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
	S0419	A. BUILDING: _____ B. WING _____	11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS AT PRAIRIE TRAIL	1275 SW STATE STREET ANKENY, IA 50023

(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: 34 Number of tenants with cognitive disorder: 2 Total census of Assisted Living Program: 36 The following regulatory insufficiencies were cited during the onsite infection control survey as well as the initial certification visit conducted to determine compliance with certification for an Assisted Living Program. The Program was encouraged to review recommended CDC and IDPH guidance regarding screening of tenants, visitors and staff, PPE (personal protective equipment usage by staff, and disposal of PPE and equipment used for COVID-19 positive tenants.	A 000		
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.	A 003	Plan of Correction is attached DD 12/16/20	

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

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to follow its policy and procedures regardng gloves and hand washing for 2 of 3 tenants observed during a medication pass (Tenants #4 and #6). Findings follow: When observed on 11-9-20 at approximately 11:55 a.m. Staff A administered medications to three tenants, including Tenant #4 and Tenant #6. Staff A completed hand washing in Tenant #6's apartment. She donned gloves and then retrieved a facial tissue for Tenant #6 from a drawer in a stand in the living area. She handed Tenant #6 the facial tissue and administered eye drops without doffing her gloves, completing hand hygiene and donning new gloves after touching a contaminated surface with a gloved hand. After the eye drops were administered, Staff A doffed the gloves and no hand hygiene was observed. Staff A went to Tenant #4's apartment to administer medications. She washed her hands in Tenant #4's kitchen and used a cloth towel located on the sink that was not a single use towel. After the medications were administered to Tenant #4 the staff rewashed her hands and used the same non-single use towel located on the sink. When interviewed on 11-20-20 at 1:43 p.m. the Program Director (nurse) said the expectation was that staff used hand sanitizer in apartments (unless hands were visibly soiled) and used the Program's sinks with automatic soap and paper towel dispensers for hand washing. The expectation regarding gloves was when the task was completed, the gloves were removed and	A 003		

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A 003	Continued From page 2 hand hygiene was completed. Review on 11-10-20 of the Program's Use of Gloves policy and procedure indicated to wash hands before applying gloves and to wash hands after removing gloves. The Handwashing policy and procedure indicated after washing hands to dry thoroughly using a single use towel and to use a towel to shut off the faucet.	A 003		
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 delegations within 30 days of employment for 2 of 6 staff reviewed (A and B). Findings follow: Review on 11-3-20 of Staff A's employment and training records revealed a hire date of 5-11-20. Nurse delegations documents were not found at the time of the onsite.	A 059		

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A 059	Continued From page 3 Review on 11-3-20 of Staff B's employment and training records revealed a hire date of 9-4-20. Nurse delegation documents were not found at the time of the onsite. The hire date for the Program Director (current delegating nurse) was 10-19-20. The delegations that were not found for Staff A and Staff B should have completed by a prior delegating nurse. On 11-10-20 at 1:43 p.m. the Program Director (nurse) revealed the delegations for Staff A and Staff B could not be located.	A 059		
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 document nurses' notes by exception for 2 of 5 tenants reviewed (Tenants #4 and #5). Findings follow: 1. On 11-10-20 review of Tenant #4's file	A 071		

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A 071	Continued From page 4 revealed Progress Notes dated 7-30-20 indicated staff responded to a pendant and found Tenant #4 on the floor with no injuries noted. The next entry in the Progress Notes was dated 10-15-20 which documented Tenant #4 returned to the Program. An evaluation form dated 10-14-20 indicated Tenant #4 returned to the Program following hospitalization and a stay at the skilled nursing facility (SNF). Nurses' notes were not documented indicating why Tenant #4 left the building or regarding the two month absence including a hospitalization and SNF stay. 2. On 11-10-20 review of Tenant #5's file revealed Progress Notes dated 8-6-20 indicated a fax was sent to the physician and a urinalysis (UA) was requested. Tenant #5 had complained of lower back pain and increased confusion was noted. The next entry in Progress Notes was dated 9-2-20. The entry indicated urine samples were collected for the UA ordered on 8-6-20 but both samples needed to resubmitted. Progress Notes dated 9-18-20 indicated Tenant #5 had increased confusion and anxiety and new orders were obtained including a UA. Progress Notes dated 10-29-20 reflect orders were received for UA with culture and sensitivity. On 10-30-20 Progress Notes indicated the UA returned with no new orders. Nurses' notes were not completed to follow up on UA orders for 8-6-20 and 9-18-20. 3. When interviewed on 11-10-20 at 2:09 p.m. the Program Director confirmed these findings.	A 071		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 084	Continued From page 5	A 084		
A 084	481-69.26(2) Service Plans 481-69.26(231C) Service plans. 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop a preliminary service plan prior to the occupancy agreement for 1 of 2 tenants reviewed admitted in the past six months (Tenant #4). Findings follow: Review of Tenant #4's file on 11-10-20 an admission date of 7-6-20. A preliminary service plan was dated 7-6-20. The Residency Agreement was signed on 7-1-20, which was prior to the development of the service plan. On 11-10-20 at 3:14 p.m. the Executive Director confirmed Tenant #4's Occupancy Agreement was signed on 7-1-20 which was prior to the development of the preliminary service plan.	A 084		
A 089	481-69.26(4)a Service Plans	A 089		

