DEPARTMENT OF INSPECTIONS AND APPEALS ok

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0448	A. BUILDING: _____ B. WING _____	C 03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLAND FARMS SENIOR LIVING	2800 SUNSET DRIVE NORWALK, IA 50211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 34 Number of tenants with cognitive disorder: 5 TOTAL census of Assisted Living Program: 39 The following regulatory insufficiencies were cited during the investigation of Complaint #111304-C.	A 000	See Attached POC 3/1/23	
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 according to physician's orders. This pertained to 1 of 1 tenants reviewed with medication changes after a hospital admission (Tenant #1). Finding follows: Record review of Tenant #1's file on 3/1/23 revealed the following:	A 285		

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

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A 285	Continued From page 1	A 285		

Discharge instructions for hospital stay from 1/1/23 to 1/6/23 revealed weakness, shortness of breath, hemoglobin of 6.5 and required admission for blood transfusion. Diagnoses included iron deficiency, anemia, chronic atrial fibrillation, chronic renal insufficiency, hypertension, hypothyroidism, and congestive heart failure. His International Normalized Ratio (INR) was 8 upon admission and 4.6 on 1/5/23 (normal range 2.0 to 3.0 for patients routinely anticoagulant). Further review noted to follow up with the primary physician within one week and follow up with cardiology and hematology as scheduled. Discharged medications revealed no order for warfarin and the discharge face sheet noted to stop taking warfarin.

Discharge instructions for hospital stay from 2/2/23 to 2/3/23 noted he was admitted for weakness and falls. Further review revealed the hospital put warfarin on hold with his INR level at 11.2 upon admission and Tenant #1's level was 2.0 when discharged. The physician noted Tenant #1 required a follow up with him in one week, follow up with hematology as scheduled, and required an appointment with cardiology in one month to discuss if anticoagulation should be restarted.

Review of Medication Administration Records (MAR) revealed Program staff administered 2.5 milligrams (mg) of warfarin every Monday, Wednesday, and Friday and 5 mg every Sunday, Tuesday, Thursday, and Saturday during the month of January 2023. Further review revealed Program staff administered 2.5 milligrams (mg) of warfarin every Monday, Wednesday, and Friday and 5 mg every Sunday, Tuesday, Thursday, and Saturday from 2/4/23 to 2/18/23. The staff noted the warfarin was discontinued per nurse on

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A 285	Continued From page 2 2/27/23. When interviewed on 3/1/23 at 1:55 p.m. the Registered Nurse (RN) stated discharge instructions are reviewed when a tenant returned from the hospital. She said she did not know why she overlooked the information related to discontinuing the warfarin. She confirmed she completed a change of condition on 1/9/23, 2/7/23, and 2/26/23 and noted he continued to take warfarin on the assessments and service plans. She confirmed she never received the discharge orders from 2/3/23 and failed to obtain them for review. On 3/2/23 at 2:50 p.m. the RN reported if a person had an INR of 11 and suffered an injury that caused bleeding, they would be a critical risk of major bleeding and possible death if not found right away.	A 285		
A 120	481-69.21(3) Occupancy Agreement 69.21(3) The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to review and update the occupancy as needed to reflect any change in services or financial arrangements. This pertained to 1 of 1 tenants reviewed billed an increase in room and board (Tenant #1). Finding follows: Record review on 3/1/23 of Tenant #1's	A 120		

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A 120	Continued From page 3 Occupancy Agreement signed 4/22/22, revealed a room and board fee of $2,850.00 a month. Continued review noted basic services provided included three meals per day plus snacks, weekly laundry and housekeeping services and daily wellness checks. The Executive Director (ED) provided an email dated 2/14/23. that noted Tenant #1 moved to a new apartment on the first floor and there would be no financial charge in the base rent. Review of Resident Change Form dated 2/14/23. revealed in increase in the room rate from $2,850.00 to $4,000.00 a month. When interviewed on 3/1/23 the ED stated tenants have two plans to choose from. The Care Free plan only provided five meals per month, monthly laundry and housekeeping, and no wellness checks. The Assisted Living provided the services outlined in the Occupancy Agreement. She stated she was unaware of the information in the Occupancy Agreement differed from the brochures. She provided a handout of the Care Free package verses the Assisted Living package. The ED reported this information was reviewed with Tenant #1 and his daughter but had no signed documentation of the agreement. She confirmed she failed to review and update the Occupancy Agreement to reflect the change in the room and board fee.	A 120		
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	A 290		

