

The program will monitor performance to ensure compliance as follows:

- Process to be audited periodically and no less than monthly for six months for compliance by Executive Director of designee.

Date insufficiencies corrected by June 29, 2019

A037- Evaluation of Tenant

Regulatory Insufficiency-The program failed to complete evaluations within 30 days of tenant occupancy.

Plan of Correction:
The insufficiencies will be corrected as follows:

- The program will evaluate and complete an initial evaluation on all tenants upon move in as well as 30 days after tenant admission. Tenants 2 and 3 have been updated.
- All resident will be evaluated upon admission and within 30 days of admission per our Policy and Procedure for Resident Service Plan- see attachment D.

The following measures will be taken to ensure the problem does not recur:

- Process to be audited periodically and no less than monthly for six months for compliance by Executive Director of designee.

Date Insufficiency to be corrected- June 29, 2019

A068- Tenant Documents

Regulatory Insufficiency- The program failed to obtain signed authorizations including release of medical information and media.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Tenants 1, 2 and 3 will complete all necessary authorizations including release of medical information and media release.

The following measures will be taken to ensure the problem does not recur:

- Workflow process has been changed to allow for authorizations and releases to be completed upon admission. In-service education will be provided to personnel assigned to this task

The program will monitor performance to ensure compliance as follows:

- Process to be audited periodically and no less than monthly for six months for compliance by Executive Director of designee.

Date insufficiencies corrected by June 29,2019

A071- Tenant Documents-

Regulatory Insufficiency- The program failed to ensure completion of nurse notes by exception.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The nurse will provide a detailed note of all related incidents as indicated by incident report form completion for tenant 2.
- Follow up on incidents related to change in condition or updated conditions as needed will also be provided by the nurse for tenant 3.

The Following measures will be taken to ensure the problem does not recur:

- Process to be audited periodically and no less than monthly for six months for compliance by Executive Director of designee.

Date Insufficiency to be corrected- June 29, 2019

A085- Service Plans

Regulatory Insufficiency- The program failed to update service plans within 30 days of admission.

Plan of Correction:

The insufficiencies will be corrected as follows:

- All Service plans will be reviewed and updated wit in 30 days of admission by the nurse. The service plans will be updated for tenants 1,2,3 to meet requirements. See attachment D.
- All evaluations and service plans, for all tenants, will be completed prior to move-in, within 30 days, with significant change, and minimally annually thereafter to ensure accuracy to meet the needs of each tenant

The following measures will be taken to ensure the problem does not recur:

- Program Nurse or designee will be notified by healthcare staff of any tenant needs not being met by their service plan through the EMR communication tool.
- Program Nurse or designee will follow-up on concerns with nursing assessment and potential interventions.

Date insufficiency to be corrected – June 29, 2019

A089- Service Plans

Regulatory insufficiency- The program failed to develop service plans to reflect the identified needs of the tenants.

The insufficiencies will be corrected as follows:

- Updated assessment will be completed for Tenant #1 to include appropriate interventions for identified needs.

The following measures will be taken to ensure the problem does not recur:

- *Resident Service Plan Policy and Procedure* (Attachment E) will be reviewed with healthcare staff at the June 19, 2019 scheduled in-service.
- Healthcare staff instructed to notify Program Nurse or designee of any tenant needs not being met by current service plan so appropriate follow-up and assessment can be completed.
- All evaluations and service plans, for all tenants, will be completed prior to move-in, within 30 days, with significant change, and minimally annually thereafter to ensure accuracy to meet the needs of each tenant.

The program will monitor performance to ensure compliance as follows:

- Program Nurse or designee will be notified by healthcare staff of any tenant needs not being met by their service plan through the EMR communication tool.
- Program Nurse or designee will follow-up on concerns with nursing assessment and potential interventions.

Date insufficiencies corrected by June 29, 2019