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
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 impairment: 21 Number of tenants with cognitive impairment: 19 Total census: 40 The investigation of Complaint #119891-C was completed and did not result in any regulatory insufficiencies. The following regulatory insufficiencies were cited the investigation of Complaint #114653-C, Incidents #114823-I, #116471-I and #119442-I and the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000		
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 established policies and procedures related to door alarms, elopement and visual checks. This pertained 1 of 7 current (Tenant #1) and 1 of 2 former (Tenant C1) tenants reviewed. Findings follow: 1. On 3/28/24 review of an incident report	A 150	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 150	Continued From page 1	A 150		

indicated on 9/23/23 at 2:48 p.m. staff reported the interior memory care door alarm went off and then an exit door alarm went off. Staff in the memory care unit completed a head count and noted Tenant #1 was missing. A search was completed in the general population area and outside around the building. When Tenant #1 was not found, the Community Director called emergency services. At 3:59 p.m. police arrived with Tenant #1 sitting in the front seat. Vital signs were taken and no injuries were noted. The weather was noted as 75 degrees and partly cloudy. An electronic wandering monitoring device was placed on Tenant #1's left ankle.

An Internal Investigation indicated on 9/23/23 Tenant #1 exited the building at 2:48 p.m. The M2 (memory care) door alarm sounded at 2:46 p.m. Staff responded but noted two other tenants inside the memory care door. At 2:48 p.m. the E1 (exterior) door sounded. Staff responded but did not locate a tenant outside of the door. Staff completed a head count, noted Tenant #1 was missing and started a search. Tenant #1 was returned by the local police department at 3:59 p.m. A full assessment was completed and no injuries were noted. The investigation noted the M2 alarm alerted staff and they saw two tenants standing by the door, looked down the hallway and saw no tenants. Two minutes later the E1 alarm sounded and it was noted Tenant #1 was missing. Staff searched the general population area and outside of the building. The Community Director was called. After she arrived, she called 911 and Tenant #1 was returned to the building by police. Employee statements from Staff C, J and F were part of the packet.

a. Staff C's document indicated prior to the elopement Tenant #1 had said he wanted to get out of that place and walked towards the exit

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A 150	Continued From page 2	A 150		

Continued From page 2

door. He was redirected away from the door. She said she heard M2 (memory care) door alarm go off but did not see Tenant #1 there. Later on she heard the E1 (exterior) door alarm go off and knew she had not seen Tenant #1 in awhile. She said Staff J and her both went to the M2 door alarm, after E1 alarm went off. She said Staff J opened the M2 door and did not see Tenant #1. After the E1 door alarm went off she walked outside the door and did not see Tenant #1. She said a head count was not completed.

b. Staff J's document indicated Staff C heard the E1 door alarm going off after Staff C and Staff J had both run to get M2 door alarm shut off. Staff J said they did not start a head count as they thought it was the other two tenants until Staff C heard the E1 door alarm going off.

c. Staff F's document indicated Staff C met him in the office to ask about the code for the door. He was not aware of any alarms that went off when Tenant #1 exited the building. He walked outside the door after he was told about a tenant. He said a head count was not completed and they focused in on one particular tenant. He indicated when asked if there was anything to know that the tenant could have been long gone before his absence was noticed.

All three received Counseling Documentation Forms for not following the policy and procedure for door response/visual checks on 9/23/23 which resulted in an elopement.

When interviewed on 3/28/24 at 3:40 p.m. Staff C stated she worked second shift and floated back and forth on both sides of the building administering medications. She said earlier in the day, about 2:30 p.m. Tenant #1 said he wanted to get out of the building. She was in memory care when she first heard the M2 door alarm go off.

