PARTMENT OF INSPECTIONS AND APPEALS

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0413 | A. BUILDING: _____ B. WING _____ | C 02/10/2022 |

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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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| A 000 | Initial Comments<br><br>Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site.<br><br>Memory Care Unit<br><br>Number of tenants without cognitive disorder: 2<br><br>Number of tenants with cognitive disorder: 4<br><br>TOTAL Census of Assisted Living Program for People with Dementia: 6<br><br>A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. An onsite infection control survey and Complaints #102062-C, 101743-C, 101741-C, 101740-C, 101739-C, 101738-C, 101728-C, 101988-C, 102087-C and 102112-C were also completed. The following regulatory insufficiencies were cited. | A 000 | | |
| A 105 | 481-67.2 Program Policies and Procedures<br><br>481-67.2 Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. | A 105 | | |

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| A 105 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the Program failed to follow established policy and procedure related to the COVID-19 pandemic. This potentially affected 6 of 6 tenants (Tenant #1 - #6). Finding follows:<br><br>Observations from 1/18-2/9/22 revealed staff failed to wear their masks appropriateley during the following dates and times:<br><br>a. 1/19/22 at 10:15 a.m. staff moved mask down to speak to the surveyor.<br>b. 1/19/22 at 10:43 a.m. staff placed on a mask when he noticed the surveyor.<br>c. 1/19/22 at 10:50 a.m. staff required reminders to social distance as he moved his mask down to speak to the surveyor.<br>d. 1/19/22 at 11:05 a.m. staff wore a mask that continued to fall below her nose.<br>e. 1/19/22 at 11:35 a.m. two staff stood side by side and one placed on a mask when she noticed the surveyor.<br>f. 1/19/22 from 11:10 a.m. - 11:34 a.m. as staff administered medications, she constantly readjusted her mask and allowed it to fall below her nose.<br>g. 1/19/22 at 11:34 a.m. staff at front failed to wear mask until she noticed the surveyor.<br>h. 1/25/22 at 11:35 a.m. staff in hallway failed to wear a mask until he noticed the surveyor.<br>i. 1/25/22 at 11:39 a.m. one staff failed to wear a mask in the dining room and one staff with her mask below her nose.<br>j. 1/25/22 at 1:35 p.m. staff entered the building, walked behind the front desk without a | A 105 | | |

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| A 105 | Continued From page 2 | A 105 | | |

mask, and placed on a mask after they noticed the surveyor.
k. 1/25/22 at 1:55 p.m. staff behind the front desk failed to wear a mask until she noticed the surveyor.
l. 1/25/22 at 2:05 p.m. staff walking towards front desk through the dining room, noticed the surveyor and stated, "I literally just threw out my mask" and continued to walk around the front desk area without a mask.
m. 1/25/22 at 2:11 p.m. staff behind the front desk failed to wear a mask and followed another staff to look at the daily assignment sheets. When the surveyor asked her what she should do she placed on her mask.
n. 1/26/22 at 11:55 a.m. staff in dining room failed to wear a mask until she noticed surveyor.
o. 1/26/22 at 12:05 p.m. two staff wore their masks below their noses.
p. 1/26/22 at 1:08 p.m. stood near a staff front desk with no mask on.
q. 1/26/22 at 1:10 p.m. two staff chatted with their masks below the nose and mouth.
r. 1/26/22 at 1:48 p.m. staff near the front door wore their mask below the nose and mouth.
s. 1/31/22 at 2:35 p.m. staff stood at the front desk and wore their mask below the nose and mouth.
t. 1/31/22 at 3:09 p.m. staff at front desk wore no mask within six feet of other staff.
u. 1/31/22 at 3:35 p.m. staff wore their mask below the nose and mouth.
v. 1/31/22 at 3:50 p.m. staff failed to wear a mask.
w. 2/1/22 at 10:50 a.m. staff wore their mask below the nose and mouth.
x. 2/1/22 at 12:45 p.m. staff walking through hallway and failed to wear a mask.
y. 2/7/22 at 3:40 p.m. two staff walked in hallway one failed to wear a mask until she

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| A 105 | Continued From page 3 | A 105 | | |

noticed the surveyor.
z. 2/8/22 at 11:55 a.m. staff wore mask below the nose and mouth.
aa. 2/9/22 at 1:38 p.m. staff failed to wear a mask.

