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
	S0421	A. BUILDING: _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNSYLVANIA PLACE	**ONE PENNSYLVANIA PLACE OTTUMWA, IA 52501**

(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 impairment: 31 Number of tenants with cognitive impairment: 2 Total census: 33 The following regulatory insufficiencies were cited during the investigation of Complaint #127298-C.	A 000		
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 complete evaluations due to a significant change in condition for 1 of 3 tenants reviewed (Tenant #1). Findings follow:	A 145		

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

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A 145	Continued From page 1 Record review on 6/25/25 revealed Tenant #1's Health and Functional Assessments and Cognitive Assessments completed 12/16/24 and 5/09/25 respectively. The assessments dated 12/16/24 indicated Tenant #1 was independent with ambulation and transfers, with no assistive devices. Tenant #1 was also independent with bathing, dressing, grooming and hygiene. The assessment noted the tenant required routine meal delivery and support to ensure she was eating, but didn't indicate she had difficulty feeding herself. She was not on a therapeutic or altered texture diet. A nursing progress note dated 3/04/25 indicated Tenant #1 was treated at the hospital emergency department (ED) for pneumonia and returned to the assisted living program, with a new order for an antibiotic. Tenant #1 returned to the ED on 3/05/25, with no new findings. The progress notes didn't indicate the reason for the return to the ED. Review of the hospital ED records revealed Tenant #1 was diagnosed with left lower lobe pneumonia on 3/04/25 and was prescribed an antibiotic. According to the 3/05/25 ED record, emergency medical services (EMS) transported Tenant #1 to the ED due to an incident of running naked in the hallways. Tenant #1 denied the allegation. She presented with mild disorientation on exam, but was pleasant and cooperative, per the ED notes. The ED recommended Tenant #1 returned to the assisted living program. A review of additional nursing progress notes revealed the following: - On 3/08/25 Tenant #1 went outside in her pajamas that were not winter weather appropriate. The tenant told the nurse she didn't	A 145		

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A 145	Continued From page 2	A 145		

feel good and thought she would go outside and die. Tenant #1 agreed to go back inside and hourly safety checks were implemented.

- On 3/09/25 staff reported Tenant #1 appeared agitated and confused during the early morning hours, said she was looking for her sister, had an unsteady gait and tried to go outside without adequate warm clothing. Due to her need for close supervision, Tenant #1 agreed to visit the Memory Care unit for approximately an hour, until she returned to baseline and went back to her apartment. Later in the day, Tenant #1 was noted to be very disheveled looking and was struggling to walk.
- On 3/12/25 Tenant #1 required assistance of two staff in the morning. She was unable to walk. Staff assisted her with her shower and noted a strong odor of urine, with a reddened peri area. According to a nursing progress note at 2:38 p.m. Tenant #1 was lying on her couch in a fetal position, difficult to arouse. She needed assistance to sit up and to walk. Staff called 911 and EMS transported Tenant #1 to the local hospital emergency department. She was discharged back to the Assisted Living program the same day, with continued difficulty walking.
- On 3/13/25 Tenant #1 was unsteady on her feet and needed staff assistance. She seemed confused.
- On 3/15/25 when staff brought Tenant #1 her evening meal, they found her naked on the couch, with urine on self and couch. All of her windows were open and the apartment was cold. Staff assisted the tenant to clean up and get dressed. Later that evening, staff called 911 when Tenant #1 showed signs of a possible stroke.

A review of hospital discharge records revealed Tenant #1 was hospitalized from 3/15/25 to 3/18/25. Her diagnosis included acute metabolic

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A 145	Continued From page 3	A 145		

encephalopathy, suspected secondary to dehydration; SIRS (Systemic Inflammatory Response Syndrome); generalized weakness with fall; severe protein calorie malnutrition; acute hyperglycemia; hypercalcemia, suspected secondary to dehydration and hypmagnesemia. The hospital provided new prescriptions for Potassium Chloride and Magnesium Oxide supplements. The discharge diet was listed as cardiac, with moist minced solids and mildly thickened liquids. A speech therapy evaluation recommended mildly thickened liquids with no straws; small single bites and sips; crushed pills, given one at a time with applesauce and a recommendation for "100% feeding assistance and supervision with all PO (oral) intake." The discharge instructions also advised the tenant to follow up with her primary care provider within one week and to have labs repeated.