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A 089	Continued From page 6 481-69.26(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 preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans reflected the identified needs of 4 of 5 tenants reviewed (Tenants #2, #3, #4 and #5). Findings follow: 1. Review of Tenant #2's file on 11-10-20 revealed the service plan dated 10-14-20 indicated Tenant #2 received staff assistance with one medication. Staff administered the liquid medication for Tenant #2's hiatal hernia. Tenant #2 self-administered all other medications. When interviewed on 11-10-20 at 2:09 p.m. the Program Director said an outside home health agency set up Tenant #2's medications with the exception of a liquid medication. Staff administered the liquid medication. A Home Health Certification and Plan of Care document indicated Tenant #2 was prescribed a blood thinner - Clopidogrel 75 milligram (mg), one tablet daily. Progress Notes indicated Tenant #2 had eight incident notes regarding falls or near falls between 8-12-20 and 10-14-20. The service plan dated 10-14-20 did not reflect Tenant #2 was prescribed a blood thinner or that home health set up Tenant #2's medications.	A 089		

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A 089	Continued From page 7 2. Review of Tenant #3's file on 11-10-20 revealed the service plan dated 9-28-20 reflected assistance needed with hygiene and grooming. The service plan did not specify the type of assistance that was needed for hygiene and grooming. The service plan also indicated Tenant #3 received hospice services, but did not specify the services provided. On 11-10-20 at 2:09 p.m. the Program Director said hospice provided bathing assistance for Tenant #3. 3. Review of Tenant #4's file on 11-10-20 revealed the service plan dated 10-15-20 documented Tenant #4 had a medication machine in his apartment that was filled by family. The plan stated he was independent with medications. The service plan also reflected staff administered medications three or less times per day. The medication machine, which contained hydrocodone and aspirin was maintained by family. A Discharge Instructions For Care document (medication list) indicated Tenant #4 was prescribed Clopidogrel 75 mg, daily as well as Nitroglycerin as needed for chest pain. On 11-10-20 at 2:09 p.m. the Program Director confirmed staff administered Tenant #4's medications except Nitroglycerin, which he self-administered. The tenant's service plan did not provide clarity on who administered Tenant #4's medications. It also did not reflect Tenant #4 was prescribed blood thinner medication and Nitroglycerin. 4. Review of Tenant #5's file on 11-10-20	A 089		

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A 089	Continued From page 8 revealed Progress Notes dated 8-6-20 indicated a fax was sent to the physician and a urinalysis (UA) was requested. Tenant #5 had complained of lower back pain and increased confusion was noted. Progress Notes dated 9-18-20 indicated Tenant #5 had increased anxiety and confusion and new orders were obtained including a UA, increased Buspar to 20 mg at bedtime and an order for clonazepam to be taken as needed. The service plan dated 8-13-20 did not reflect increased confusion or interventions. 5. When interviewed on 11-10-20 at 2:09 p.m. the Program Director confirmed these findings.	A 089		

12/22/20

December 3, 2020

Department of Inspections and Appeals
Attn: Linda Kellen
Lucas State Office Building
321 East 12th St
Des Moines, IA 50319

Subject: Plan of Correction for Vintage Hills Assisted Living

There is currently a document being submitted to change the name from Vintage Hills at Prairie Trail Assisted Living to Independence Village Ankeny.