Observations revealed staff failed to wear eye protection throughout the on site visit from 1/18 -2/10/22.

On 1/25/22 the Program nurse informed the surveyor four tenants in the memory care unit tested positive over the weekend. On 1/31/22 the nurse updated the COVID status with an additional tenant who tested positive.

Record review on 2/1/22 revealed the Program's COVID-19 Control Measures (revised 11/22/21). According to the policy, "anyone entering the facility must wear a facemask (cloth face covering is not to be utilized by HCP (Health Care Professionals)." Further review revealed, "for facilities residing in a county where the Community Transmission Level is substantial or high, employees providing services to residents must wear a face mask and eye protection."

When interviewed on 1/19/21, 1/25/21 and 1/26/21 the nurse confirmed all staff were required to wear masks while in the building and included the assisted living and memory care areas. When interviewed on 2/8/22 the Regional Clinical Director and Vice President of Operations - Assisted Living confirmed staff were required to wear masks at all times in the building.

Record review of the Centers for Disease Control and Preventions (CDC) COVID tracker data seven day metrics for 2/1/22 revealed the Program's county of residence noted a high rate

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| A 105 | Continued From page 4<br>of positivity. | A 105 | | |
| A 130 | 481-67.2(1)e Program Policies and Procedures<br><br>67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:<br><br>e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to complete incident reports as required. This potentially affected 6 of 6 tenants (Tenants #1 - 6) and 1 of 3 closed files reviewed (#C2). Finding follows:<br><br>Record review throughout the on site visit revealed the Program failed to produce incident reports for November and December 2021. When interviewed on 1/25/22 at 3:28 p.m. the Director said the only answer he could provide was there were no incident reports for those months. Further review revealed Monthly regional Clinical QA (Quality Assurance) Report for December noted Incidents/Accidents on 12/12/21, 12/11/21 and 12/12/21 but no incident reports could be provided.<br><br>Record review on 1/25/21 revealed #C2's Physician's notes dated 12/14/20 diagnosed a right hip fracture. According to the notes #C2 presented with hip pain. Further review revealed Genesis Hospice Interdisciplinary Group Notes | A 130 | | |

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| A 130 | Continued From page 5<br>dated 12/14/21 and completed by the Hospice Registered Nurse (RN) noted upon arrival the memory care unit manager met the RN in the hall and informed the RN #C2's when staff tried to get her into the wheelchair it was too painful.<br><br>When interviewed on 1/25/21 the Director said he didn't know if an IR was completed as he was not the Director until March 2021. He could not located IRs for January and February 2020. | A 130 | | |
| A 135 | 481-67.2(1)f Program Policies and Procedures<br><br>67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:<br><br>f. A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to ensure copies of completed incident reports were kept on file for three years. This potentially affected 6 of 6 tenants (Tenants #1-#6).<br><br>Record review throughout the on site visit revealed the Program failed to produce incident reports for November and December 2021.<br><br>When interviewed on 1/25/22 at 3:28 p.m. the Director said they only answer he could provide was there were no incident reports for those | A 135 | | |

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| A 135 | Continued From page 6<br>months. Further review revealed Monthly regional Clinical QA (Quality Assurance) Report for December which Incidents/Accidents on 12/12/21, 12/11/21 and 12/12/21 but no incident reports could be provided. | A 135 | | |
| A 140 | 481-67.2(2)a Program Policies and Procedures<br><br>67.2(2) The program's policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:<br><br>a. Reporting requirements for staff and employees<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to develop/implement policies for allegations of dependent adult abuse. This potentially affected 6 of 6 tenants (Tenants #1 - #6). Finding follows:<br><br>Record review on 2/8/22 revealed the Program's Abuse Prevention Program revised 2/2020. When interviewed on 2/8/22 the Regional Clinical Director indicated page 68 of this policy included the required information for dependent adult abuse. Further review revealed the policy failed to include the specific reporting requirements. | A 140 | | |
| A 145 | 481-67.2(2)b Program Policies and Procedures<br><br>67.2(2) The program's policies and procedures | A 145 | | |

