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 _____	C 11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF ANKENY AL	**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. General Population Program Number of tenants without cognitive disorder: 28 Number of tenants with cognitive disorder: 9 Total Population of Program at time of on-site: 37 TOTAL census of Assisted Living Program: 37 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program No regulatory insufficiencies were cited during the investigation of Complaints #107945-C. The following regulatory insufficiencies were cited during the investigation of Complaint #108196-C and Complaint #108349-C.	A 000	See Attached POC	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policies and procedures regarding incident reports, medication errors, and staff presence. This potentially affected 3 of 4 sample tenants (Tenant #1, Tenant #3 and Tenant #4) and potentially affected all 37 tenants residing at the Program.	A 150		

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

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A 150	Continued From page 1 Findings follow: 1. Review of incident reports during the visit revealed a lack of follow up from the Wellness Director and/or Executive Director. Examples included, but were not limited to: a. On 10/11/22 staff documented when they returned to the dining room, Tenant #4 was on the floor with her back against the wall. The tenant was bleeding from her head and was sent to the hospital. A visitor reported the fall to staff. The incident report provided no follow up from the Wellness Director or the Executive Director. b. On 10/13/22 staff documented Tenant #1 found in the garden with no clothing on. The incident report provided no follow up from the Wellness Director and/or the Executive Director The Incident/Accident Reporting policy directed upon completion of an incident report, the Wellness Director would review perform follow up as indicated. The incident report would then be sent to the Executive Director for review and follow up as appropriate. On 10/20/22 at 10:13 a.m. the Wellness Administrator confirmed these findings and acknowledged the lack of follow up on the incident reports. 2 . Record review revealed Tenant #3's Medication Administration Records (MAR) for May and June 2022 included an order for hydrocodone to be administered every six hours. The MAR listed administration times at 8:00 a.m., noon, 4:00 p.m., and 8:00 p.m. The narcotic count sheet for May and June 2022 noted days	A 150		

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A 150	Continued From page 2 the hydrocodone had been administered 1 1/2 to 3 hours apart. The Program's Medication Error policy listed failure to administer medication as ordered as a medication error. No medication error reports could be located. The Wellness Administrator confirmed these findings on 10/20/22 at 10:13 a.m. acknowledged the lack of follow up on the incident reports. On 11/3/22 at 11:44 a.m. the Regional Wellness Director stated the pharmacy entered the physicians orders on the MAR. The Regional Wellness Director confirmed the Program is ultimately responsible to ensure the orders are entered correctly.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate care, treatment, and services. This affected 1 of 4 sample tenants directly (Tenant #3) and potentially affected 37 of 37 tenants in the assisted living. Findings follow:	A 160		

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A 160	Continued From page 3 1. Record review of Tenant #3's medication administration records (MAR) revealed an order for 7.5-325 milligrams (mg) of hydrocodone/APAP to be administered every 6 hours for pain. The MAR listed 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. (every 4 hours) as the administration times. Review of the Narcotic Record revealed from 5/20/22-06/2/22 staff administered an additional dose of hydrocodone/APAP at 2:00 am (5 total doses daily) and failed to document as administered on the MAR. Additional review of the Narcotic Record from 5/19/22 - 6/2/22 revealed the following: a. On 5/19/22 staff administered the medication at 12:30 a.m., 3:30 a.m., 9:30 a.m., 10:40 a.m., 3:30 p.m., and 8:10 p.m. (six doses) b. On 5/21/22 staff administered an additional dose of hydrocodone/APAP 1.5 hours after a dose had been given. c. On 5/22/22 staff administered an additional dose of hydrocodone/APAP within three hours of the previous dose d. On 5/25/22 staff administered an additional dose of hydrocodone/APAP an hour and a half after the previous dose e. On 5/26/22 staff administered an additional dose of hydrocodone/APAP within two hours of the previous dose f. On 5/30/22 staff administered an additional dose of hydrocodone/APAP within 1.5 hours if the previous dose. When interviewed the family reported Tenant #3 seemed "out of it" some days, which was unusual for her.	A 160		