This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the Community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding.

Please accept the following Plan of Correction as outlined below:

A. ***481-67.2 Program policies and procedures***. The Program shall follow the policies and procedures established by a program. The Program will follow its policy and procedures regarding gloves and handwashing.

   1. ***Corrective Action***: Staff A was re-inserviced by the Program Director on 11/10/20.

   2. ***Measures to ensure the problem does not recur***: All staff were in-serviced regarding gloves and handwashing. This training was completed by 12/07/20.

   3. ***How the Program plans to monitor performance to ensure compliance:*** The Program Director (or designee) will complete two random "glove and handwashing" audits per month. The results will be submitted to the Quality Assurance committee for three months and determine if further monitoring is required.

   4. ***Date of Compliance***: Corrective action has been taken and completed on 12/07/20.

B. ***481-67.9(4)b Staffing.*** Nurse delegation will be completed within 30 days of employment.

   1. ***Corrective Action***: The delegations for Staff A and Staff B were completed by the current Program Director on 12/04/2020.

   2. ***Measures to ensure the problem does not recur***: The current Program Director was hired on 10/19/2020. She will complete new delegations for all staff by 12/17/20.

LDIX
12/16/20

3. ***How the Program plans to monitor performance to ensure compliance***: The Program Director or designee will audit all new Wellness employee files each month to ensure they have been delegated and submit the findings to the Quality Assurance committee. This will occur for three consecutive months to determine if further monitoring will be required.

4. ***Date of Compliance***: Corrective action has been taken and completed on 12/17/20.

C. ***481-69.25(i) Tenant Documents.*** The Program will document nurses' notes by exception.

1. ***Corrective Action***: The Program Director or designee completed late entry progress notes on Tenants #4 and #5 so that their documents were up to date and accurate.

2. ***Measures to ensure the problem does not recur***: The Program Director or designee will conduct a daily (Monday thru Friday) review of alerts in Point Click Care at stand up.

3. ***How the Program plans to monitor performance to ensure compliance***: The Program Director or designee will audit three tenant files each month and submit the findings to the Quality Assurance committee. The audit will review the findings for compliance. This will occur for three consecutive months to determine if further monitoring will be required.

4. ***Date of Compliance***: Corrective action has been taken and completed on 12/07/20.

D. ***481-69.26(2) Service Plans.*** The Program will develop a preliminary service plan prior to the occupancy agreement.

1. ***Corrective Action***: The Program Director involved with Tenant #4's Service Plan was terminated on 07/20/2020.

2. ***Measures to ensure the problem does not recur***: The Program Director or designee will audit all new Assisted Living admissions to ensure Service Plans are developed prior to signing the occupancy agreement and submit those findings to the Quality Assurance committee.

3. ***How the Program plans to monitor performance to ensure compliance***: The Quality Assurance committee will review all Assisted Living admissions to ensure a preliminary service plan was developed prior to occupancy. The Quality Assurance committee will monitor for three months to determine if further monitoring is required.

4. ***Date of Compliance***: Corrective action has been taken and completed on 12/03/20.

E. ***481-69.26(4)a Service Plans.*** The Program will ensure service plans reflect the identified needs of tenants.

1. ***Corrective Action***: The Program Director or designee updated the Service Plans for Tenants #2, #3, #4, and #5 on 11/10/20 to ensure they reflected their identified needs.

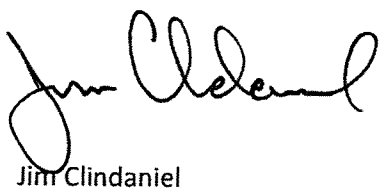
2. ***Measures to ensure the problem does not recur***: The Program Director or designee will audit three Service Plans to ensure they reflected the residents identified needs.

3. ***How the Program plans to monitor performance to ensure compliance***: The Program Director or designee will audit three Service Plans each month and submit the findings to the Quality Assurance committee. The audit will review the findings for compliance. This will occur for three consecutive months to determine if further monitoring will be required.

4. ***Date of Compliance***: Corrective action has been taken and completed on 12/03/20.

If you have any questions or concerns, please feel free to contact me at jclindaniel@independencevillages.com or (515) 639-2191.

Sincerely,



Jim Clindaniel
Executive Director