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| A 145 | Continued From page 7<br>on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:<br><br>b. Requirements that the victim and alleged abuser be separated.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to develop/implement policies for allegations of dependent adult abuse. This potentially affected 6 of 6 tenants (Tenants #1 - #6). Finding follows:<br><br>Record review on 2/8/22 revealed the Program's Abuse Prevention Program revised 2/2020. When interviewed on 2/8/22 the Regional Clinical Director indicated page 68 of this policy included the required information for dependent adult abuse. Further review revealed the policy failed to include the requirement to separate the victim and the alleged abuser. | A 145 | | |
| A 160 | 481-67.3(2) Tenant Rights<br><br>481-67.3 Tenant rights. All tenants have the following rights:<br><br>67.3(2) To receive care, treatment and services which are adequate and appropriate.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the | A 160 | | |

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| A 160 | Continued From page 8<br><br>Program failed to ensure tenants received appropriate and adequate services in a timely manner. This affected 1 of 1 current tenants (Tenant #1) reviewed and potentially affected 6 of 6 tenants (Tenants #1- #6). Finding follows:<br><br>Record review revealed a nurses note for Tenant #1. According to the note, Tenant #1 needed assistance and when she responded she found a wound to Tenant #1's arm. When asked how staff would know Tenant #1 needed assistance, the nurse responded Tenant #1 would yell if she needed help. When questioned about the incident on 1/29/22 the nurse admitted only one staff person had been working. Record review on 2/3/22 revealed the Program's Accident, Incident and Medication Error Reporting policy dated October 2016. According to the policy the Program would provide safety checks as indicated in the tenant's service plan for tenants unable to use an emergency response pendant.<br><br>Record review of Tenant #1's service plan revealed the following information under safety, "Tenant #1 will be encouraged to call for assistance as necessary". She will remain in Betty's Garden so she can be monitored at all times.<br><br>When interviewed on 2/1/22 the Program Nurse said the tenants do not have or use a pendant for emergencies. She said they check on them every two hours for toileting. She could not provide documentation of the checks. In addition she could not provide system/program/staff procedures directing how to respond to the emergency needs of the tenants.<br><br>When interviewed on 2/1/22 the Program Nurse said Tenant #1 yells for help when she needs it. | A 160 | | |

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| A 160 | Continued From page 9<br><br>Further record review revealed a document entitled Incident Report Follow up Investigation provided by the Director. According to the report the Program's Nurse reviewed camera footage of the memory care unit and noted that Staff A "in the same spot for 2 hours prior to the incident."<br><br>Record review on 2/8/22 revealed the Program's Staffing policy dated 7/19/19. According to the policy dementia specific programs shall have one or more staff person who monitor tenants as indicated in the tenant's service plan. Staff are directed to check on tenants as indicated in the tenant's service plan. | A 160 | | |
| A 270 | 481-67.5(2)f(1) Medications<br><br>67.5(2) Each program shall follow its own written medication policy, which shall include the following:<br><br>f. When medications are administered traditionally by the program:<br><br>(1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). | A 270 | | |

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| A 270 | Continued From page 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to ensure medications were administered by staff who had successfully completed a department-approved medication aide/manager training/test. This pertained to 5 of 6 staff reviewed (Staff A, Staff B, Staff C, Staff D and Staff E). Finding follows:<br><br>Record review on 2/9/22 revealed documentation of staff's medication training revealed Staff A, B and C failed to complete a department-approved medication aide/manager training/test. Further review revealed Staff D and E failed to complete the course by the 3/1/21 as required. Records revealed the Program hired Staff D on 1/20/20 and she completed the course on 7/14/21. The Program hired Staff E on 8/2/11 and completed the course on 7/9/21.<br><br>Further review revealed the Program's Policy entitled Medication Management (10/16). According to the policy, administration and/or any portion of the medication process will be performed by licensed nurses or universal workers who have received delegation.<br><br>When interviewed on 2/8/22 the Program nurse confirmed three staff had not completed the department approved course and two had not completed it within required time frame. | A 270 | | |
| A 285 | 481-67.5(2)f(4) Medications<br><br>67.5(2) Each program shall follow its own written medication policy, which shall include the following: | A 285 | | |