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A 160	Continued From page 4 On 11/3/22 at 11:44 a.m. the Regional Wellness Director stated the pharmacy entered the physician's orders on the MAR. They confirmed the Program is ultimately responsible to ensure the orders are entered and administered correctly. 2. The Program provided an email dated 10/12/22 from the Property Administrator to families informing them the pendant system was not working and hourly checks would be implemented and documented. Interviews with tenants and family members during the course of the visit revealed concerns related to lack of routine checks in case of a medical emergency related to history of falls, heart conditions, diabetes, and cognitive impairment. Interviews with two agency staff on 10/20/22 confirmed they received no training from the Program and were unaware the pendants were not working. The entrance form completed by the Program noted nine tenants with at least a moderate cognitive impairment. On 10/20/22 the Wellness Director relayed, via email, the Program had no policy developed to specifically address protocols when pendants did not work to ensure the safety of the tenants. He confirmed the safety checks were not documented.	A 160		
A 225	481-67.4(5) Program Notification to Department 481-67.4(231B,231C,231D) Program notification	A 225		

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A 225	Continued From page 5 to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(5) When a tenant attempts suicide, regardless of injury. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to report a suicide attempt to the Iowa Department of Inspections and Appeals (the Department) within 24 hours or next business day for 1 of 1 tenants reviewed with an attempted suicide (Tenant #4). Findings follow: Record review on 10/18/22 revealed Tenant #4's Progress Notes dated 9/1/22 documented she was observed in the street with her walker by a passerby. Tenant #4 reported to staff she was leaving because she did not want to be there anymore and planned on walking into traffic to end her life. She refused to return to the building and her daughter was notified. Tenant #4 agreed to leave with her daughter and went to psychiatric urgent care and was admitted. Continued record review failed to indicate the incident was reported to the Department. On 10/18/22 at 3:03 p.m. The Wellness Administrator confirmed these findings.	A 225		
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:	A 270		

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A 270	Continued From page 6 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). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed and passed a Department approved medication aide or medication manager course prior to administering medications. This pertained to 1 of 4 staff reviewed that administered medications. (Staff A). Findings follow: Record review of staff files on 10/18/22 revealed Staff A was hired 12/6/21. Documentation of training to administer medications could be located. On 10/18/22 at 10:34 a.m. the Wellness Coordinator confirmed Staff A administered medications and failed to obtain the required training and certification.	A 270		

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A 280	Continued From page 7	A 280		
A 280	481-67.5(2)f(3) 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: (3) The program shall maintain a list of each tenant's medications and document the medications administered. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document medications (meds) when administered. This pertained to 1 of 4 tenants reviewed (Tenant #3). Findings follow: Record review of Tenant #3's medication administration records (MAR) revealed an order for 7.5-325 milligrams (mg) of hydrocodone/APAP to be administered every 6 hours for pain. The MAR listed 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. (every 4 hours) as the administration times. Review of the Narcotic Record revealed from 5/20/22-06/2/22 staff administered an additional dose of hydrocodone/APAP at 2:00 am (5 total doses daily) and failed to document as administered on the MAR. On 11/3/22 at 11:44 a.m. the Regional Wellness Director stated the pharmacy entered the physicians orders on the MAR and confirmed the Program is ultimately responsible to ensure the orders are entered correctly.	A 280		

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A 285	Continued From page 8	A 285		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications (meds) according to doctors orders. This pertained to 1 of 4 tenants reviewed (Tenant #3). Findings follow: Record review of Tenant #3's medications administration records (MAR) revealed an order for 7.5-325 milligrams (mg) of hydrocodone/APAP to be administered every 6 hours for pain. The MAR listed 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. (every 4 hours) as the administration times. Review of the Narcotic Record revealed from 5/20/22-06/2/22 staff administered an additional dose of hydrocodone/APAP at 2:00 am (5 total doses daily) and failed to document as administered on the MAR. Additional review of the Narcotic Record from 5/19/22 - 6/2/22 revealed the following:	A 285		

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A 285	Continued From page 9 a. On 5/19/22 staff administered the medication at 12:30 a.m., 3:30 a.m., 9:30 a.m., 10:40 a.m., 3:30 p.m., and 8:10 p.m. (six doses) b. On 5/21/22 staff administered an additional dose of hydrocodone/APAP 1.5 hours after a dose had been given. c. On 5/22/22 staff administered an additional dose of hydrocodone/APAP within three hours of the previous dose d. On 5/25/22 staff administered an additional dose of hydrocodone/APAP an hour and a half after the previous dose e. On 5/26/22 staff administered an additional dose of hydrocodone/APAP within two hours of the previous dose f. On 5/30/22 staff administered an additional dose of hydrocodone/APAP within 1.5 hours if the previous dose. On 11/3/22 at 11:44 a.m. the Regional Wellness Director stated the pharmacy entered the physicians orders on the MAR and confirmed the Program is ultimately responsible to ensure the orders are entered and administered correctly.	A 285		
A 290	481-67.5(2)g Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policy and	A 290		