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A 150	Continued From page 3 There were two tenants standing in front of the door and it was thought they had set off the alarm. She did not see Tenant #1 by the door. Staff went to door M2 and opened it but did not see him. Approximately five minutes later the second door alarm was heard. She thought back to the comment Tenant #1 had made earlier. She told Staff J and they went through every apartment in memory care. The Community Director was called and she sent Staff F out to look for Tenant #1 in a car. The police were also contacted. The police found him down the highway and brought him back with no injuries. The time gone from the building was an hour to an hour and a half. She said the door alarms functioned as they should. The tenant had worn had shorts, a t-shirt and shoes. He did not use an assistive device. When interviewed on 4/4/24 at 11:22 a.m. the Community Director said she received a telephone call from staff stating they could not find Tenant #1. They had walked through the unit and checked closets and apartments. The M2 door alarm had gone off, staff had checked and saw two other tenants there. She did not recall if the staff had reported they opened the door. The exit door in the general population then went off and Staff C had a feeling (regarding Tenant #1). She went to the door and cleared it and started looking. Tenant #1 was not found and staff called the Community Director. She advised them to look outside and she came to the building. She called the nurse on-call and the police department. On the phone the police stated they believed they had just found him and were bringing him back to the building. The police reported Tenant #1 had said he was looking for his car. He was located east of town by the golf course. An assessment was completed and	A 150		

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A 150	Continued From page 4	A 150		

there were no injuries. They gave him some water as he was warm. He was wearing shorts and t-shirt with shoes and socks. His gait was steady but he appeared to be worn out. The alarms functioned on both the M2 and E1 doors. The second door alarm was within minutes of the first alarm. She would have expected to be called sooner, but the staff checked everywhere and then called her after. Staff were expected to do a head count at the first alarm (M2) when it was noted the two other tenants were located. However, staff did not complete a head count until after the E1 alarm. She did not recall if staff looked outside the E1 door after it alarmed. She said if the policy had been followed completely staff should have found him outside the exterior door.

On 4/1/24 review of Tenant #1's file revealed he was staged at a five on the Global Deterioration Scale (GDS) and resided in the memory care unit at the time of the elopement. The service plan in place at the time reflected Tenant #1 received eight visual checks per shift for safety and he was independent with ambulation.

The driving directions from Google Directions indicated from the Program to Orchid Lane where Tenant #1 was located was a distance of 1.8 miles and three minute drive by car. On foot it was 1.7 miles and an estimated time of 37 minutes.

When observed on 4/3/24 at approximately 5:10 p.m. to 5:30 p.m. the building was located on highway 57, with a posted speed limit of 35 miles per hour (mph) in front of the building. It was a two lane road, that was west/east, with a sidewalk located on the north side of the road. The highway crossed several driveways, business

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A 150	Continued From page 5	A 150		

entrances and cross streets. It changed to 45 mph as it traveled to the east toward the highway 57/highway 14 intersection. That intersection was a two way stop from the north and south. Traffic from the west and east did not stop. Highway 14 turned to the south and highway 57 continued to the east. After the intersection the speed limit increased to 55 mph. There was no sidewalk and minimal shoulder on the road. It was a two lane highway with a speed limit of 55 mph. The highway went up hill and Orchid Lane was a turn north off of the highway. There were no markings on Orchid Lane and no posted speed limit sign was observed. The road was paved where it turned off of highway 57. Driving distance was 1.4 miles driven by car. This was a possible route that Tenant #1 took when he eloped.

The State Climatologist provided the following weather conditions at the time of the elopement: the temperature was 84 degrees, the relative humidity was 52%, the heat index was 86%, the winds were from the southeast at 18 mph gusting to 30 mph and there were low clouds but no precipitation.

2. Review on 4/1/24 of an incident report indicated on 7/1/23 at 11:30 a.m. staff found Tenant C1 in another tenant's apartment and tried to redirect him. He got up and left the apartment of the other tenant. Staff reported Tenant C1 was angry. The Program received a telephone call from a person in the community who observed Tenant C1 walking past their house. The person from the community escorted him back to the building. There was no injury and vital signs were within normal limits. The weather was 78 degrees and partly cloudy.