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| A 285 | Continued From page 11<br>f. When medications are administered traditionally by the program:<br><br>(4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and record review the Program failed to ensure tenants received medications as prescribed. This affected 1 of 1 current tenants reviewed (Tenant #1). Finding follows:<br><br>Tenant 1's MAR included all meds (medications) passed per med minder. Examples include but are not limited to the following dates the staff failed to administer and/or document they administered medications per the med minder:<br>a. 12/1/21 - noon<br>b. 12/8/21 - noon<br>c. 12/10/21 - noon<br>d. 12/22/21 - evening<br>e. 12/27/21 - evening<br>f. 11/1/21 - morning and noon<br>g. 11/25/21 - evening<br>h. 11/28/21 - evening<br>i. 11/30/21 - evening<br><br>When interviewed on 2/8/22 the Program Nurse explained that she felt the errors were in staff documenting the task as completed. She confirmed staff should document when they administer or complete a task. | A 285 | | |
| A 135 | 481-69.22(1) Evaluation of Tenant | A 135 | | |

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| A 135 | Continued From page 12<br><br>69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to evaluate tenant functional, cognitive and health status prior to tenant signing the Occupancy agreement and taking occupancy. This affected 1 of 1 current tenants reviewed (Tenant #1). Finding follows:<br><br>Record review on 1/31/22 revealed Tenant #1's evaluations dated 8/19/21. Further review revealed Tenant #1's Occupancy Agreement dated 10/10/21. When interviewed the Program Nurse provided a document entitled Assisted Living Facility Initial Assessment dated 6/17/21. Review of the document revealed no scored objective cognitive evaluation and generic health information. When interviewed the Program Nurse said Tenant #1 had been receiving respite services from 6/1/21 - 10/1/21 when she became a tenant of the Program. | A 135 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|
| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

| (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 |
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| A 140 | Continued From page 13 | A 140 | | |
| A 140 | 481-69.22(2) Evaluation of Tenant<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program Nurse failed to complete evaluations within 30 days of occupancy. This affected 1 of 1 current tenants (Tenant #1) reviewed. Finding follow:<br><br>Record review on 1/31/22 revealed Tenant #1's evaluations were dated 8/19/21. Further review revealed Tenant #1's Occupancy Agreement dated 10/10/21. When interviewed the Program Nurse provided a document entitled Assisted Living Facility Initial Assessment dated 6/17/21. Review of the document revealed no scored objective cognitive evaluation and generic health information. When interviewed the Program Nurse said Tenant #1 had been receiving respite services from 6/1/21 - 10/1/21 when she became a tenant of the Program. She admitted she failed to complete 30 day evaluations. | A 140 | | |
| A 145 | 481-69.22(3) Evaluation of Tenant<br><br>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 | A 145 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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|---|---|---|---|---|
| A 145 | Continued From page 14<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to evaluate tenants' functional, cognitive and health status annually or with a significant change. This affected for 1 of 1 current tenants reviewed (Tenant #1). Findings follow:<br><br>Record review on 2/1/22 revealed Tenant #1's nurses notes dated 11/17/21. According to the entry Tenant #1 complained of right and left leg pain but could not tell the nurse if she had fallen. Further review of notes revealed no other notations regarding the tenants pain.<br><br>When interviewed on 2/1/22 the nurse admitted the tenant had been admitted to the hospital for the pelvic break. She provided a nurse review but failed to complete the required evaluations when the tenant returned to the Program. | A 145 | | |
| A 345 | 481-69.25(3) Tenant Documents<br><br>69.25(3) All records shall be protected from loss, damage and unauthorized use.<br><br>This REQUIREMENT is not met as evidenced | A 345 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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|---|---|---|---|---|
| A 345 | Continued From page 15<br>by:<br>Based on interview and record review the Program failed to ensure tenant records were protected from loss, damage and unauthorized use. This potentially affected 6 of 6 tenants (Tenants #1 - #6). Finding follows:<br><br>On 1/18/21 after Incident Reports (IR) were requested the nurse explained the Program could not locate IRs for November and December of 2021.<br><br>When interviewed on 1/25/22 at 3:28 p.m. the Director said the only answer he could provide was that there are no incident reports for those months. Further review revealed Monthly regional Clinical QA (Quality Assurance) Report for December which Incidents/Accidents on 12/12/21, 12/11/21 and 12/12/21 but no incident reports could be provided. | A 345 | | |
| A 360 | 481-69.26(3) Service Plans<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to update service plans within 30 days of occupancy and with significant changes. This affected 1 of 1 current tenants reviewed (Tenant #1). Finding follows: | A 360 | | |