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A 290	Continued From page 10	A 290		

procedure regarding documentation and destruction of narcotic medications and report missing narcotics. This pertained to 1 of 1 tenants with orders for narcotics (Tenant #3). Findings follow:

1. Record review on 10/31/22 of the Narcotic Record count sheets revealed the following:

On 6/22/22 60 tablets of hydrocodone/APAP 5-325 milligrams (mg) were entered as received and none were administered. They were destroyed on 8/17/22.

On 6/28/22 60 tablets of hydrocodone/APAP 5-325 mg were entered as received and none were administered. They were destroyed on 8/17/22.

The Medication Administration Record (MAR) noted the hydrocodone/APAP 5-325 mg was discontinued and a new order for hydrocodone/APAP 7.5-325 mg started on 5/19/22.

Review of the Disposal of Discontinued Medication Policy stated discontinued medications would be destroyed within 30 days.

2. Record review on 10/31/22 of the pharmacy packing slips revealed the Program received 270 tablets of hydrocodone 5-325 mg on 5/16/22 at 6:32 p.m. and six tablets of hydrocodone 5-3.25 mg on 8/19/22 at 1:45 p.m.

The Narcotic Record count sheet dated 5/17/22 indicated 90 on hand, 7.5 tablets administered, 27.5 destroyed, and a new sheet started with the remaining 55 tablets. No count sheet with a starting count of 55 could be located.

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A 290	Continued From page 11 Continued review revealed on 6/22/22 and 6/28/22 60 tablets were entered as on hand and destroyed on 8/17/22. No count sheet for the remaining 60 of the 270 tablets could be located. No count sheet for the six tablets received 8/19/22 could be located. On 10/4/22 the Program emailed the pharmacy to acknowledge the missing 55 tablets. The Program indicated they would continue to look into it. Review of the Program's Controlled Substance and Preventing Drug Theft policy noted when the Program received a controlled substance it would be counted by two staff and added to the controlled substance count sheet. Further review revealed any missing narcotics would be reported to the police and the state licensing authority. The Program failed to follow it's policy to accurately document received narcotics and report the missing narcotics. The Regional Wellness Director confirmed these findings on 11/3/22 at 11:44 a.m.	A 290		
A 340	481-67.9(4)a 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: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained	A 340		

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A 340	Continued From page 12 and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program's newly hired Registered Nurse (RN) failed to provide training within 60 days of beginning employment to ensure staff were competent to meet the needs of the tenants. This pertained to 4 of 4 staff reviewed (Staff A, Staff C, Staff E and Staff F). Findings follow: Record review of staff files on 10/18/22 revealed the delegating RN was hired 5/9/22. 2. Staff A was hired 12/6/21 and no training from the new RN could be located. 3. Staff C was hired 3/30/21 and no training from the new RN could be located. 4. Staff E was hired 5/26/21 and no training from the new RN could be located. 5. Staff F was hired 7/15/21 and no training from the new RN could be located. On 10/18/22 at 10:34 a.m. the Wellness Coordinator confirmed these findings.	A 340		
A 345	481-67.9(4)b 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	A 345		

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A 345	Continued From page 13 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's Registered Nurse (RN) failed to provide training to staff within 30 days of hire to ensure staff were competent to meet the needs of the tenants. This pertained to 4 of 4 caregiver staff reviewed (Staff A, Staff C, Staff E and Staff F). Findings follow: Record review of staff files on 10/18/22 revealed the following: 1. Staff A was hired 12/6/21 and no training from the RN could be located. 2. Staff C was hired 3/30/21/21 and no training from the RN could be located. 3. Staff E was hired 5/26/21 and no training from the RN could be located. 4. Staff F was hired 7/15/21 and no training from the RN could be located. On 10/18/22 at 10:34 a.m. the Wellness Coordinator confirmed these findings.	A 345		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult	A 380		

