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
	S0435	A. BUILDING: _____ B. WING _____	C 06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK ESTATES AL MEMORY CARE	3212 GREENHILL CIRCLE CEDAR FALLS, IA 50613

(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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 13 Total Census of Assisted Living Program for People with Dementia: 14 The investigation of Complaints #97628-C, #103656-C and #104629-C was completed and the following regulatory insufficiencies were identified:	A 000	**Unless otherwise noted, the POC date is 7/12/22. The Director will ensure overall compliance.**	
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 observation, interview and record review the Program failed to follow its policy and procedure related to medication administration. This potentially affected all of the tenants (census of 14). Findings follow: On 5-24-22 at approximately 2:00 p.m. the medication room was observed. The Director was present during the observation. A plastic crate was observed on the top shelf in the medication room. The crate was not secured and was open on the top. There were medications (discontinued) in the crate. There was also a basket with medication bottles for Tenant #2. The	A 150	A 150- A cabinet with a lock will be installed no later than July 12th, the med managers and Director will be the only staff with access to a key. All extra medications and medications waiting to be destroyed will be stored in this cabinet.	

ok 9/1/22

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A 150	Continued From page 1 medications in the basket were also not secured. When interviewed on 5-24-22 at the time of the observation the Director said the medications in the crate were discontinued and she was waiting for the other nurse to destroy them. Discontinued medications were typically destroyed within 30 days. Narcotic medications awaiting destruction were kept in the locked drawer until they were destroyed. The medications in the basket were the extra medications for Tenant #2 that did fit in the medication cart. When observed on 5-25-22 at approximately 11:20 a.m. Staff B administered medications to tenants in the dining area. In the course of the medication pass Staff D (non-medication manager) asked Staff B for her keys to make a copy in the office. Staff B provided Staff D the keys and Staff D returned the keys to Staff B during the medication pass. Review of the ALP Monitoring Entrance Form indicated a census of 14 tenants and all 14 tenants received medications administered by the Program. Review of the Program's Medication Administration policy and procedure revealed medications administered by the program would be "stored in locked storage that is not accessible to persons other than employees responsible for administration or storage of medications." When interviewed on 5-24-22 at approximately 2:00 p.m. and 5-26-22 at 11:05 a.m. the Director confirmed all staff (medication managers and non-medication passers) had access to the medication room. She confirmed only the medication managers had the keys to the	A 150		

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A 150	Continued From page 2 medication cart and narcotic box. Medication managers were not to give their keys to other staff.	A 150		
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 observation, interview and record review the Program failed to administer medications and treatments as prescribed. This pertained to 4 of 5 current tenants observed on the medication pass (Tenants #3, #4, #5 and #6) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. When observed on 5-25-22 at approximately at 11:20 a.m. Staff B started a medication pass and administered medications to Tenants #3, #5 and #6. All three tenants had an order for Miralax Powder 17 grams, 1 capful in 8 ounces of liquid daily. Staff B prepared Tenant #3's Miralax in a small disposable cup (3 oz) and mixed with water. She administered the Miralax which was not mixed with 8 oz of liquid as ordered.	A 285	A 285- All Med Managers will be re-delegated medication administration 7/13/22	

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A 285	Continued From page 3 Staff B prepared Tenant #5's Miralax in a small disposable cup (3 oz) and mixed with water. She administered the Miralax which was not mixed with 8 oz of liquid as ordered. Staff B prepared Tenant #6's Miralax in a small disposable cup (3 oz) and mixed with water. She administered the Miralax which was not mixed with 8 oz of liquid as ordered. During the medication pass it was observed Staff B transferred the Miralax back and forth between disposable cups (appeared to be attempting to mix it). Continued observation revealed at 11:59 a.m. Staff B administered medications to Tenant #4, including ondanestron tablet, 4 milligram (mg), dissolve one tablet in the mouth three times daily before meals. At the time the medication was administered to her, Tenant #4 had already eaten her meal. The medication was not given prior to the meal as ordered. Further observation on 5-25-22 at 4:37 p.m. revealed a container of the disposable cups used during the medication pass was observed in the medication room. The size of the disposable cups used during medication pass was observed in original packaging and were noted as 3 ounces. 2. Record review on 5-25-22 and 5-26-22 of Tenant C2's file revealed a Progress Note document indicating Tenant C2 had peripheral vascular disease with mild edema to the bilateral lower extremities. Compression stockings were ordered on 5-3-22 to be worn daily and taken off at night. Review of Tenant C2's May 2022 medication administration records (MARs)	A 285	A- 285 - A new order check sheet will be created by 7/12/22 and attached to each new order, prior to filing order in chart new order check list must be completed. Check sheet will include that order has been entered into the MAR.	