An Internal Investigation indicated on 7/1/23 at

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A 150	Continued From page 6 10:30 a.m., Tenant C1 exited the memory care unit, the door alarm sounded. He then went through the front door of the building at 10:30 a.m. unattended. Staff responded to the door alarm, searched outside the memory care door, did not see anyone and shut off the door alarm. A local community member observed Tenant C1 near the bank (later clarified as a church) in Parkersburg at 11:14 a.m. The community member assisted him back to the building at 11:17 a.m. During that time the nurse was called and was alerted by another local community member of Tenant C1 out walking. The nurse called the program and asked if they knew his whereabouts. The Findings of the Investigation were that staff responded to the door alarm in 38 seconds. She went through the memory care door and down to the general population door and did not see anyone. Staff A asked Staff B if she saw anyone and she said no. A head count was not done. Visual checks were signed off for Tenant C1 at 10:40 a.m. and 10:44 a.m. by Staff K when Tenant C1 was not in the building from 10:30 a.m. until 11:17 a.m. The Investigative Conclusion included staff interview revealed the memory care door did not always latch and staff had to ensure it latched (maintenance was made aware). It was protocol to start a head count when the alarm alerted, which was not followed. Tenant C1 exited at 10:30 a.m. and returned at 11:17 a.m. per video footage. He did not sustain any injuries. The statement provided to staff at the program from the local community member (former staff member) indicated she called the Healthcare Coordinator at 11:14 a.m. when Tenant C1 was seen walking down the street. The community member witnessed him walking near Bethel Church, pulled over and got out of the car to walk	A 150		

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A 150	Continued From page 7	A 150		

with him. The community member walked back to the building with Tenant C1. Tenant C1 was determined to walk home. Spoke with staff and asked if they knew he was out and Staff J said they had heard the alarm but were so busy.

Employee Investigation Questions were completed for the three staff working at the time of the elopement and indicated the following:
a. Staff A's document indicated Tenant C1 was last seen at 10:30 a.m. in another tenant's apartment. When asked how she was notified about Tenant C1 leaving, she said she received a call from the Healthcare Coordinator who asked if Tenant C1 was in the building because she had just received a call from a local community member who was walking him back. Staff A said she went and looked and ran to the front lobby but did not go out of the door. She asked Staff B if she had seen any other tenants and she said no. A head count was not completed. She said a staff member did not show up at 10:00 a.m. and they were busy.
b. Staff B's document indicated Tenant C1 was last seen in another tenant's apartment. She learned of Tenant C1 missing when another staff reported a community member was bringing Tenant C1 back. She was not aware of any alarm notifications but as on the other side of the general population.
c. Staff J's document indicated Tenant C1 was last seen about 10:30 a.m. in another tenant's apartment. She was notified Tenant C1 had exited when the Healthcare Coordinator called about 11:00 a.m. and staff checked his apartment and he was not there. She indicated the alarm sound was questioned between Staff A and Staff J.

Further record review revealed Counseling

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A 150	Continued From page 8	A 150		

Continued From page 8

Documentation Forms were completed for Staff A and Staff B for not following the policy regarding door response/visual checks which resulted in an elopement on 7/1/23. Staff J also received a Counseling Documentation Form for not following the policy regarding door response/visual checks which resulted in an elopement on 7/1/23 and Staff J signed off visual checks at 10:40 a.m. and 10:44 a.m. when Tenant C1 was not in the building.

When interviewed on 3/28/24 at 9:15 a.m. Staff A said she and Staff J were getting a tenant dressed when she heard a scream and found Tenant C1 in another tenant's apartment. Staff separated them and he went down the hall. She heard M1 (memory care) door alarm sound and received a page. She came out the general population, looked around. Staff B was out there and Staff A asked her if she had seen Tenant C1 and she said no. She figured if he had gone out the door she would have seen him. Staff A did not look out of the front door or exterior doors. She looked in entryway of the building but not outside of the building. Staff J started a head count and they received a telephone call that someone had seen him walking around. She was then told was told a prior staff member had him and she brought him back in approximately 15 minutes. He had no injuries and was dressed appropriately for the weather. She said she should have gone out of the front door when the elopement occurred.

When interviewed on 4/2/24 at 2:27 p.m. the Healthcare Coordinator said she received a telephone call from someone in the community. The person called and had picked up Tenant C1 and brought him back. When the Healthcare Coordinator arrived he had already been brought

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A 150	Continued From page 9	A 150		

back to the building. He had no injuries. She said she did not know how he was able to leave the building but the alarms did function. She was not the on-call nurse that weekend. He was dressed appropriately for the weather and did not use an assistive device. After the elopement his visual checks were increased to every 30 minutes and an electronic wandering monitoring device was placed.