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(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 380	Continued From page 14 abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed dependent adult abuse training as required by Iowa Code section 235B.16. This pertained to 4 of 7 staff reviewed (Staff A, Staff B, Staff C and Staff D). Findings follow: Chapter 235B.16 requires that employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every three years thereafter. A review of personnel records on 10/18/22 revealed the following: 1. Staff A was hired 12/6/21 and no dependent adult abuse training could be located. 2. Staff B was hired 3/28/19 and no dependent adult abuse training could be located. 3. Staff C was hired 3/30/21 and no dependent adult abuse training could be located. 4. Staff D was hired 12/1/21 and no dependent adult abuse training could be located. On 10/18/22 at 10:34 a.m. the Wellness Coordinator confirmed these findings.	A 380		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A	A 135		

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 _____	C 11/09/2022

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A 135	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluate the functional, cognitive, and health status prior to occupancy for 3 of 4 tenants reviewed (Tenant #1, Tenant #3, and Tenant #4). Findings follow: Record review on 10/19/22 of tenant files revealed the following: 1. Tenant #1 was admitted on 2/17/22. No cognitive assessment completed prior to occupancy could be located. 2. Tenant #3 was admitted on 5/16/22. No scored cognitive assessment completed prior to occupancy could be located. 3. Tenant #4 was admitted on 5/9/22. No functional, cognitive, and health assessments completed prior to occupancy could be located. The Wellness Coordinator confirmed these	A 135		

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A 135	Continued From page 16 findings on 10/20/22.	A 135		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to evaluate the functional, cognitive, and health status within 30 days of occupancy for 3 of 4 tenants reviewed (Tenant #1, Tenant #2, and Tenant #3). Findings follow: Record review on 10/19/22 of tenant files revealed the following: 1. Tenant #1 was admitted on 2/17/22. No functional, cognitive, and health assessments completed within 30 days of occupancy could be located. 2. Tenant #2 was admitted on 1/31/22 No functional, cognitive, and health assessments completed within 30 days of occupancy could be located. 3. Tenant #3 was admitted on 5/16/22. No functional, cognitive, and health assessments completed within 30 days of occupancy could be located.	A 140		

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A 140	Continued From page 17 The Wellness Coordinator confirmed these findings on 10/20/22.	A 140		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to evaluate the functional, cognitive, and health status as needed when a tenant exhibited a significant change in condition to determine continued eligibility for 4 of 4 tenants reviewed (Tenant #1, Tenant #2, Tenant #3, and Tenant #4). Findings follow: Record review on 10/19/22 of tenant Progress Notes revealed the following: 1. Tenant #1 eloped from the Program and required monitoring at all times for safety. A home health aide was hired to provide supervision for the overnight hours. No functional, cognitive, and	A 145		

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A 145	Continued From page 18 health assessments could be located for the change in services. 2. Tenant #2 returned from the hospital on 6/14/22 with a Foley catheter and would be removed at the follow up appointment. On 8/17/22 he required wound care on his back due to a biopsy procedure four days prior. No functional, cognitive, and health assessments could be located for these changes in health status. 3. Tenant #3 was admitted to hospice care on 9/21/22. No cognitive assessment could be located for this change in health status. 4. Tenant #4 managed her own medications upon admission and on 6/20/22 the Program took over medication administration. On 9/1/22 she walked into traffic and told staff she wanted to end her life. She was admitted for psychiatric treatment and returned on 9/16/22. No functional, cognitive, and health assessments could be located for these changes in health status. The Wellness Coordinator confirmed these findings on 10/20/22.	A 145		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 350		

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A 350	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans based on the required evaluations to meet the specific service needs for 2 of 4 tenants reviewed (Tenant #2 and Tenant #4). Findings follow: Record review on 10/19/22 of tenant files revealed the following: 1. Tenant #2 was admitted on 1/31/22 No functional, cognitive, and health assessments completed within 30 days of occupancy could be located. He returned from the hospital on 6/14/22 with a Foley catheter and to be removed at the follow up appointment. On 8/17/22 he required wound care on his back due to a biopsy procedure four days prior. No functional, cognitive, and health assessments could be located for these changes in health status. The tenant's service plan was not updated to meet his specific needs based on the required evaluations. 24. Tenant #4 was admitted on 5/9/22. No functional, cognitive, and health assessments completed prior to occupancy could be located. She managed her own medications upon admission and on 6/20/22 the Program took over medication administration. On 9/1/22 she walked into traffic and told staff she wanted to end her life. She was admitted for psychiatric treatment and returned on 9/16/22. No functional, cognitive, and health assessments could be located for these changes in health status. The Program failed to update the tenant's service plan to reflect her change in condition and based on the required assessments to meet her specific needs.	A 350		