DEPARTMENT OF INSPECTIONS AND APPEALS

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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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|---|---|---|---|---|
| A 360 | Continued From page 16<br><br>Record review on 2/1/22 revealed Tenant #1's nurses notes with an entry on 11/17/21. According to the entry Tenant #1 complained of right and left leg pain but could not tell the nurse if she had fallen. Further review of notes revealed no other notations regarding the tenants pain.<br><br>Further record review revealed Tenant #1's occupancy agreement was signed on 10/1/21. Tenant #1's service plan was dated 6/21/21.<br><br>When interviewed on 2/1/22 the nurse admitted the tenant had been admitted to the hospital for the pelvic break. She provided a nurse review but failed to update the service plan with a significant change. She confirmed she failed to update Tenant #1's service plan within 30 days of occupancy. | A 360 | | |
| A 520 | 481-69.29(2) Staffing<br><br>69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and record review the Program failed to have a system/program/staff procedures directing how to respond the emergency needs of the tenants. This affected 1 of 1 current tenants and potentially affected 6 of 6 tenants (Tenants | A 520 | | |

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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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| A 520 | Continued From page 17<br>#1-#6). Finding follows:<br><br>Record review revealed a nurses note for Tenant #1. According to the note, Tenant #1 needed assistance and when she responded she found a wound to Tenant #1's arm. When asked how staff would know Tenant #1 needed assistance, the nurse responded she would yell if she needed help. When questioned about the incident on 1/29/22 the nurse admitted only one staff person had been working. Record review on 2/3/22 revealed the Program's Accident, Incident and Medication Error Reporting policy dated October 2016. According to the policy the Program provided safety checks as indicated in the tenant's service plan for tenants unable to use an emergency response pendant.<br><br>Record review of Tenant #1's service plan revealed the following information under safety, Tenant #1 will be encouraged to call for assistance as necessary. She will remain in Betty's Garden so she can be monitored at all times.<br><br>Record review on 2/8/22 revealed the Program's Staffing policy dated 7/19/19. According to the policy dementia specific programs shall have one or more staff person who monitor tenants as indicated in the tenant's service plan. Staff are directed to check on tenants as indicated in the tenant's service plan.<br><br>When interviewed on 2/1/22 the Program Nurse said the tenants do not have or use a pendant for emergencies. She said they check on them every two hours for tolleting. She could not provide documentation of the checks. In addition she could not provide system/program/staff procedures directing how to respond to the | A 520 | | |

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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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| A 520 | Continued From page 18<br>emergency needs of the tenants.<br><br>When interviewed on 2/1/22 the Program Nurse said Tenant #1 yells for help when she needs it. Further record review revealed a document entitled Incident Report Follow up Investigation provided by the Director. According to the report the Program's Nurse reviewed camera footage of the memory care unit and noted that Staff A "in the same spot for 2 hours prior to the incident." | A 520 | | |
| A 530 | 481-69.29(4) Staffing<br><br>481-69.29(231C) Staffing.<br><br>69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans.<br><br>A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and record review the Program failed to include direction regarding tenants need to be monitored/checked in tenant service plans. This affected 1 of 1 | A 530 | | |