When interviewed on 4/4/214 at 11:22 a.m. the Community Director said she was not in her current position until 7/5/23 and she was previously a resident assistant. She did not have much to do with the paperwork. She said when a door alarm went off, staff should respond immediately and check outside of the door. They need to check visually and then follow up with head count.

Review of Tenant C1's file on 4/1/24 revealed he was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan in place at the time of elopement reflected Tenant C1 was independent with ambulation. He required safety checks and resided in the memory care unit. The Documentation Survey Report from July 2023 reflected visual checks eight times per shift. On 7/1/23 the 10:00 a.m. check was documented at 10:40 a.m. by Staff J. The 11:00 a.m. check was documented at 10:44 a.m. by Staff J. Both checks were documented when Tenant C1 was not in the building and staff were unaware he had eloped.

The walking directions per Google Directions from the Program to Bethel Lutheran Church reflected it was 0.3 of a mile and estimated it would take six minutes.

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A 150	Continued From page 10 When observed on 3/28/24 at approximately 2:20 to 2:50 p.m. the possible route Tenant C1 traveled when he eloped was observed. The highway 57/14 in front of the building had a posted speed limit of 35 mph. It was a west/east road, two lane road. Driving west on highway 57/14, a right turn (north) on 2nd street/Church Street/Miller Avenue and then a right turn on to 3rd Avenue. That street was a two way north/south street with post speed limit of 25 mph. The State Climatologist provided the following weather conditions at the time of Tenant C1's elopement: temperature was 80 degrees, relative humidity was 58%, winds were from the east, southeast, at 3 mph and there was no heat index. There were low clouds and no precipitation. 3. Review of the Program's Door Alarm Response protocol indicated if a notification had been received regarding a breach or opened door, staff was to immediately respond to the door. Staff would look inside and outside of the door to know who last used the door. After it was determined who came in or out, staff reset the door. If they did not know who went in or out of the door, they would immediately do a head count of all tenants. If a tenant was not accounted for staff would immediately call the emergency contact, the director and nurse on-call and the local police department. The Program's Missing Resident Elopement policy indicated in the event a tenant was missing, the staff who noticed the tenant was missing would notify the director or designee, who then assumed the lead role and would take the following steps: notify all staff within the building that the tenant was missing, do a thorough	A 150		

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A 150	Continued From page 11 search inside the building, call the people on the emergency contact list to see if they have taken the person out, if not found notify the director and/or nurse, assign staff to search outside the building. If the tenant was not found call 911. The Program's Visual Check protocol indicated staff made visual contact of the tenant and documented the visual according the scheduled time. The key was for the tenant to be viewed throughout the entire shift and ensure safety. If a tenant was not in their apartment they should check the memory care unit and building. If the tenant was not found to notify staff in the building and to refer to policies and procedures for a missing tenant or elopement.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure tenants were treated with consideration, respect, dignity and autonomy regarding 1 of 1 tenants inolved in incident 119442-I (Tenant #2). Findings follow: 1. On 4/1/24 review of an Internal Investigation document dated 3/6/24 indicated the date of the incident was 3/5/24 at 1:49 p.m. and the location	A 155		

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A 155	Continued From page 12	A 155		

was the memory care dining room. There were two witnesses Staff B and Staff I. The staff suspected of maltreatment was Staff E. The tenant involved was Tenant #2. The description of the incident indicated on 3/5/24 Tenant #2 and staff were seated at the dining room table. While Staff E was speaking Tenant #2 threw water on her. Staff E stood up, made physical contact with Tenant #2 and yelled at her to go to her apartment. No injuries were noted. Staff E was suspended pending investigation.