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A 350	Continued From page 20 The Wellness Coordinator confirmed these findings on 10/20/22.	A 350		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans prior to admission and/or failed to obtain the required signatures for 4 of 4 tenants reviewed (Tenant #1, Tenant #2, Tenant #3, and Tenant #4). Findings follow: Record review on 10/19/22 of tenant files revealed the following: 1. Tenant #1 was admitted on 2/17/22. The Service Plan dated 2/17/22 failed to be signed by her representative or Program staff. 2. Tenant #2 was admitted on 1/31/22. The Service Plan dated 1/31/22 failed to be signed by him or Program staff.	A 355		

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A 355	Continued From page 21 3. Tenant #3 was admitted on 5/16/22. The Service Plan was created on 5/23/22 and signed by her representative and Program staff on 5/24/22. 4. Tenant #4 was admitted on 5/9/22. The Service Plan was created on 4/27/22 and signed by her representative and Program staff on 5/26/22. The Wellness Coordinator confirmed these findings on 10/20/22.	A 355		
A 370	481-69.26(3)a 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. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans and obtain the required signatures after a significant change in condition for 4 of 4 tenants reviewed (Tenant #1, Tenant #2, Tenant #3, and Tenant #4). Findings follow: Record review on 10/19/22 of tenant Progress Notes revealed the following: 1. Tenant #1 eloped from the Program and required monitoring at all times for safety. A home	A 370		

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A 370	Continued From page 22 health aide was hired to provide supervision for the overnight hours. The Program failed to update Tenant #1's service plan to reflect the change in services and failed to obtain required signatures for the change. 2. Tenant #2 returned from the hospital on 6/14/22 with a Foley catheter and would be removed at the follow up appointment. On 8/17/22 he required wound care on his back due to a biopsy procedure 4 days prior. The Program failed to update Tenant #2's service plan to reflect the change in services and obtain the required signatures. 3. Tenant #3 was admitted to hospice care on 9/21/22. The Program failed to obtain signatures for the update to the Tenant #3's service plan. 4. Tenant #4 managed her own medications upon admission and on 6/20/22 the Program took over medication administration. On 9/1/22 she walked into traffic and told staff she wanted to end her life. She was admitted for psychiatric treatment and returned on 9/16/22. The Program failed to update Tenant #4's service plan to reflect the change in services and obtain the appropriate signatures following the change. The Wellness Coordinator confirmed these findings on 10/20/22.	A 370		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall	A 430		

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A 430	Continued From page 23 provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure comprehensive nurse reviews were completed every 90 days or as needs changed for 2 of 4 tenants reviewed (Tenant #1, and Tenant #3). Findings follow: Record review on 10/19/22 of tenant files revealed the following: 1. Tenant #1 was admitted on 2/17/22 and her service plan dated 2/17/22 documented she required assistance with activities of daily living and medication administration. No quarterly nurse reviews documenting and/or assessing her health status since admission could be located. 2. Tenant #3 was admitted on 5/16/22 and required assistance with activities of daily living and medication administration. No quarterly nurse reviews documenting and/or assessing her health status since admission could be located. The Wellness Coordinator confirmed these findings on 10/20/22.	A 430		
A 520	481-69.29(2) Staffing 69.29(2) In lieu of providing access to a personal	A 520		

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A 520	Continued From page 24 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). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program served at least one tenant with a cognitive impairment and failed to develop written procedures to address how to respond to emergency needs. This potentially affected 37 of 37 tenants at the Assisted Living Program. Findings follow: On 10/13/22 during the on-site visit the Wellness Director informed the surveyor the pendant system failed to work due to the Internet being down the past few days. The Program provided an email dated 10/12/22 from the Property Administrator to families informing them the pendant system was not working and hourly checks would be implemented and documented. Interviews with several tenants and family members at various days/times expressed concerns related lack of routine checks in case of a medical emergency related to history of falls, heart conditions, diabetes, and cognitive impairment. Interviews with 2 agency staff on 10/20/22 confirmed they received no training from the Program and were unaware the pendants had not been working.	A 520		