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A 285	Continued From page 4 revealed the order for the compression stockings was not on the MAR. The physician ordered treatment was not documented as completed. 3. When interviewed on 5-26-22 at 11:05 a.m. the Director confirmed Miralax should be mixed in the larger plastic cups and not the 3 oz cups. She said staff assisted with the compression hose for Tenant C2; however, it was not on the MAR.	A 285		
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 shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received nurse delegated training within 30 days of employment for 5 of 5 unlicensed direct care staff reviewed (Staff A, B, C, D and E). Findings follow: 1. When observed on 5-24-22 at approximately 11:20 a.m. Staff A administered medications to Tenant #3. She administered an eye drop, checked her blood glucose and injected her insulin. Tenant #3's eye drop, blood glucose check and insulin administration was completed as she sat in a chair by the medication cart located near the dining area. There were five to six other tenants in the dining area at the time of	A 345	A-345- Med Managers will be re-educated on medication administration and proper hand hygiene 7/13/22	

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A 345	Continued From page 5 administration. Staff A did not remove her gloves after the completion of the blood glucose check prior to signing off the blood glucose check on the computer. On 5-25-22 at 11:20 a.m. Staff B was observed administering medications to Tenant #3. Staff B completed hand hygiene, donned gloves, took Tenant #3's blood glucose. Staff D asked Staff B for a topical medication from the med cart for Tenant #4. Staff B provided the topical medication to Staff D without removing her gloves. Staff B used an alcohol wipe to wipe the insulin pen. Staff D then handed the topical medication back to Staff B. Staff B took the medication without a glove change or hand hygiene, then administered Tenant #3's insulin. She then administered Tenant #3's eye drop, without a glove change or hand hygiene. Staff B then administered Tenant #3's Miralax, without a glove change or hand hygiene. Staff B then doffed her gloves and completed hand hygiene. 2. Review of the Program's Insulin Pen Delegation form indicated to check the order and, in a private location, hand the tenant an alcohol swab to cleanse the area. If the tenant was not able, staff was to cleanse the area. Staff was to dial the units as ordered and hand the insulin pen to the tenant. The tenant was to inject or, if they were unable, staff could inject for them. Staff was to instruct the tenant to place the cap on the needle and unscrew from the pen and dispose of it in the sharps container. 3. Record review on 5-24-22 and 5-25-22 of Staff A's training documents revealed a hire date of 2-28-22. Staff A's delegations were dated 4-7-22 but did not include training related to the administration of eye drops, topical medications	A 345		

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A 345	Continued From page 6 or inhalers. Record review on 5-24-22 and 5-25-22 of Staff B's training documents revealed a hire date of 1-25-22. Staff B's delegation for sliding scale insulin was completed on 3-7-22. Delegations were not completed for oral medications, blood glucose monitoring, insulin, eye drops, inhalers or topical medications. Record review on 5-24-22 and 5-25-22 of Staff C's training documents revealed a hire date of 4-20-22. Staff C's delegations, dated 4-20-22, did not include blood glucose monitoring, eye drops, inhalers or topical medications. Record review on 5-24-22 and 5-25-22 of Staff E's training documents revealed a hire date of 3-30-22. There were no nurse delegations completed for Staff E at the of the investigation. Record review on 5-24-22 and 5-25-22 of Staff G's training documents revealed a hire date of 3-2-21. Staff G's delegations did not include blood glucose monitoring, insulin, topical medication or inhalers. 4. When interviewed on 5-26-22 at 11:05 a.m. and 6-1-22 at 10:44 a.m. the Director confirmed Staff A, B, C, D and E administered medications. Staff assisted with medication administration including oral medications, inhalers, blood glucose monitoring, eye drops and topical medications. The Director had trained Staff A, B, C and G on those tasks. She had not completed the training with Staff E. All delegation records available for the staff listed were provided.	A 345		