2. On 4/1/24 at approximately 2:45 p.m. and 4/4/24 at 11:20 a.m. the video of the alleged incident between Staff E and Tenant #2 was observed. The date and time of the video was 3/5/24 at 1:49 p.m. The Community Director identified the staff seated at the table as Staff B, Staff E and Staff I and also identified Tenant #2. Staff E was seated next to Tenant #2. Tenant #2 had a glass of water and was observed drinking it. At 1:51 p.m. Tenant #2 threw her water in Staff E's face. Staff E was seated to the right of Tenant #2. Staff E stood up quickly, reached for the cup and it appeared there was brief physical contact made from Staff E to Tenant #2. She appeared to yell at Tenant #2 and told her to go to her room now and she was not putting up it with anymore. Tenant #2 walked away, Staff E went over to the dish container/bin and threw the cup in the container. Tenant #2 said a phrase of profanity and then was told by Staff B to go (voice of Staff B identified by the Community Director).

3. Employee Investigation Questions were completed by the Program indicated the following:
- Staff B's document indicated she was aware of a verbal or physical altercation between Staff E and Tenant #2 that occurred the day prior. She

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
	S0300	A. BUILDING: ____ B. WING ____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 155	Continued From page 13	A 155		

said that Tenant #2, Staff E, Staff I and herself were seated at the table. Staff E gave Tenant #2 some water. She drank the water and threw the rest at Staff E. She said Staff E then grabbed the cup and told Tenant #2 to go to her apartment. Tenant #2 got up, used profanity and then refused to go to her room.

- Staff I's document indicated she was aware of a verbal or physical altercation between Staff E and Tenant #2. She said Staff E gave Tenant #2 water. Staff B, Staff E and Staff I were seated talking with Tenant #2. She said Tenant #2 looked at Staff E and threw a glass of water in Staff E's face. Staff E jumped up and pushed Tenant #2's chair and told her to go to her room. Tenant #2 got up and used profanity. Staff E said she was done with it. She said that if nothing was done about it she was calling the police.

A Notice of Investigatory Suspension dated 3/6/24 indicated the description of the allegation indicated it was reported that Staff E shoved a tenant in memory care and demanded that she go to her room. The document indicated Staff E's comments included that Tenant #2 threw water in her face after punching (or pinching) her in the arm. Staff E moved Tenant #2's chair away from the table and asked her to go to her room. Staff E said she went to her room without saying or doing anything.

Record review revealed a letter dated 3/12/24 indicating Staff E's employment was terminated effective immediately due to policy or safety violation/conduct or behavior. Counseling Documentation Forms were completed for Staff B and Staff I for witnessing an incident between staff and a tenant on 3/5/24 and not reporting to the nurse or director as required by policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

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A 155	Continued From page 14 4. When interviewed on 4/1/24 at 3:04 p.m. Staff I said a few days ago around 1:00 p.m. she was done with her job duties and brought a tenant back to the memory care unit to visit with others. Staff B, Staff E, Staff I and Tenant #2 were all seated at the table. She did not remember what they were visiting about. Staff E had gotten a glass of water for Tenant #2. Staff E and Tenant #2 were seated side by side and Tenant #2 threw water in Staff E's face. She said Staff E jumped up and started yelling. She remembered Staff E pushed Tenant #2's chair backwards. She told her to go to her room. She thought Staff E had pushed her on the arms of the chair. Staff E yelled at her to go to her room and Tenant #2 used profanity. She said there was no response from Tenant #2 other than the words said. She said Staff E was angry. Staff I said she should have reported it right away but she said other times when things were reported they were not addressed. She said she did not go and check on Tenant #2. During an interview on 4/2/24 at 2:27 p.m. the Healthcare Coordinator said Staff E came to her and told the Healthcare Coordinator something had to be done (regarding Tenant #2). She said Tenant #2 had thrown water in her face. She said Staff E felt that the Healthcare Coordinator was not listening and marched off. The Healthcare Coordinator and Community Director looked at the video to see what had happened. The incident occurred towards the end of the shift. It looked like Staff E grabbed her and ordered Tenant #2 to her room. She said she would have expected staff to give Tenant #2 something to do or to take her for a walk. She said another staff should have deescalated the situation. When interviewed on 4/4/24 at 11:22 a.m. the	A 155		

