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 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF ANKENY AL	1275 SW STATE STREET ANKENY, IA 50023

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A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 31 Number of tenants with cognitive impairment: 4 Total census: 35 The following regulatory insufficiencies were cited during the investigation of ComplaintS #113886-C and 114057-C.	A 000	See Attached POC 12/31/23	
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 consistently follow established policy/procedure for incident reports. This pertained to 1 of 4 reviewed (Tenant #2). Findings follow: Review of Incident Reports (IR) during the visit revealed lack of follow up from the Wellness Director and/or Executive Director. Eamples included, but were not limited to: On 6/26/23 staff documented they responded to Tenant #2's pendant and found him on the floor. Tenant told staff he hit his head on the dresser.	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 The IR provided no follow up by the Wellness Director or Executive Director. On 4/22/23 staff documented they found Tenant #2 on floor outside his apartment. The IR provided no follow up by the Wellness Director or Executive Director. On 4/28/23 staff documented they found Tenant #2 laying across his bed and needed help up. The IR provided no follow up by the Wellness Director or Executive Director. On 6/24/23 staff documented they responded to Tenant #2's pendant to find him on the floor next to his chair. Review on 7/25/23 of the Program's Incident Reporting policy revealed the policy directed upon completion of the IR, the Wellness Director would do follow up and indicated. The IR would be sent to the Executive Director for review and follow up as needed. During the exit on 7/25/23 the administrative team acknowledged the Program failed to follow policy for incident reporting.	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:	A 160		

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A 160	Continued From page 2 Based on interview and record review the Program failed to consistently ensure tenants received care, treatment and services which were adequate and appropriate. This pertained to 3 of 4 tenants reviewed (Tenant #1, Tenant #2, and Tenant #4). Finding follows: Record review on 7/24/23 of Tenant #1's Progress notes revealed on 7/3/23 the nurse entered a note of Tenant #1's INR (international normalized ratio) was 2.5 and to continue Coumadin 6 mg daily and recheck in one week. Further review of Tenant #1's Medication Administration Record (MAR) revealed no notation on 7/10/23 of an INR recheck. On 7/13/23 the nurse noted a recheck of Tenant #1's INR with his new machine. The INR measured 2.8 and the nurse contacted a service line and metro Geriatrics. Further review revealed a note at 5:00 p.m. that Warfarin (Coumadin) 5 mg and 1 mg were not in the medication cart. An additional entry noted Trazadone 5 mg was not available on the medication cart. Further review revealed an entry on 7/14/23 for a new order Coumadin 5.5 mg daily, recheck INR 7/19/23. An entry on 7/23/23 noted that 1/2 tablet .5mg of Coumadin unavailable. During the exit on 7/25/23 the administrative team acknowledged they had provided all available documentation. Record review on 7/24/23 revealed Tenants #1, #2 and #4's service plans included under home management the following - housekeeping provided on scheduled days. During the on-site visit staff confirmed the Program had not had a housekeeper for many months and cleaning had been completed by them. They said they did not have time to complete cleaning therefore it went undone. On 7/20/23 a family member approached the surveyor to point out the Program	A 160		

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A 160	Continued From page 3 failed to complete weekly cleaning as they had promised before her mother moved into the Program. During the exit on 7/25/23 the administrative team acknowledged the Program failed to complete housekeeping as agreed.	A 160		
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 consistently administer medications as ordered. This pertained to 1 of 4 tenants reviewed (Tenant #1). Finding follows: Record review on 7/24/23 revealed Tenant #1's Progress notes. Record review revealed a note from 7/13/23 Warfarin (Coumadin) 5 mg and 1 mg not in the medication cart. An additional entry noted Trazadone 5 mg not available on the medication cart. Further review revealed an entry on 7/14/23 for a new order Coumadin 5.5 mg daily. An entry on 7/23/23 noted 1/2 tablet .5mg of Coumadin unavailable. During the exit on 7/25/23 the administrative team acknowledged they had provided all available documentation of medications.	A 285		