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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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| A 530 | Continued From page 19<br>current tenants reviewed (Tenant #1) and potentially 6 of 6 tenants (#1 - #6). Finding follows:<br><br>Record review on 1/21/22 revealed an entry in Tenant #1's nurses notes. According to the entry the caregiver in memory care notified the writer Tenant #1 in her room saying "help me, help me." The nurse documented Tenant #1 was taking off her shirt and the left long sleeve was adhered to skin on her left inner arm. No active bleeding noted. Wound estimated to be 2 to 2.5 centimeters. Wound cleansed with cleanser and saturated material/skin -loosened and material was taken off. Area was pink pink under the skin with no active bleeding/drainage. The nurse noted she observed subcutaneous tissue was coming out of the bed of the wound. She noted "fatty like" tissue was oozing out. Further review of an incident report dated 1/29/22 at 9:30 p.m. completed by Staff A revealed the following statement, "skin tear, I don't know what happened." The second page of the incident report could not be produced by the Program.<br><br>Record review of Tenant #1's service plan revealed the following information under safety, Tenant #1 will be encouraged to call for assistance as necessary. She will remain in Betty's Garden so she can be monitored at all times.<br><br>When interviewed on 2/1/22 the Program's Nurse confirmed Tenant #1 did not have a pendant but would "call out" for help when needed. She admitted the Tenant's service plan failed to include direction for staff to check on Tenant #1.<br><br>Record review on 2/8/22 revealed the Program's Staffing policy dated 7/19/19. According to the | A 530 | | |

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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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| A 530 | Continued From page 20<br>policy dementia specific programs shall have one or more staff persons who monitor tenants as indicated in the tenant's service plan. Staff are directed to check on tenants as indicated in the tenant's service plan. | A 530 | | |
| A 540 | 481-69.29(6) Staffng<br><br>69.29(6) All programs employing a new delegating nurse after January 1, 2010, shall require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training shall train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to ensure the delegating nurse completed the required training. This potentially affected 6 of 6 tenants (Tenants #1-#6). Finding follows:<br><br>When interviewed on 2/1/22 the delegating nurse explained she had three more videos to watch and was not given the opportunity for an in-person class. She could not provide documentation of the required training. | A 540 | | |

DEPARTMENT OF INSPECTIONS AND APPEALS

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| COURTYARD ESTATES AT WALCOTT - BETTY'S GAR | 510 NORTH MAIN STREET WALCOTT, IA 52773 |

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| A 840 | 481-69.39(1) Respite Care Services<br><br>69.39(1) Length of stay. Respite care services shall be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period. The 12-month period begins on the first day of the respite care individual's stay in the program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to ensure tenant respite stays were no longer than 30 consecutive days and for a no more than 60 days in a consecutive 12-month period. This affected 1 of 1 current tenants (Tenant #1). Finding follows:<br><br>Record review on 1/31/22 revealed Tenant #1's Occupancy Agreement (OA) dated 10/1/21. Further review revealed Tenant #1's face sheet/Resident Biographical Record indicated admit date as 6/18/21. Review of Tenant #1's Health and Functional Assessment (Evaluations) were completed on 8/19/21 and marked as 30 day evaluation. When interviewed the Program Nurse said Tenant #1 had received respite services prior to 10/1/21 (the date of the OA). Further review revealed a Respite/Recuperative stay contract for 6/18/21 - 7/18/21. When interviewed the Program Nurse said Tenant #1 had received Respite services until she became a tenant of the Program on 10/1/21.<br><br>When interviewed on 2/1/22 the Program Nurse confirmed Tenant #1 had utilized respite prior to her occupancy. | A 840 | | |

**Courtyard Estates of Walcott**

**510 N. Main St.**

**Walcott, Iowa 52773**

**573-284-4211**

Date: 2/10/22

Re: recert, Investigations #101728-C, 101738-C, 101739-C, 101740-C, 101741-C, 101743-C, 101988-C, 102062-C, 102087-C & 102112-C, and the onsite infection control visit

**A-105**

481-67.2 Program Policies and Procedures

481-67.2 Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Facility staff will follow policies and procedures in regards to Covid-19 Control Measures.