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
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 155	Continued From page 15 Community Director said the Healthcare Coordinator had come to her and was visibly upset. She said Staff E had come to her and was aggressive and told her something needed to be done. Staff E told her Tenant #2 threw water at her. Staff E told the Healthcare Coordinator she was going to call state on her. She called Staff E and asked her to come back in and talk about the situation but she refused to come that day. The next morning the Community Director watched the video. She sent the video to corporate staff and it was decided to report it. In the video there were three staff, Staff B, Staff E and Staff I at the table with Tenant #2. She said they were talking about something and you could see Staff E's arms moving. Tenant #2 threw water on Staff E. The Community Director said she was appalled by Staff E's reaction. Staff E stood up, touched/turned Tenant #2. She yelled and pointed for Tenant #2 to go her room. Staff E threw the water glass in the common area. She said tenants were not isolated in their apartments and she should not have thrown the water glass. She said Staff B said at first she thought it was okay. Staff I said she was shocked and said it was not okay. She also talked with Staff E and she apologized for how she approached the Healthcare Coordinator. Staff E was told it was reported to the state. Staff E said Tenant #2 threw water, Staff E grabbed the glass and told her to go to her room. She did not recall touching the chair or Tenant #2. Staff E was told she was suspended and she said she did not do anything wrong. Staff E's employment was later terminated. Attempts were made to contact Staff B and Staff E via phone as both staff were longer employed; however, the attempt was unsuccessful.	A 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 155	Continued From page 16 5. Review of Tenant #2's file on 4/2/24 revealed a diagnosis of Alzheimer's disease and she was staged at five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The service plan with a 12/13/23 activation date indicated she had occasional behavior issues, was physically abusive towards others. If physically aggressive towards another tenant staff were to separate them, monitor spacing and limit interactions. In summary, Tenant #2 was not treated with respect or dignity regarding an incident that occurred on 3/5/24. Tenant #2 was observed on video seated with three staff and she threw water onto Staff E Video and interviews indicated Staff E jumped up, took the water glass and made brief physical contact with Tenant #2. She appeared to yell at Tenant #2 to go to her room and that she was not putting up with it anymore. Staff E also threw the cup in the dish container/bin. Two other staff also witnessed the incident, failed to report it to leadership staff and failed to check on Tenant #2 after the incident.	A 155		
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: Based on interview and record review the	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C **04/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57** **PARKERSBURG, IA 50665**

(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 160	Continued From page 17	A 160		

Program failed to provide care, treatment and services that were adequate and appropriate for 3 of 6 of current (Tenants #1, #5 and #6) and 2 of 2 discharged (Tenant C1 and Tenant C2) tenants reviewed. Findings follow:

1. When interviewed on 3/27/24 at approximately 1:45 p.m. and 2:17 p.m. Staff B said depending on how busy things were some things did not get done. At least twice per week laundry and showers did not get done. She said she did not think visual checks were getting done hourly at night. She said tenants were soaked regarding urinary incontinence when first shift came in and she also came in to find a tenant on the floor.

2. Review of Tenant #1's file on 4/1/24 revealed the Monthly Task Log for February 2024 reflected a task for staff to provide visual and safety checks hourly. On 2/17/24 from 2:00 p.m. until 2/18/24 at 1:00 a.m. the checks were charted as task not completed. It was also charted as task not completed on 2/23/24 from 10:00 p.m. until 2/24/24 at 1:00 a.m.

3. Review of Tenant #5's file on 4/3/24 reflected the Monthly Task Log for February 2024 reflected the task of bathing twice per week on Tuesday and Friday. The task was charted as task not completed on 2/27/24.

4. Review Tenant #6's file on 4/3/24 of reflected the Monthly Task Log for February 2024 reflected cares were charted as task not completed on 2/17/24, including for escorts, transferring, grooming/hygiene, dressing and toileting. Additionally, the task of bathing twice per week on Tuesday and Friday, was charted as task not completed on 2/27/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57** **PARKERSBURG, IA 50665**

(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 160	Continued From page 18	A 160		

5. Review of Tenant C1's file on 4/1/24 revealed the Monthly Task Log for December 2023 reflected task not completed from 12/14/23 to 12/19/23 for daily bed making, daily garbage removal, grooming and dressing. It also reflected task not completed on 12/14/23 and 12/18/23 for bathing, which was scheduled twice per week. Hourly visual checks were not documented as completed from 12/13/23 to 12/14/23. The checks were also not documented as completed every hour on the following dates: 12/15/23, 12/16/23, 12/17/23, 12/18/23, 12/19/23 and 12/20/23.