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A 290	Continued From page 7	A 290		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 2 of 2 current tenants reviewed (Tenant #1 and Tenant #2) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings followed: 1. Review of Tenant #1's file on 5-25-22 and 5-26-22 revealed an After Visit Summary indicating Tenant #1 was hospitalized from 4-19-22 to 4-22-22. Orders were received including a change to a Medihoney wound/burn dressing order. The orders indicated to apply to the area on the right buttock three times per day after cleansing and cover with gauze. It was a change to how and when to complete the treatment. The After Visit Summary was noted on 4-25-22. Tenant #1's April and May 2022 medication administration records (MARs) did not reflect the order as indicated on the After Visit Summary. A discontinue order for the wound treatment was not found.	A 290	A-290 Nurses notes will be written by exception, effective immediately. Including for new orders and skin issues that have resolved and for transfers to the hospital.	

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A 290	Continued From page 8 When interviewed on 5-26-22 at 11:05 a.m. the Director said the area was healed and it was resolved. Continued record review of Progress Notes revealed the last entry was dated 4-26-22. A nurse's note was not completed related to the order noted above, the status of the wound and if an order was received from the primary care provider to discontinue the order on the After Visit Summary. 2. Review of Tenant #2's file on 5-25-22 and 5-26-22 revealed the March 2022 MAR which reflected he was to receive prednisolone suspension 1%, one drop in the right eye, once daily and one drop in the left eye twice daily. The MAR reflected Tenant #2 refused the medication on 3-6-22 and he was not able to take the medication from 3-27-22 to 3-30-22 as it was not available. Tenant #2's April 2022 MAR reflected Mirtazapine tablet 15 milligram (mg), one tablet every evening was not available to administer from 4-1-22 to 4-8-22 (with the exception of 4-4-22 where it was documented as given) as it was not available to administer. The most recent entry in Progress Notes was dated 2-11-22. Continued record review revealed Nurse's notes were not documented by exception, including when medications were not available to administer. 3. Review of Tenant C1's file on 5-25-22 and 5-26-22 revealed a Laboratory Services document dated 5-6-22 indicating a urine sample was collected on 5-4-22. It showed no growth after 18 hours. There was no bladder infection.	A 290		

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A 290	Continued From page 9 A Progress Note dated 4-29-22 revealed an initial assessment was completed and Tenant C1 had a skin tear on her bilateral hands and "macerated skin on her buttocks." When interviewed on 5-26-22 at 11:05 a.m. the Director said Tenant C1 was admitted on 4-29-22 and arrived via medical transport on a cot and was "soaking wet." Her spouse rode with her in the medical transport and said she would not let the medical transport staff change her. Two staff took her to the bathroom, one on each side. She had an excoriated area on her buttocks. The Director stated she talked to the tenant's family daily about taking her to the hospital. Further record review revealed no nurse's notes regarding Tenant C1's excoriated buttocks that was noted at admission. Nurse's notes were not documented related to the urinalysis (UA) order and the results of the UA. Nurse's notes were also not documented regarding the frequent requests/discussions with Tenant C1's family to have Tenant C1 sent to the hospital for evaluation. 4. Review of Tenant C2's file on 5-25-22 and 5-26-22 revealed Telephone Order forms and Progress Notes (physician) indicated the following orders: - On 4-1-22 Nystatin powder, apply topically to groin three times per day until the rash resolved was ordered. - On 4-1-22 Tylenol 325 mg tablet, one tablet three times per day was ordered. - On 4-22-22 an order to discontinue (previously ordered) Levaquin due to no bacterial growth was ordered. - On 4-26-22 orders were received to apply	A 290		

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A 290	Continued From page 10 Voltaren topical gel 1% to bilateral knees three times daily, consultation with an orthopedics related to cortisone injection in the right knee and to discontinue scheduled Tylenol. - On 5-3-22 an order was received for compression stockings wear daily and off at night. Continued record review of nurse's notes revealed entries were not completed related to the new orders noted above. When interviewed on 5-26-22 at 11:05 a.m. the Director said Tenant C2 had increased confusion and an irregular heartbeat and was sent to the hospital on 5-9-22. She tested positive for COVID-19 and was in the intensive care unit. Tenant C2 did not returned to the building and passed away at the hospital. Record review revealed the most recent note in the Progress Notes was dated 5-6-22. Tenant C2 was discharged on 5-13-22. There was no entries in nurse's notes regarding Tenant C2 going to the hospital, the reason for the hospitalization or her discharge from the Program. 5. When interviewed on 5-26-22 at 3:25 p.m. the Director confirmed all nurse's notes were provided for the tenants listed above.	A 290		
A 470	481-69.28(5)a(1)(2)(3) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection.	A 470	A-470- Kitchen staff has been enrolled in food safety manager course and is currently working on completing course. Course will be completed by 7/12/22	