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A 520	Continued From page 25 The entrance form completed by the Program noted nine tenants with at least a moderate cognitive impairment. On 10/20/22 the Wellness Director confirmed by email the Program had no policy developed to specifically address when pendants were not working. He reported 9 tenants had some type of moderate to severe cognitive impairment.	A 520		
A 525	481-69.29(3) Staffing 69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure temporary agency staff received appropriate training. This affected 2 of 2 temporary staff reviewed and pertained to all temporary staff utilized by the Program since May 2022. Findings follow: Interviews with two agency staff on 10/20/22 confirmed they received no training from the Program and were unaware the pendant system had not been working. On 10/19/22 the Wellness Administrator confirmed no training was delegated to any of the temp staff employed since May 2022. He stated he assumed they received the appropriate training from their agency.	A 525		

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
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VIOLATION	HOW COMPLIANCE WILL BE ACHIEVED, MEASURE(S) TO ENSURE THE PROBLEM DOES NOT RECUR, AND PLAN TO MONITOR PERFORMANCE. OUTLINE WHO IS RESPONSIBLE FOR EACH MEASURE.	TIMELINE
A 150 481-67.2(3) PROGRAM POLICIES AND PROCEDURES 67.2(3) The program shall follow the policies and procedures established by the program. Regarding incident reports, medication errors, and staff presence.	**Achieve Compliance:** All incident reports and medication errors will be documented on appropriate forms and filed in designated binders within the Wellness office. On-Call Wellness Staff in place 24/7, between on site presence and triage call number to ensure proper handling of above stated occurences. Shift task sheets implemented to ensure staff presence for all shifts. **Prevent Recurrence:** Review of all incident reports and medication error forms, to ensure proper use and documentation to be completed no less than once weekly by lead care staff or RCS/WTS. Shift task sheets turned in to RCS/WTS daily for review. **Monitor:** Wellness Administrator or other staff nurse to complete monthly review of incident report, medication error binders, and communicate with RCS/WTS in regards to shift staffing to ensure compliance.	24/7 Nurse Triage implemented and ongoing since 9/1/22. Updated medication error form and binder re-implemented 3/1/23. Incident report form usage is ongoing-binder put together and re-implemented 12/1/22. Shift task sheets re-implemented 3/21/23.
A 160 481-67.3 TENANT RIGHTS 481 67.3 Tenant Rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. Regarding MAR, narcotic administration, order confirmation, notification of families, and safety checks.	**Achieve Compliance:** Additional training regarding eMAR usage and narcotic administration will be provided to all staff administering medications. Dual sign off with individualized signatures for all medication managers will be required in eMAR, as well as, original paper narcotic logs in the med cart binders. Wellness Administrator and staff nurses to receive additional training in regards to order confirmation and verification of pharmacy initiated orders. Procedure and document for completing safety checks implented for when emergency pendant system is not working trained to community staff. **Prevent Recurrence:** eMAR and narcotic adminstration audits will be completed weekly by lead care staff or RCS/WTS. Coaching and additional eMAR training provided to medication managers as needed to maintain compliance. In the event that emergency pendants are not working, safety checks will be implemented within 1 hour of notification of system failure and repeated hourly until system is in working order. Documentation of said safety checks will be submitted to RCS/WTS and/or Wellness Administrator or staff nurse daily. **Monitor:** Wellness Administrator or staff nurse to ensure weekly reviews of eMAR and narcotic administration are completed by care staff or RCS/WTS. Wellness Administrator or staff nurse to complete monthly review of all dual signatures paper and eMAR for discrepancies. In the event of of emergency pendant system not working Wellness Adminstrator or staff nurse to review safety check documentation daily.	Current staff training and delegations- with specific focus on narcotics completed prior to 12/1/23. New hire training and delegations are ongoing. PCC eMAR training made available via Relias and Smartsheet webite as well. Hourly check sheets and procedure re-trained to staff 1/19/23. Monthly reviews of dual signatures and narcotic binders implemented 3/1/23.
A 225 481-67.4(5) PROGRAM NOTIFICATION TO DEPARTMENT 481-67.4(231B, 231C, 231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(5) When a tenant attempts suicide, regardless of injury.	**Achieve Compliance:** Review of DIA regulations completed with all management staff. Reportable Incidents Tool created and available on Community Compliance Sharepoint. All major incidents will be reported, first to Regional Wellness Director within 24 hours of incident and then to DIA also within 24 hours, or the next business day, by the most expeditious means available. **Prevent Recurrence:** Morning Stand Up meetings held at the community every Monday-Friday with all incidents and safety concerns discussed. **Monitor:** Wellness Administrator, staff nurse, or RCS/WTS present in every Morning Stand Up meeting to ensure proper reporting/documentation of incidents is completed.	Review of DIA regulations and expectations for reporting completed 1/19/23. Morning Stand Up meetings are ongoing Monday-Friday.