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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 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 delegating nurse failed to consistently ensure staff were sufficiently trained within 60 days of her employment. This pertained to 1 of 4 staff reviewed (Staff D). Finding follows: Record review on 7/24/23 revealed the delegating nurse failed to complete a review to ensure Staff D had been sufficiently trained and competent in all tasks. According to documentation Staff D had been delegated on 8/30/21. According to the Program Entrance form the interim delegating nurses were hired on 9/21 and 10/22. When interviewed on 7/24/23 at 12:05 p.m. the Regional Wellness Director confirmed the Program had provided all training documentation for staff.	A 340		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified	A 345		

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A 345	Continued From page 5 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's delegating nurse failed to consistently ensure staff were trained to meet the individual needs of the tenants. This pertained to 1 of 4 staff reviewed (Staff A). Finding follows: Record review on 7/19/23 revealed the Program hired Staff A on 4/3/23. Further review revealed no documentation of nurse delegation. When interviewed on 7/24/23 at 12:05 p.m. the Regional Wellness Coordinator confirmed the Program had provided all employee training documents.	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 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 consistently ensure staff received Dependent Adult Abuse training as required. Chapter 235B.16 requires that	A 380		

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A 380	Continued From page 6 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. This pertained to 2 of 4 staff reviewed (Staff A and D). Finding follows: Record review on 7/19/23 revealed no certificate of Dependent Adult Abuse (DAA) training for Staff A. Further review revealed the Program hired Staff D on 5/7/21 and she completed DAA training on 1/3/22 (not within six months). When interviewed on 7/24/23 at 12:05 p.m. the Regional Wellness Director confirmed the Program had provided all documentation of staff DAA training.	A 380		
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 consistently complete evaluations within 30 days of occupancy. This pertained to 2 of 4 tenants reviewed (Tenant #1 and #4). Finding follows: Record review on 7/24/23 revealed Tenant #1's	A 140		

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A 140	Continued From page 7 initial evaluations completed on 6/1/22. Further review revealed the Program failed to complete 30-day evaluations for Tenant #2. Record review on 7/24/23 revealed Tenant #4's a wellness evaluation completed on 4/22/22. The Program failed to complete cognitive evaluation prior to occupancy and health, functional and cognitive evaluations within 30 days of occupancy. During the exit on 7/25/23 the administrative team acknowledged the Program failed to complete 30-day evaluations or could not produce documentation to support the evaluation was done.	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	A 145		

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A 145	Continued From page 8 Program failed to consistently complete evaluations as needed but with a significant change and not less than annually. This pertained to 2 of 4 tenants reviewed (Tenant #2 and #3). Findings follow: Record review on 7/24/23 revealed Tenant #2's Progress note dated 6/12/23 noted Tenant #2's admission to hospice. Further review revealed no evaluations completed for this significant change in condition. Further record review on 7/24/23 revealed Tenant #2's Progress Note for hospice. The Program completed health and functional evaluations but failed to complete cognitive evaluation for a significant change. Record review on 7/24/23 revealed the Program failed to complete Tenant #3's annual evaluations. Further record review revealed the Program completed Tenant #3's initial evaluations on 6/1/22. The Program failed to provide any documentation of annual evaluations. During the exit on 7/25/23 the administrative team acknowledged the Program failed to complete evaluations annually or with a significant change in condition or could not produce documentation to support the evaluation was done.	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 9 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure service plans were updated annually or with a significant change of condition for 1 of 2 tenants admitted in 2023 (Tenant #3). Findings follow: Record review on 7/24/23 revealed no signed service plan for Tenant #3. Further review revealed the Program noted a change of condition on 9/22/22 but failed to update the service plan. Record review on 7/24/23 revealed the Program failed to complete Tenant #3's annual service plan. Further record review revealed the Program completed Tenant #3's initial evaluations on 6/1/22 but did not provide a service plan. The Program failed to provide any documentation of annual service plan. During the exit on 7/25/23 the administrative team acknowledged the Program failed to update service plans or could not produce documentation to support the evaluation was done.	A 350		
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	A 370		