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A 470	Continued From page 11 a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by: (1) Obtaining certification as a dietary manager; or (2) Obtaining certification as a food protection professional; or (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide food safety training for staff who served and prepared food. Additionally the Program also failed to have one staff who was directly responsible to food preparation complete a state-approved food protection program. This potentially affected all of the tenants (census of 14). Findings follow: 1. Observation of the kitchen on 5-24-22 at approximately 1:20 p.m. revealed items in the pantry open and not dated, as well as items in the refrigerator and freezer. The refrigerator contained leftovers of roast and vegetables dated	A 470	other staff in kitchen has completed there food safety and sanitation course. kitchen staff and caregivers were re-educated on proper procedure for getting residents second portions of food on June 2nd 2022. New production sheets were created Weekly kitchen audits will be performed to ensure proper documentation is being completed and food safety protocols are being followed 7/13/22	

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A 470	Continued From page 12 5-15-22 (observation 9 days later). Continued observation on 5-25-22 at approximately 11:30 a.m. revealed Staff I, dietary staff, dished up the food which was served to the tenants at the tables. One tenant requested a second portion of food and Staff D took the soiled dish to the serving counter. Staff I accepted the soiled dish and put another portion of food on the soiled dish. Later in the meal service Staff I passed out cookies table to table and two tenants requested additional items from the meal. Staff I took the two soiled plates to the serving counter (not observed but appeared to wash her hands and remove her gloves). She then served food on the two soiled plates and took them to the tenants. During the meal service one tenant requested a sandwich. Staff I had gloves on and had touched various surfaces with the gloves as she served the meal. She then prepared the peanut butter and jelly sandwich without completing hand hygiene and donning new gloves. 2. When interviewed on 5-4-22 at 12:40 p.m. Staff H, dietary staff, confirmed she had not received training on food safety and sanitation. When interviewed on 5-25-22 at 12:38 p.m. Staff I, dietary staff, confirmed she had not received training on food safety and sanitation. 3. Record review on 5-24-22 revealed the Director had State Food Safety Food Manager Certification dated 5-1-20. No other current staff had the state approved protection course including Staff H and Staff I, both dietary staff. Record review on 5-24-22 and 5-25-22 revealed Staff H was hired on 3-2-22 and was a dietary	A 470	Once Weekly inventory of fridge and pantry will be completed, all items that are open and not labeled with an open date will be discarded, leftovers that are 7 days or more old will be discarded. Left overs that are not dated will be labeled, Staff completing inventory will sign documentation to show it has been completed. This will take effect on June 25th 2022.	

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	S0435	A. BUILDING: _____ B. WING _____	C 06/01/2022

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A 470	Continued From page 13 staff. Staff H did not have any documented food safety and sanitation training. Record review on 5-24-22 and 5-25-22 revealed Staff I was hired on 8-24-21 and was the kitchen manager. Staff I did not have any documented food safety and sanitation training. 4. When interviewed on 5-26-22 at 11:05 a.m. the Director confirmed she used to work in the kitchen when the building first opened. She said it had been four to five months since she had worked in the kitchen. She confirmed Staff H and Staff I both prepared and served food and did not have any food safety training.	A 470		
A 510	481-69.28(8) Food Service 69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure foods were prepared and held at safe temperatures. This potentially affected all tenants (census of 14). Finding follow: 1. When observed on 5-25-22 from 4:45 p.m. to 5:18 p.m. Staff H served the evening meal. The meal included Shepherd's pie, pea salad, cantaloupe and red velvet cake. 2. Review of an Oak Park Rolling Inventory/Production Sheet reflected temperatures for the food served at the evening	A 510	A510-Kitchen Staff re educated on food safety and recommended food temps. 6/25/22	