A 270 481-67.5(2)f(1) MEDICATION 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. **A 280 481-67.5(2)f(3) MEDICATION A 280 481-67.5(2)f(3) MEDICATION A 285 481-67.5(2)f(4) MEDICATION**	**Achieve Compliance:** Additional training regarding eMAR usage and narcotic administration will be provided to all staff administering medications. Dual sign off with individualized signatures for all medication managers will be required in eMAR, as well as, original paper narcotic logs in the med cart binders. Wellness Administrator and staff nurses to receive additional training in regards to order confirmation and verification of pharmacy initiated orders. Review of all current employee medication manager certificates and delegations. New Hire Orientation schedule implemented to ensure all new staff have completed med manager certification and delegations prior to working independently on med administration. **Prevent Recurrence:** eMAR and narcotic adminstration audits will be completed weekly by lead care staff or RCS/WTS. Coaching and additional eMAR training provided to medication managers as needed to maintain compliance. RCS/WTS/ Wellness Administrator review of new employee status prior to orientation completion and being scheduled to work independently within the community. **Monitor:** Wellness Administrator or staff nurse to ensure weekly reviews of eMAR and narcotic administration are completed by care staff or RCS/WTS. Wellness Administrator or staff nurse to complete monthly review of all dual signatures paper and eMAR for discrepancies. Wellness Administrator or staff nurse to review and update employee certification information quarterly to maintain compliance.	Dual sign in PCC eMAR implemented 12/1/22. Review of eMAR and med cart binders implemented 3/1/23. Additional training and delegations for current staff completed prior to 12/1/22. Current staff documentation/certificate audit completed in December 2022. New Hire training schedule and reviews implemented for all new hires after 1/1/23.
A 290 481-67.5(2)g MEDICATION g. Narcotics protocol, including destruction and reconcilliation, shall be determined by the program's registered nurse.	**Achieve Compliance:** Dual signatures will be required for receipt of narcotics and administration on original paper narcotic logs in the med cart binder and in eMAR with individualized signatures for all medication managers and nurses. Narcotic count at the beginningand end of each shift with 2 staff members to be continued and documented in med cart binders. Medication and Narcotic disposition binder to be maintained in Wellness office. Wellness Administrator and staff nurses to receive additional training in regards to order confirmation, verification of pharmacy initiated orders, and applying dual signature documentation for eMAR administration. **Prevent Recurrence:** Dual signature requirement trained to all medication managers and staff nurses. Review of med cart binders, eMAR adminstration record and disposition binder completed weekly by Lead staff/RCS/WTS. Dual signature requirement trained to all medication managers and staff nurses. **Monitor:** Wellness Administrator or staff nurse to complete monthly review of med cart binders, eMAR adminstration record and disposition binder to ensure compliance.	Dual sign for receipt of narcotics is ongoing. Medication disposition binder implemented 1/1/23. Reviews of med cart binders and eMAR administration record weekly implemented 3/20/23.
A 340 481-67.9(4)a STAFFING a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. **A 345 481-67.9(4)b STAFFING** b. Within 30 days of beginning employment, all program staff shall received straining by the program's registered nurse(s). **A 380 481-67.9(6) STAFFING** Dependent Adult Abuse Training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16	**Achieve Compliance:** Review of all current employee medication manager certificates, delegations and adult dependant abuse certificate. New Hire Orientation schedule implemented to ensure all new staff have completed medication manager certificates, delegations and adult dependant abuse certificate prior to working independently in the community. New Wellness Adminstrator onboarding to include delegation of all staff within initial 60 days of employment. **Prevent Recurrence:** Review of delegations and additional eMAR training provided to all medication managers as needed to maintain compliance. RCS/WTS/ Wellness Administrator review of new employee status prior to orientation completion and being scheduled to work independently within the community. Regoinal Wellness Director review Wellness Adminstrator delegations within initial 60 days of employment. **Monitor:** Quarterly reviews of all Wellness employee files by RCS/WTS, staff nurses, Wellness Administrator and Regional Wellness DIrector to ensure certifications/delegations are complete and up to date to maintain compliance.	Current staff training and delegations- with specific focus on narcotics completed prior to 12/1/23. New hire training and delegations are ongoing. New Hire training schedule and reviews implemented for all new hires after 1/1/23. PCC eMAR training made available via Relias and Smartsheet webite as well. Current staff documentation/certificate audit completed in December 2022.