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A 290	Continued From page 4 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 obtain discharge instructions when a tenant returned from the hospital. This pertained to 1 of 1 tenants reviewed with medication changes after a hospital admission (Tenant #1). Finding follows: See concerns cited at Iowa Administrative Code (IAC) 481 - Chapter 69.26(4)a for additional information. Record review on 3/1/23 revealed Tenant #1's Medication Administration Records (MAR) revealed staff administered walfarin from 2/4/23 to 2/18/23. Additional record review revealed Tenant #1's service plan dated 3/1/23 documented Tenant #1 took warfarin. Record review of Tenant #1's file on 3/1/23 revealed Tenant #1's discharge instructions from his hospital stay on 1/1/23 to 1/6/23. Tenant #1's physician discharge instructions included discontinuation of the medication warfarin. Continued record review revealed Tenant #1's discharge instructions from his hospital stay from 2/2/23 to 2/3/23. The instructions noted the hospital put Tenant #1's warfarin on hold upon his addmission to the hospital. The instructions	A 290		

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A 290	Continued From page 5 further direced Tenant #1 scheduled an appointment with cardiology in one month to discuss if an anticoagulation should be restarted. When interviewed on 3/1/23 at 1:55 p.m. the Registered Nurse (RN) stated discharge instructions are reviewed when a tenant returned from the hospital. She said she did not know why she overlooked the information related to discontinuing the warfarin in January 2023. She confirmed she completed a change of condition on 1/9/23, 2/7/23, and 2/26/23 and noted he continued to take warfarin on the assessments and service plans. She confirmed she never received the discharge orders from 2/3/23 and failed to obtain them for review. When interviewed on 3/2/23 at 2:50 p.m. the RN reported if a person had an INR of 11 and suffered an injury that caused bleeding, they would be a critical risk of major bleeding and possible death if not found right away.	A 290		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as warranted.. This pertained to 1 of 1 tenants reviewed with medication changes after a hospital admission (Tenant #1). Finding follows:	A 395		

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A 395	Continued From page 6 Record review of Tenant #1's file on 3/1/23 revealed the following: Discharge instructions for hospital stay from 1/1/23 to 1/6/23 revealed weakness, shortness of breath, hemoglobin of 6.5 and required admission for blood transfusion. Diagnoses included iron deficiency, anemia, chronic atrial fibrillation, chronic renal insufficiency, hypertension, hypothyroidism, and congestive heart failure. His International Normalized Ratio (INR) was 8 upon admission and 4.6 on 1/5/23 (normal range 2.0 to 3.0 for patients routinely taking an anticoagulant). Further review noted to follow up with the primary physician within one week and follow up with cardiology and hematology as scheduled. Discharged medications revealed no order for warfarin and the discharge face sheet noted to stop taking warfarin. Health and Functional Assessment dated 1/9/23 noted he returned from the hospital with no change in level of care. Continued review revealed the nurse documented he received anticoagulation therapy. The service plan failed to be updated to reflect the warfarin was discontinued. Discharge instructions for Tenant #1's hospital stay from 2/2/23 to 2/3/23 noted he was admitted for weakness and falls. Further review revealed the hospital put warfarin on hold with his INR level at 11.2 upon admission and his level was 2.0 when discharged. The physician noted Tenant #1 required a follow up with him in one week, follow up with hematology as scheduled, and required an appointment with cardiology in one month to discuss if anticoagulation should be restarted.	A 395		

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A 395	Continued From page 7 Health and Functional Assessment dated 2/7/23 noted he received anticoagulation therapy. The service plan failed to be updated to reflect the warfarin was discontinued. Review of Medication Administration Records (MAR) revealed Program staff administered 2.5 milligrams (mg) of warfarin every Monday, Wednesday, and Friday and 5 mg every Sunday, Tuesday, Thursday, and Saturday during the month of January 2023. Further review revealed Program staff administered 2.5 milligrams (mg) of warfarin every Monday, Wednesday, and Friday and 5 mg every Sunday, Tuesday, Thursday, and Saturday from 2/4/23 to 2/18/23. The staff noted the warfarin was discontinued per nurse on 2/27/23. When interviewed on 3/1/23 at 1:55 p.m. the Registered Nurse stated discharge instructions are reviewed when a tenant returned from the hospital. She said she did not know why she overlooked the information related to discontinuing the warfarin. She confirmed she completed a change of condition on 1/9/23, 2/7/23, and 2/26/23 and noted he continued to take warfarin on the assessments and service plans. She confirmed she never received the discharge orders from 2/3/23 and failed to obtain them for review.	A 395		
A 425	481-69.27(1)b 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 425		