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 510	Continued From page 14 meal including the pea salad. The temperature recorded of the pea salad served was 54 degrees. Continued review of recorded food temperatures indicated the following: - On 5-2-22 at breakfast pancakes were 93 degrees and sausage was 101 degrees. - On 5-2-22 at dinner steak fries were 91 degrees. - On 5-4-22 at dinner vegetable barley soup was 102 degrees. - On 5-5-22 at breakfast french toast sticks were 93 degrees and sausage was 91 degrees. - On 5-6-22 at breakfast banana chocolate pancakes were 89 degrees. - On 5-23-22 at breakfast waffles were 93 degrees and sausage was 93 degrees. - On 5-24-22 at breakfast the juice was 51 degrees. - On 5-26-22 at breakfast the juice was 50 degrees. Further record review of food service documentation records provided revealed inconsistent documentation of the food temperatures from 5-15-22 to 5-25-22. 3. When interviewed on 5-26-22 at 12:46 p.m. the Owner said staff had to monitor the temperature of the food. Staff were not monitoring the temperature like they should. When interviewed on 5-26-22 at 11:05 a.m. and 6-1-22 at 10: 44 a.m. the Director said she there had not been any food bourne illness in the building. All food temperatures available during the time period requested were provided.	A 510		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 870	Continued From page 15	A 870		
A 870	481-69.39(4) Respite Care Services 69.39(4) Written direction to staff. The program nurse shall document the care needs of the respite care individual based on the assessment conducted pursuant to subrule 69.39(3) and provide the documentation to staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide written direction to staff and document the care needs for 1 of 1 discharged respite tenants reviewed (Tenant C1). Findings follow: Record review on 5-25-22 and 5-26-22 revealed Tenant C1 moved in as a respite admission on 4-29-22 and was discharged on 5-9-22. Tenant C1 was admitted from an out of state skilled nursing facility (SNF). Tenant C1's diagnoses included dementia, type 2 diabetes mellitus without complications, depression and Alzheimer's disease. She was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. The Senior Living Assessment/ISP had an effective date of 4-27-22 and a locked date of 4-29-22. The assessment indicated Tenant C1 did not have pain and did not show signs of pain. It indicated she needed reminders for eating, did not prefer in-apartment dining, ambulated with assistance of one person and a walker and was not resistant to cares. When interviewed on 5-24-22 at 2:51 p.m. Staff C stated Tenant C1 was always in bed and never got up on second shift. The tenant was repositioned every couple of hours and fluids	A 870	A-870 Service Plan will accurately reflect the needs of each tenant and will be updated within 48 hours of a significant change. This is effective immediately	

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A 870	Continued From page 16 were offered. Tenant C1 was incontinent of bladder and bowel and staff changed her in bed. She was dressed in bed and sponge baths were also given in bed. Tenant C1 laid in the fetal position on her right side and screamed the entire shift. She did want to be repositioned to her left side. Tenant C1 could not press her pendant and was checked on every one to two hours. On 5-25-22 at 4:24 p.m. Staff F said Tenant C1 was mainly a two person assist. She was never able to get the tenant up and walking. Toileting cares were provided in bed and she was checked every two hours. Her food was chopped up and she was fed either by staff or family. She was provided a sponge bath once or twice a week as staff could not get her up from bed. The tenant laid on her right side in the fetal position. She screamed a lot. She was able to say she was in pain but could not say where. She was in bed 80% of the time in the fetal position. She could not use her pendant and was checked every 30 minutes to one hour. The Director sent her to the hospital where it was discovered she had a fractured vertebrae. When interviewed on 5-25-22 at 9:32 a.m. Staff J said Tenant C1 was constantly in pain, hallucinated and yelled all of the time. On 5-26-22 at 11:05 a.m. the Director said the Program was to be a short term placement between the SNF out of state and long term care placement locally. She said she started an assessment on 4-27-22 based on information she had received and then finished the assessment on 4-29-22. The assessment was completed, the service plan was signed and the respite agreement was signed. Regarding her cares, Tenant C1 needed help with everything. Bathing	A 870		