A nurse review dated 3/20/25 noted Tenant #1 returned to the program with a modified diet, which the tenant did not want to follow upon return. The nurse provided education to the tenant regarding swallowing precautions. The nurse review noted Tenant #1 used a wheelchair to and from the dining room due to increased weakness and safety concerns. The tenant also had increased incontinent episodes and increased assistance with ADLs (activities of daily living). Tenant #1 had a decline in cognitive abilities and continued with erratic behaviors such as talking to people and items that were not there.

According to nursing progress notes dated 3/20/25, Tenant #1 had difficulty feeding self and walking. Progress notes on 3/21/25 also noted difficulty feeding self and used a wheelchair due to inability to ambulate. Tenant #1 had an

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A 145	Continued From page 4 unwitnessed fall on 3/21/25 and required staff assistance to get off the floor. A nursing note on 3/21/25 indicated the nurse spoke with Tenant #1's power of attorney (POA) regarding her decline and increased need of assistance with toileting/incontinence, ambulation/mobility and feeding. The POA was agreeable to referrals to local nursing homes. Nursing progress noted on 3/22/25 indicated Tenant #1 had an unwitnessed fall. She continued to need staff assistance for ambulation/mobility, incontinence care/toileting and eating/feeding self. A thorough health assessment and an updated functional and cognitive evaluation regarding significant change of condition could not be located in Tenant #1's record until 5/09/25. On 6/26/25 at 10:50 a.m. the Director of Nursing verified the program failed to complete updated assessments/evaluations for Tenant #1 based on significant change of condition that began on/around 3/08/25 and continued upon return from a hospitalization on 3/18/25.	A 145		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.	A 360		

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A 360	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plan due to significant change for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review on 6/25/25 revealed Tenant #1's service plans completed 12/16/24 and 5/09/25. The service plan dated 12/16/24 indicated Tenant #1 was independent with ambulation and transfers, with no assuasive devices. Tenant #1 was also independent with bathing, dressing, grooming and hygiene. The service plan noted the tenant required frequent support and education regarding the importance of eating when taking medication, but didn't indicate difficulty feeding herself. She was not on a therapeutic or altered texture diet. Nursing progress notes and hospital records from 3/04/25 to 3/22/25 indicated Tenant #1 had a significant decline in overall functioning. (Cross reference 69.22(3) for details). Tenant #1 had increased needs in the areas of toileting/incontinence, ambulation, bathing, grooming and hygiene and safety checks/monitoring. Tenant #1 also displayed increased cognitive impairment and unusual/erratic behavior. A review of hospital discharge records revealed Tenant #1 was hospitalized from 3/15/25 to 3/18/25. Her diagnosis included acute metabolic encephalopathy, suspected secondary to dehydration; SIRS (Systemic Inflammatory Response Syndrome); generalized weakness with fall; severe protein calorie malnutrition; acute hyperglycemia; hypercalcemia, suspected secondary to dehydration and hypmagnesmia.	A 360		

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A 360	Continued From page 6 The hospital provided new prescriptions for Potassium Chloride and Magnesium Oxide supplements. The discharge diet was listed as cardiac, with moist mince solids and mildly thickened liquids. A speech therapy evaluation recommended mildly thickened liquids with no straws; small single bites and sips; crushed pills, given one at a time with applesauce and a recommendation for "100% feeding assistance and supervision with all PO (oral) intake." The discharge instructions also advised the tenant to follow up with her primary care provider within one week and to have labs repeated. A nurse review dated 3/20/25 noted Tenant #1 returned to the program with a modified diet, which the tenant did not want to follow upon return. The nurse provided education to the tenant regarding swallowing precautions. The nurse review noted Tenant #1 used a wheelchair to and from the dining room due to increased weakness and safety concerns. The tenant also had increased incontinent episodes and increased assistance with ADLs (activities of daily living). Tenant #1 had a decline in cognitive abilities and continued with erratic behaviors such as talking to people and items that were not there. The nurse review noted the service plan should be revised due to the level of assistance required with ADLs. A review of Tenant #1's record revealed her service plan was not updated until 5/09/25. On 6/26/25 at 10:50 a.m. the Director of Nursing verified the program failed to update the service plan for Tenant #1 in a timely manner based on significant change of condition that began on/around 3/08/25 and continued upon return from a hospitalization on 3/18/25.	A 360		

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