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A 425	Continued From page 8 b. To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a nurse review as warranted by a significant change in condition. This pertained to 1 of 1 tenants reviewed with medication changes after a hospital admission (Tenant #1). Finding follow: Record review on 3/1/23 revealed Tenant #1's discharge instructions from his hospital stay from 2/2/23 to 2/3/23. The instructions noted the hospital put Tenant #1's warfarin on hold upon his admission to the hospital. The instructions further directed Tenant #1 scheduled an appointment with cardiology in one month to discuss if an anticoagulation should be restarted. Continued record review revealed Tenant #1's Medication Administration Records (MAR) revealed staff administered warfarin from 2/4/23 to 2/18/23. Additional record review revealed Tenant #1's service plan dated 3/1/23 documented Tenant #1 took warfarin. Continued record review of Tenant #1's file failed to reveal a nursing review of Tenant #1's discharge orders from his hospital stay on 2/2/23 to 2/3/23. Cross-reference: Iowa Administrative Code (IAC) 481 - Chapter 69.26(4)a	A 425		

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A 425	Continued From page 9 When interviewed on 3/1/23 at 1:55 p.m. the Registered Nurse stated discharge instructions are reviewed when a tenant returned from the hospital. She said she did not know why she overlooked the information related to discontinuing the warfarin. She confirmed she completed a change of condition on 1/9/23, 2/7/23, and 2/26/23 and noted he continued to take warfarin on the assessments and service plans. She confirmed she never received the discharge orders from 2/3/23 and failed to obtain them for review. When interviewed on 3/2/23 at 2:50 p.m. the RN reported if a person had an INR of 11 and suffered an injury that caused bleeding, they would be a critical risk of major bleeding and possible death if not found right away.	A 425		

Plan of Correction
Holland Farms Assisted Living
2800 Sunset Drive
Norwalk, IA 50211

Re: Investigation #111304-C

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: When medications are administered by the program: Medications and treatments shall be administered as prescribed by the tenant's physician, advanced RNP or PA.*

1. Discharge orders obtained by the facility given directly to the Director of Nursing or designee.

2. Orders containing any high-risk med changes will prompt a nurse review and note in chart regarding med change, service plan updated per facility policy.

3. Any med changes will be signed off by either the Executive Director or an additional RN and noted on DC orders for accuracy in addition to the Director of Nursing for a minimum of one year as long as no additional instances of correction are found. Regional RN or Divisional Operations will complete a quarterly audit to follow up on process for one year.

4. This has been corrected as of 3/1/2023.

A 120 481-69.21 (3) Occupancy Agreement

69.21 (3) The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements.

1. Financial/level of care TOA addendum created to explain charges and services for Carefree and Assisted Living options. Tenant review and signature required.

2. TOA addendum to be reviewed and signed by the Executive Director.

3. Copy of TOA addendum given to tenant and kept on file for review.

4. Implemented on 3/1/2023

A290 481-69.25 (1) Tenant Documents

69.25 (1) *Documentation for each tenant shall be maintained by the program and shall include: when any personal or health-related care is delegated to the program the medical information sheet,*

documentation of health professional orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception.

1. Discharge orders obtained by the facility given directly to the Director of Nursing or designee.

2. Orders containing any high-risk med changes will prompt a nurse review and note in chart regarding med change, service plan updated per facility policy.

3. Any med changes will be signed off by either the Executive Director or an additional RN and noted on DC orders for accuracy in addition to the Director of Nursing for a minimum of one year as long as no additional instances of correction are found. Regional RN or Divisional Operations will complete a quarterly audit to follow up on process for one year.

4. This has been corrected as of 3/1/2023.

A395 481-69.26 (4)a Service Plans

69.26(4) The service plan shall be individualized and shall indicate at a minimum: a. the tenant's identified needs and preferences for assistance.

1. Discharge orders obtained by the facility given directly to the Director of Nursing or designee.

2. Orders containing any high-risk med changes will prompt a nurse review and note in chart regarding med change, service plan updated per facility policy.

3. Any med changes will be signed off by either the Executive Director or an additional RN and noted on DC orders for accuracy in addition to the Director of Nursing for a minimum of one year as long as no additional instances of correction are found. Regional RN or Divisional Operations will complete a quarterly audit to follow up on process for one year.

4. This has been corrected as of 3/1/2023.

A425.481-69.27 (1)b Nurse Review

69.27 (1) *If a tenant does not receive personal or health-related care but an observed significant change in the tenants 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.*

1. Discharge orders obtained by the facility given directly to the Director of Nursing or designee.

2. Orders containing any high-risk med changes will prompt a nurse review and note in chart regarding med change, service plan updated per facility policy.

3. Any med changes will be signed off by either the Executive Director or an additional RN and noted on DC orders for accuracy in addition to the Director of Nursing for a minimum of one year as long as no additional instances of correction are found. Regional RN or Divisional Operations will complete a quarterly audit to follow up on process for one year.

4. This has been corrected as of 3/1/2023.