A 135 481-69.22(1) EVALUATION OF TENANT **A 140 481-69.22(2) EVALUATION OF TENANT** **A 145 481-69.22(3) EVALUATION OF TENANT**	**Achieve Compliance:** Assessment of health, cognitive, and functional to be completed pre-move in, 30 day post admission, with significant change, and annually. Wellness Form 7 used for health and functional and SLUMS and BCRS used for cognitive. Evaluations will be completed and documented in Point Click Care and recurring schedules set. **Prevent Recurrence:** Pre-move in asessments completed and follow up communication is sent to community prior to resident taking occupancy. Upon occupancy, a 30 day assessment date is established. Annual schedule is initiated after 30 day is completed. Significant change are initiated and tracked by staff registered nurses. Community wellness team to hold weekly meeting regarding all residents and addressing concerns/significant changes that have occured. Level of Care tracking tool implemented to reflect current resident and evaluation dates. **Monitor:** Wellness Administrator/staff nurses to review and maintain evaluation schedule monthly to ensure compliance.	Level of care audit completed for all residents February 2023. Evaluation schedules updated for all residents.
A 350 481-69.26(1) SERVICE PLANS **A 355 481-69.26(2) SERVICE PLANS** **A 370 481-69.26(3)a SERVICE PLANS**	**Achieve Compliance:** Audit of all residents level of care and service plans to be completed to reflect current needs/services with signatures from resident/respresentative and community staff obtained. Prior to admission of all residents service plans will be reviewed and signed. All service plan changes to be documented within 72 hours of the change. Service plan binder to be kept in Wellness office for review and signatures from all Wellness staff. **Prevent Recurrence:** Community Wellness team to hold weekly meeting regarding all residents and addressing concerns/service plan changes. Level of care tracking tool to be reviewed monthly. Move in momentum tool used for all new move ins to ensure documentation is received and service plan is agreed upon/signed prior to admission. **Monitor:** Wellness Administrator/Staff Nurse to review level of care tracking tool and service plan binder atleast monthly to ensure accuracy and compliance.	Level of care audit completed for all residents February 2023. Evaluation schedules updated for all residents. Care conferences and Service plans updated at this time as well.
A 430 481-69.27(1) NURSE REVIEW	**Achieve Compliance:** Evaluations will be completed and documented in Point Click Care and recurring schedules set. Iowa Major Nurse Review completed every 90 days per individual residents evaluation schedule. **Prevent Ruccurence:** Monthly monitoring of evaluation schedules to be completed to ensure compliance. Wellness office calendar to be used for due dates of reviews. **Monitor:** Evaluation schedule in Point Click Care to be reviewed at the beginning of each month by Wellness Adminstrator/ staff nurses to determine which residents are due and ensure compliance.	Level of care audit completed for all residents February 2023. Evaluation schedules updated for all residents. Care conferences and Service plans updated at this time as well.
A 520 481-69.29(2) STAFFING **A 520 481-69.29(3) STAFFING**	**Achieve Compliance:** Training checklist implemented for all new and agency staff to be completed during their initial shift in the community. Procedure and document for completing safety checks implented for when emergency pendant system is not working trained to community staff. **Prevent Recurrence:** In the event that emergency pendants are not working, safety checks will be implemented within 1 hour of notification of system failure and repeated hourly until system is in working order. Documentation of said safety checks will be submitted to RCS/WTS and/or Wellness Administrator or staff nurse daily. Completed training checklists to be stored in employee files. **Monitor:** Wellness Administrator or staff nurse to ensure weeklyIn the event of of emergency pendant system not working Wellness Adminstrator or staff nurse to review safety check documentation daily. RCS/WTS/Wellness Administrator to review training checklist is completed for all new hires and agency staff.	Current staff training and delegations- with specific focus on narcotics completed prior to 12/1/23. New hire training and delegations are ongoing. New Hire training schedule and reviews implemented for all new hires after 1/1/23. Current staff documentation/certificate audit completed in December 2022. Hourly check sheets and procedure re-trained to staff 1/19/23.