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A 370	Continued From page 10 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 consistently ensure service plans were signed and dated. This pertained to 1 of 4 tenants reviewed (Tenant #1). Finding follows: Record review on 7/19/23 revealed Tenant #1's service plan print date 7/3/23. Further review revealed the Program nurse and the tenant signed the service plan but failed to date the service plan. Record review on 7/24/23 revealed no signed and dated service plan for Tenant #3. On 7/19/23 the Licensed Practical Nurse (LPN) of Clinical Operations confirmed the service plan did not include a date of signature. Record review on 7/24/23 revealed the Program failed to complete Tenant #3's service plan for a significant change of condition on 7/13/23. During the exit on 7/25/23 the administrative acknowledged the Program failed to update service plans as needed.	A 370		
A 420	481-69.27(1)a 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 provide for a registered nurse:	A 420		

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A 420	Continued From page 11 a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently complete 90-day nurse reviews as required. This pertained to 3 of 4 tenants reviewed (Tenant #2, #3, and #4). Findings follow: Record review on 7/24/23 revealed the following examples (including but not limited too) regarding nurse reviews: Tenant #2's latest 90-day nurse review dated 2/9/23. Further review revealed the Program failed to complete 90-day nurse reviews for Tenant #2 in 10/22 and 1/23. Tenant #3's most recent nurse review dated 7/13/23 and the most recent prior to this review dated 9/22/23. Further review revealed the Program failed to complete 90-day nurse reviews for Tenant #3 in 12/23, 3/23 and 6/23. Tenant #4's most recent nurse review dated 6/16/23. The Program failed to complete 90 nurse reviews for Tenant #4 in 8/22, 11/22, 2/23 and 5/23. During the exit on 7/25/23 the administrative acknowledged the Program failed to complete 90 day nurse review.	A 420		

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A 520	Continued From page 12	A 520		
A 520	481-69.29(2) Staffing 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). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to implement/document the staff procedure for addressing the emergency needs of tenants with cognitive disorder. This pertained to 2 of 2 sample tenants (Tenants #3 and #4) with cognitive disorder. Finding follows: Record review on 7/19/23 revealed the Program failed to develop/implement a written policy to address emergency needs of tenants who had mild cognitive impairment. On 7/19/23 at 2:19 p.m. The Clinical Operations Nurse confirmed the Program had not developed/implemented a policy/procedure to address the emergency needs of tenants. She acknowledged this policy seemed directed more towards door security and not all tenant safety needs. During the exit on 7/25/23 the administrative staff acknowledged the Program failed to complete 90-day reviews consistently.	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	A 525		

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A 525	Continued From page 13 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 interviews and record review the Program failed to consistently ensure all personnel including agency/contract staff were appropriately trained to meet the tenant needs. This pertained to 3 of 4 program staff and 2 of 2 agency/contract staff reviewed (Staff A, B, C and AS E and AS F). Finding follows: Record review Record review on 7/20/23 revealed no training documentation for 3 of 4 staff and 2 of 2 Agency Staff (AS) AS D and E. When interviewed on 7/21/23 the Clinical Operations Nurse confirmed the Program failed to ensure all staff including agency staff were trained to meet the tenants needs.	A 525		

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	**Achieve Compliance:** All incident reports will be documented on appropriate forms and filed in designated binders within the Wellness office. Incident reports and Medication Error forms to be reviewed by Wellness Adminstrator/ RCS/WTS by end of next business day. On-Call Wellness Staff in place 24/7, between on site presence and triage call number to ensure proper handling of above stated occurences. **Prevent Recurrence:** Review of all incident reports to ensure proper use and documentation to be completed no less than once weekly by lead care staff or RCS/WTS. **Monitor:** Wellness Director or other staff nurse to complete monthly review of incident reports, 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. On-Call community staff implementation is ongoing. Incident report form usage is ongoing- binder put together and re-implemented October 2023. Weekly review of incident reports during weekly community Wellness meeting implemented November 2023.
A 340 481-67.9(4)a STAFFING **A 345 481-67.9(4)b STAFFING** **A 380 481-67.9(6) STAFFING**	**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, dementia specific training and adult dependant abuse certificate prior to working independently in the community. New Wellness Directior 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 Director review of new employee status prior to orientation completion and being scheduled to work independently within the community. Regoinal Wellness Director review Wellness Director delegations within initial 60 days of employment. **Monitor:** Quarterly reviews of all Wellness employee files by RCS/WTS, staff nurses, Wellness Director and/or Regional Wellness Director to ensure certifications/delegations are complete and up to date to maintain compliance. Wellness Director and RCS/WTS to review new hire orientation completion 30 days after start date with community.	Current staff re-delegations to be completed in November 2023. New hire training and delegations are ongoing. New Hire training schedule and reviews implemented for all new hires after 10/1/23. PCC eMAR training and dementia training made available via Relias 9/1/23. Current staff documentation/certificate audit completed to be completed November 2023, with plan put in place for compliance by end of year 2023.