**2. Measures taken to ensure the problem does not recur.**

Staff was inserviced on Covid-19 Control Measures on 3/10/22

**3. How the Program plans to monitor performance to ensure compliance.**

Director or Designee will perform random rounds to monitor compliance with Covid-19 Control Measures.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

Courtyard Estates of Walcott--Betty's Garden

510 N. Main St.

Walcott, Iowa 52773

573-284-4211

Date: 2/10/22

Re: recert, Investigations #101728-C, 101738-C, 101739-C, 101740-C, 101741-C, 101743-C, 101988-C, 102062-C, 102087-C & 102112-C, and the onsite infection control visit

**A-130**

481-67.2(1)e Program Policies and Procedures

67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:

e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Wellness Director will review Staff Communication Report daily to ensure Incident Reports have been completed for all accidents or unusual occurrences that affect tenants

**2. Measures taken to ensure the problem does not recur.**

Staff was inserviced on the facility Accident, Incident and Medication Error Reporting policy on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Wellness Director and LPN monitor Staff Communication Report to ensure Incident Reports are completed as required for regulatory compliance.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

Courtyard Estates of Walcott—Betty's Garden

510 N. Main St.

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**A-135**

5 481-67.2(1)f Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:

f. A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years.

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.

Wellness Director will store Incident Reports in a safe manner for a minimum of three years

2. Measures taken to ensure the problem does not recur

Wellness Director was inserviced on retaining Incident Reports in a safe manner for a minimum of three years

3. How the Program plans to monitor performance to ensure compliance.

Incident Reports will be maintained in a binder in the Wellness Director office and randomly audited to include a minimum of three years reports by the Wellness Director or Designee

4. The date by which the regulatory insufficiency will be corrected.

3/10/22

Courtyard Estates of Walcott—Betty's Garden

510 N. Main St.

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**A-140**

481-67.2(2)a Program Policies and Procedures

67.2(2) The program's policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:

a. Reporting requirements for staff and employees

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Facility correct Dependent Adult Abuse Prevention, Identification, Investigation, and Reporting Policy was located and staff was inserviced

**2. Measures taken to ensure the problem does not recur.**

Staff was inserviced on Adult Abuse Prevention, Identification, Investigation, and Reporting Policy on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Director or Designee will perform random audits to monitor that upon initial employment, each employee shall be provided with a copy of the facility's policies and procedures relating to abuse identification and reporting requirements.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

**Courtyard Estates of Walcott-Betty's Garden**

**510 N. Main St.**

**Walcott, Iowa 52773**

**573-284-4211**

Date: 2/10/22

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**A-145**

481-67.2(2)b Program Policies and Procedures 67.2(2)

The program's policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:

b. Requirements that the victim and alleged abuser be separated.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Facility correct Dependent Adult Abuse Prevention, Identification, Investigation, and Reporting Policy was located and staff was inserviced

**2. Measures taken to ensure the problem does not recur.**

Staff was inserviced on Adult Abuse Prevention, Identification, Investigation, and Reporting Policy on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Director or Designee will perform random audits to monitor that upon initial employment, each employee shall be provided with a copy of the facility's Adult Abuse Prevention, Identification, Investigation, and Reporting Policy.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

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573-284-4211

Date: 2/10/22

Re: recert, Investigations #101728-C, 101738-C, 101739-C, 101740-C, 101741-C, 101743-C, 101988-C, 102062-C, 102087-C & 102112-C, and the onsite infection control visit

**A-160**

0 481-67.3(2) Tenant Rights

All tenants have the following rights:

67.3(2) To receive care, treatment and services which are adequate and appropriate.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Safety check will be determined based on the individual needs of each tenant and identified in the individual service plan for each tenant.

**2. Measures taken to ensure the problem does not recur.**

Staff was inserviced to provide appropriate and adequate services to each tenant based on individualized service plans on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Wellness Director or Designee will perform random audits to monitor staff compliance with safety checks per individualized service plans.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

Courtyard Estates of Walcott—Betty's Garden

510 N. Main St.

Walcott, Iowa 52773

573-284-4211

Date: 2/10/22

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**A-270**

481-67.5(2)f(1) 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:

(1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA)

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Medication Aides/Managers will have successfully completed a department-approved medication aide/manger training/test prior to providing medication administration.

**2. Measures taken to ensure the problem does not recur.**

Wellness Director was inserviced on successful completion of medication aides/managers department-approved training/test on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Wellness Director or Designee will perform random audits to monitor staff who have successfully completed medication aids/managers department-approved training/test prior to providing medication administration.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

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**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

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant and appropriately documented.