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A 870	Continued From page 17 and incontinence cares were provided in bed. She was incontinent of bladder and bowel. Tenant C1 wanted to curl her legs up and laid on one side. She utilized a hospital bed and was offered water. The Director estimated she was transferred out of bed four times. Tenant C1 was on a mechanical soft diet and family gave permission to allow her to skip meals if asleep. Staff fed her at meals and she estimated her intake at 25%. She asked Tenant C1's spouse about an anxiety medication and he was agreeable. An order was received for lorazepam as needed, however the spouse changed his mind and requested the lorazepam not be administered. Tenant C1 yelled often and she talked to Tenant C1's family everyday about taking her out to the hospital. On 5-2-22 an appointment was set up with a nurse practitioner to see Tenant C1 on 5-6-22. On 5-6-22 after visiting with the nurse practitioner the family agreed to send her to the hospital where she was diagnosed with a compression fracture in her back. Review of Progress Notes from the SNF (prior placement) indicated the following: - On 4-14-22 Tenant C1 fell and was transferred to a hospital for evaluation. A head computed tomography was completed at the hospital. She returned after being evaluated post fall and was noted to be at her baseline. - A Daily Skilled Note dated 4-19-22 indicated she screamed and yelled when approached. For transfers she was a "two+ persons physical assist." For toileting she was a "two+ persons physical assist." The note indicated she was unable to voice discomforts, had hallucinations and screamed and yelled when her spouse was not present. She needed extensive assistance during meals and was a two person transfer. It	A 870		

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A 870	Continued From page 18 indicated she seldom followed commands. Progress Notes from the Program indicated the following: - On 4-29-22 it was noted the initial assessment was completed. Tenant C1 arrived via ambulance transport from out of state. She had a skin tear on her bilateral hands and "macerated" skin on her buttocks. She was able to communicate with one word answers only and was nonsensical. She needed assistance of one to two staff to transfer, became upset with sudden movements and yelled out when she was touched. Tenant C1 would be moving to a long term care facility as soon they could find placement and she was there temporarily. - On 4-30-22 the Director received a call from staff saying it had been very difficult to walk the tenant to a recliner. Tenant C1 kept scooting down in the chair and screamed repeatedly. Tenant C1 stopped screaming to answer staff's questions but then started screaming again. Staff was told to change her bedding and lay her back in bed as she seemed most comfortable there. The Director also told staff to give two tablets of lorazepam for agitation and screaming. - On 4-30-22 it was noted Tenant C1's family questioned why the Director thought Tenant C1 needed hospice. The Director explained Tenant C1 was not able to communicate verbally, screamed repeatedly and had little interest in food. The day prior the Director observed her try to curl up into a fetal position, she had difficulty walking and was not able to fed herself. - On 5-5-22 Tenant C1's family was notified she was screaming the majority of the time from 2:30 p.m. to the present time (note timed at 10:00 p.m.). She asked if they could send Tenant C1 to the emergency room (ER) for evaluation due to the screaming. The family member voiced	A 870		

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A 870	Continued From page 19 concerns about her laying on her right side and said she doubted she had been touched all day. The Director explained when Tenant C1's protective undergarment was wet it was changed and staff attempted to reposition her on her back or left side but she rolled back to her right side. - On 5-6-22 it was noted a nurse practitioner was there to see Tenant C1 per family request and to set up care with a provider that could see her at the Program and when she moved to a long term care facility. The nurse practitioner was informed that when Tenant C1 arrived to the Program she visibly upset, screamed out and was confused. She had 24 hour medical transport to arrive from out of state. Tenant C1's spouse reported she started screaming during the transport to Iowa. Since admission Tenant C1 screamed out "spontaneously 75% of the time." The Director had requested permission multiple times to send her to the ER for evaluation. After visiting with the nurse practitioner, the family agreed to send Tenant C1 to the ER. The tenant was diagnosed with a compression fracture in her back. Review of the tenant's service plan dated 4-29-22 (date of admission) indicated she ate a regular diet and required encouragement to eat. She required assistance in and out of the shower and to wash the areas that she was unable to wash. The service plan reflected to assist her to bathroom to sit on the toilet and help with dressing. The service plan indicated Tenant C1 was on a toileting schedule and to assist her to the bathroom. Staff provided assistance with perineal cares and provided reminders to Tenant C1 to pull her pants up and down. It also indicated Tenant C1 ambulated with assistance of one and a walker. There was no information on the tenant's constant screaming and agitation or	A 870		

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A 870	Continued From page 20 direction on what staff were to do to assist her. The service plan dated 4-29-22 was not updated and did not address Tenant C1's current care needs or written direction for staff regarding how to meet her care needs. When interviewed on 5-26-22 at 11:05 a.m. the Director confirmed no other service plans were completed for Tenant C1.	A 870		