A 140 481-69.22(2) EVALUATION OF TENANT A 145 481-69.22(3) EVALUATION OF TENANT A 350 481-69.26(1) SERVICE PLANS A 370 481-69.26(3) SERVICE PLANS A 420 481-69.27(1) NURSE REVIEW	**Achieve Compliance:** Assessment of health, cognitive, and functional to be completed pre-move in, 30 day post admission, with significant change, and annually. SPG V2 used for health and functional and BCRS and GDS used for cognitive. Evaluations will be completed and documented in Point Click Care and recurring schedules set. **Prevent Recurrence:** Pre-move in asessments/Service plan completed and follow up communication is sent to community prior to resident taking occupancy. Upon occupancy, a 30 day assessment date is established and service plan updated post assessment. Quarterly and 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 set of evaluations to be completed by 11/30/23. **Monitor:** Wellness Director/staff nurses to review and maintain evaluation schedule monthly to ensure compliance. Wellness Director to review report from weekly community Wellness meeting.	Evaluation level set with new SPG V2 evaluation to be completed for all residents November 2023. Evaluation schedules updated for all residents at this time, to ensure timely completion going forward. Implemented use of BCRS cognitive tool to calculate GDS score and input GDS evaluation 9/1/23.
A 520 481-69.29(2) STAFFING A525 481-69.29(3) STAFFING	**Achieve Compliance:** Training checklist implemented for all new and agency staff to be completed during their initial shifts in the community. Procedure and document for completing safety checks implemented for Memory Care re-trained to community staff September 2023. Request made to CSIG Compliance department November 2023 for update to the company's Personal Emergency Response policy. To include that in leiu of a pendant system in Memory Care, 2 hour safety checks with a residnet headcount are completed. **Prevent Recurrence:** Safety check documentation to be reviewed no less than weekly with corrective action to employees not completing checks. Documentation of said safety checks will be submitted to RCS/WTS and/or Wellness Director or staff nurse daily. Completed training checklists to be stored in employee files. **Monitor:** Wellness Director or staff nurse to ensure weekly. In the event of emergency pendant system not working Wellness Director or staff nurse to review safety check documentation daily. RCS/WTS/Wellness DIrector to review training checklist is completed for all new hires and staff within the first 30 days of hire.	Current staff re-training- with specific focus on safety checks completed October 2023. New hire training is ongoing. New Hire/Agency staff training schedule and reviews re-implemented for all new hires in October 2023. Current staff documentation/certificate audit to be completed November 9, 2023. Hourly check sheets and procedure re-trained to staff in November 2023.

A 160 481-67.3(2) **TENANT RIGHTS** **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. Wellness Administrator and staff nurses to receive additional training in regards to order confirmation and verification of pharmacy initiated orders. Housekeeping schedule modified and to be reviewed for compliance by Maintenance/Settings Manager. **Prevent Recurrence:** eMAR 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. Maintenance/Settings manager to audit housekeeping completion no less than weekly. **Monitor:** Wellness Administrator or staff nurse to ensure weekly reviews of eMAR are completed by care staff or RCS/WTS. Wellness Administrator to touchbase with Maintenance/ Settings manager no less than weekly to ensure complaince with schedule.	Re-training of RCS/WTS in regards to physicain order confirmation to be completed November 2023. Current staff training and delegations- with specific focus on medication administration completed prior to 12/1/23. New hire training and delegations are ongoing. PCC eMAR training made available via Relias with auto-enroll September 2023.	