**2. Measures taken to ensure the problem does not recur.**

Licensed staff and certified medication managers were inserviced on facility Medication Policy and proper documentation of administered medications on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Wellness Director or Designee will perform random audits to monitor staff compliance with medication administration policy and procedure and proper documentation of administered medications.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

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**573-284-4211**

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**A-135**

481-69.22(1) Evaluation of Tenant

69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Facility RN will conduct an evaluation of prospective tenant's functional, cognitive and health status prior to the tenant signing the occupancy agreement and taking occupancy of a dwelling unit.

**2. Measures taken to ensure the problem does not recur.**

Wellness Director was inserviced prior occupancy evaluation required for regulatory compliance on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Director or Designee will perform random audits to monitor Registered Nurse completion of an evaluation of prospective tenant's functional, cognitive and health status prior to the tenant signing the occupancy agreement and taking occupancy of a dwelling unit.

**4. The date by which the regulatory insufficiency will be corrected.**

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**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.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Facility RN or delegate will conduct an evaluation of tenant's functional, cognitive and health within 30 days of occupancy.

**2. Measures taken to ensure the problem does not recur.**

Wellness Director was inserviced regarding functional, cognitive and health status evaluations required within 30 days of occupancy on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Director or Designee will perform random audits to monitor RN or delegate completion of tenant's functional, cognitive and health status evaluation within 30 days of occupancy.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

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Date: 2/10/22

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**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

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Facility Registered Nurse (RN) or delegate will conduct annual and significant change functional, cognitive and health status assessments per the required credentialed parameters for regulatory compliance.

**2. Measures taken to ensure the problem does not recur.**

Wellness Director was inserviced regarding functional, cognitive and health status evaluations requirements annually and upon significant change on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Wellness Director or Designee will perform random audits to monitor annual and significant change evaluation completion of tenant's functional, cognitive and health status.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

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**A-345**

481-69.25(3) Tenant Documents

69.25(3) All records shall be protected from loss, damage and unauthorized use.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Wellness Director will store Incident Reports in a safe manner for a minimum of three years

**2. Measures taken to ensure the problem does not recur.**

Wellness Director was inserviced on retaining Incident Reports in a safe manner for a minimum of three years on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Incident Reports will be maintained in the Wellness Director office with random audits performed to monitor for a minimum of three years reports by the Wellness Director or Designee

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

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**A-360**

481-69.26(3) 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

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Facility RN or delegate will update the service plan within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.

**2. Measures taken to ensure the problem does not recur.**

Wellness Director was inserviced on required service plan update within 30 days of occupancy and as needed with significant change, but not less than annually on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Wellness Director or Designee will perform random audits to monitor service plan updates for regulatory compliance.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

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**A-530**

481-69.29(4) Staffing 481-69.29(231C) Staffing.

69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans.

A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Safety check will be determined based on the individual needs of each tenant and identified in the individual service plan for each tenant.

**2. Measures taken to ensure the problem does not recur.**

Staff was inserviced to provide safety checks to each tenant based on individualized service plans on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Wellness Director or Designee will monitor staff compliance with safety checks per individualized service plans per random audit.

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22

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**A-540**

481-69.29(6) Staffng

69.29(6) All programs employing a new delegating nurse after January 1, 2010, shall require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training shall train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Wellness Director completed required class for regulatory compliance on 3/14/22.

**2. Measures taken to ensure the problem does not recur.**

Wellness Director was inserviced on required assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living 03/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Director or Designee will perform random audits to monitor completion of required assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living.

**4. The date by which the regulatory insufficiency will be corrected.**

3/14/22

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**A-840**

481-69.39(1) Respite Care Services 69.39(1)

Length of stay. Respite care services shall be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period. The 12-month period begins on the first day of the respite care individual's stay in the program.

**1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.**

Respite care services will not be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period.

**2. Measures taken to ensure the problem does not recur.**

Community Relations Coordinator was inserviced on regulatory compliance regarding Respite Care on 3/10/22.

**3. How the Program plans to monitor performance to ensure compliance.**

Director or Designee will perform random audits to monitor Respite Care Tenants occupancy dates and ensure not to exceed the regulatory guidelines

**4. The date by which the regulatory insufficiency will be corrected.**

3/10/22