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
	S0459	A. BUILDING: _____ B. WING _____	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 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: 2 Number of tenants with cognitive disorder: 0 Total census: 2 The following regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification of an Assisted Living Program.	A 000		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to conduct a background check prior to employment for 2 of 6 staff reviewed (Staff A and Staff B). Finding follow: Record review on 11/21/22 of staff files revealed the following: 1. Staff A was hired 5/25/22. A Single Contact License and Background Check was completed 5/26/22.	A 400	The Plan of Correction is attached	

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

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A 400	Continued From page 1 2. Staff B was hired 6/2/22. A Single Contact License and Background Check was completed 6/1/22 and required an evaluation from the Department of Human Services for a criminal history. The employee was approved for work on 6/24/22. The Executive Director confirmed these findings on 11/21/22 at 3:55 p.m.	A 400		
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 record review the Program failed to evaluate functional, cognitive, and health status for a significant change in condition for 2 of 2 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: Record review on 11/21/22 of tenant files revealed the following:	A 145		

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A 145	Continued From page 2 1. Review of Tenant #1's Progress Notes documented the following: - 10/28/22 she felt sad and depressed and exhibited increased signs/symptoms of depression and anxiety. One on one interventions provided minimal relief and the physician was contacted for an appointment. - 10/30/22 and 11/4/22 she expressed wanting to kill herself and was very emotional. - 11/2/22 her physician was notified. - 11/7/22 contacted the physician for clarification of when to administer Lexapro. No functional, cognitive or health assessments could be located for these changes in health status. 2. Review of Tenant #2's Progress Notes documented the following: - 8/27/22 she attempted to leave the memory care unit and required redirection with minimal success. She exhibited increased agitation throughout the morning and yelled and cursed at staff. Staff administered PRN (as needed) Ativan for agitation. - 10/15/22 exhibited increased agitation and attempted to hit staff in the morning. - 10/21/22 Education provided to staff for ongoing behaviors. No functional, cognitive or health assessments could be located for these changes in health status.	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	A 350		

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A 350	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans based on the required assessments and to meet the specific needs of 2 of 2 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: Record review on 11/21/22 of tenant files revealed the following: 1. Review of Tenant #1's Progress Notes documented the following: - 10/28/22 she felt sad and depressed and exhibited increased signs/symptoms of depression and anxiety. One on one interventions provided minimal relief and the physician was contacted for an appointment. - 10/30/22 and 11/4/22 she expressed wanting to kill herself and was very emotional. - 11/2/22 her physician was notified. - 11/7/22 contacted the physician for clarification of when to administer Lexapro. No functional, cognitive or health assessments could be located for these changes in health status. The service plan failed to be based on the requried assessments and failed to include interventions to minimize her symptoms. 2. Review of Tenant #2's Progress Notes documented the following: - 8/27/22 she attempted to leave the memory	A 350		

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A 350	Continued From page 4 care unit and required redirection with minimal success. She exhibited increased agitation throughout the morning and yelled and cursed at staff. Staff administered PRN (as needed) Ativan for agitation. - 10/15/22 exhibited increased agitation and attempted to hit staff in the morning. - 10/21/22 Education provided to staff for ongoing behaviors. No functional, cognitive or health assessments could be located for these changes in health status. The service plan failed to be based on the requried assessments and failed to include interventions to minimize her behaviors.	A 350		
A 405	481-69.26(4)c Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy This REQUIREMENT is not met as evidenced by: Based on record review the Program failed to update service plans to include outside service providers for 1 of 2 tenants reviewed (Tenant #1). Findings follow: Review of Tenant #1s Progress Notes dated 8/22/22 revealed she started PT/OT (physical and occupational therapy) on 8/22/22. The service plan was not updated to include PT/OT services.	A 405		

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A 410	Continued From page 5	A 410		
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on record review the Program failed to ensure service plans included planned and spontaneous activities for 1 of 2 tenants reviewed unable to plan their own activities (Tenant #2). Findings follow: Review of Tenant #2's comprehensive assessment dated 8/17/22 revealed difficulty with producing and comprehending language and she required reminders for scheduled activities. The service plan failed to include a list of activities based on her abilities and preferences.	A 410		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced	A 545		

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A 545	Continued From page 6 by: Based on interview and record review the Program failed to provide 8 hours of dementia training within 30 days of employment for 2 of 6 staff reviewed (Staff B and Staff C). Findings follow: Record review of staff files on 11/21/22 revealed the following: 1. Staff B was hired 6/2/22 and completed .25 hours of dementia training within 30 days of employment. 2. Staff C was hired 5/25/22. No dementia training completed within 30 days of employment could be located. The Executive Director confirmed these findings on 11/21/22 at 3:55 p.m.	A 545		

January 23, 2023

Department of Inspection and Appeals

Attn: Deb Dixon

Lucas State Office Building

321 East 12th Street

Des Moines, IA 50309

Subject: Plan of Correction for Meadowview of Johnston

Please accept the following Plan of Correction as outlined below:

481-67.19(3) Record Checks

1. **Corrective Action:** Evaluation and approval to work for staff A and B were received on 11/29/2022.
2. **Measure to ensure the problem does not recur:** The business office manager was educated on the record checks and evaluations process.
3. **How the program plans to monitor performance to ensure compliance:** No employee will be hired until evaluation and approval to work has been received by the Iowa Department of Human Services. Quarterly the housing director will audit 25% of all employee files to ensure the background check, record check evaluation, and the approval letter are located in the employee's file.
4. **Date of Compliance:** Corrective action completed on 11/29/2022.

481-69.22(3) Evaluation of Tenant

1. **Corrective Action:** Tenant #1 had a full comprehensive evaluation completed by R.N. on 12/4/2022. Tenant #2 had a full comprehensive Evaluation completed by R.N. on 12/6/2022.
2. **Measure to ensure the problem does not recur:** R.N. hired on 11/16/2022 was educated on Chapter 69 481-69.22(2), by Regional Director of Health Services.
3. **How the program plans to monitor performance to ensure compliance:** The Quality Assurance Committee will audit 25% of resident files to ensure Change of Conditions are completed with with functional, cognitive and health status evaluation.
4. **Date of Compliance:** Corrective actions completed on 12/13/2022.

481-69.26(1) Service Plans

1. **Corrective Action:** Tenant #1 had a new service plan in place after the R.N. completed the comprehensive evaluation on 12/4/2022. Tenant #2 had a new service plan in place after the R.N. completed the comprehensive evaluation on 12/13/2022. Our management company, Cassia has added a place on the service plan to include any outside providers.

2. **Measure to ensure the problem does not reoccur:** R. N. hired on 11/16/2022 was educated on Chapter 481-69.26(1) , by Regional Director of Health Services.
3. **How the program plans to monitor performance to ensure compliance:** The Quality Assurance Committee will review 25% of resident files to ensure all elements are included in service plans.
4. **Date of Compliance:** Corrective actions completed on 12/13/2022.

481-69.30(1) Dementia Specific Education for Personnel

1. **Corrective Action:** Staff B is no longer employed at Meadowview of Johnston. Staff C completed 8 hours of dementia training 12/2/2022.
2. **Measure to ensure the problem does not reoccur:** All new hires will not be given a schedule for orientation until they have completed all 8 hours of required dementia training in Relias.
3. **How the program plans to monitor performance to ensure compliance:** All new hire paperwork will be reviewed by the executive director prior to employee working. The Quality Assurance Committee will audit 25% of all employee files to ensure all training is completed within 30 days of hire.
4. **Date of Compliance:** Corrective action completed on 12/13/2022.

√ 3/31/23