6. Review of Tenant C2's file on 4/1/24 revealed the service plan indicated for fall interventions included the alarm pad added to the chair and bed to alert staff if he was trying to get up. Tenant C2 was at risk for falls due to history, wounds to the lower extremities and use of assistive devices. He received eight checks per shift for falls and had alarm checks. Incident reports indicated the following:
a. On 7/27/23 at 4:50 p.m. staff entered the dining room and round Tenant C2 on the floor, sitting on buttocks in front to of his wheelchair. A skin tear was noted on the left elbow area and right upper arm. An abrasion was noted to the right upper back area.
b. On 8/3/23 at 9:40 a.m. staff heard a noise coming from Tenant C1's apartment. When staff entered the apartment he was on the floor. He had an abrasion noted to the right upper arm and buttock area. The abrasion on the right upper arm close to the elbow was cleansed, covered with Xeroform and 4 x 4 and secured with Coban tape per the hospice nurse.

The Documentation Survey Report for July 2023 indicated the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ____ B. WING ____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 160	Continued From page 19	A 160		

a. It was noted on 7/27/23 for the task of alarm checks hourly, the 4:00 p.m. was documented at 4:26 p.m. and the 5:00 p.m. check was not documented until 8:39 p.m. Tenant C2's fall was noted at 4:50 p.m.
b. A task indicated to ensure the pad alarm was under Tenant C2 and was working when he was in bed or in the chair. The documentation for the task was listed as every shift: 6 a.m. to 2:00 p.m., 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m. There were 8 omissions in the month of July 2023, where staff did not document they checked the placement and functioning of Tenant C2's personal alarms.
c. A task indicated to check the alarms hourly. There were 15 omissions in the month of July 2023, where staff did not document the alarm checks.

The Documentation Survey Report for August 2023 indicated the following:
a. It was noted on 8/3/23 the tasks of alarm checks hourly, the 9:00 a.m. and 10:00 a.m. check was charted as not applicable. Tenant C2's fall was at 9:40 a.m.
b. A task indicated to ensure the pad alarm was under Tenant C2 and was working when he was in bed or in the chair. The documentation for the task was listed as every shift: 6 a.m. to 2:00 p.m., 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m. There were over 10 omissions in the month of July 2023, where staff did not document they checked the placement and functioning of Tenant C2's personal alarms.
c. A task indicated alarm checks, "Y" indicated the alarm was functioning correctly and in place and "N" reflected the alarm was not functioning and the nurse/designee was notified. The alarms were frequently charted as a N, the alarm was not functioning, when the check was completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 160	Continued From page 20 hourly throughout the month of August, especially during the hours of 10:00 p.m. to 5:00 a.m. 7. When interviewed on 4/4/24 at 11:22 a.m. the Community Director confirmed all task records were provided for the tenants reviewed.	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 administer medications and treatments as ordered for 2 of 7 tenants reviewed (Tenant #6, Tenant #7). Findings follow: 1. Review of Tenant #6's file on 4/3/24 revealed a fax to the primary care provided (PCP) dated 2/20/24 indicating Tenant #6 sat in wet protective undergarments and would only change when she wanted to. Staff offered to go with her but she refused. An ointment or cream was requested. On 2/20/24 the PCP ordered A & D ointment twice daily and as needed. The February and March 2024 medication administration records (MARs) reflected vitamin A	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ____ B. WING ____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 285	Continued From page 21	A 285		

& D ointment, to be applied to affected area twice daily as needed. It reflected a start date of 2/22/24. The MARs did not reflect the treatment as ordered, which was twice to apply daily and as needed.

A Progress Notes dated 3/26/24 indicated Tenant #6 was assisted to the bathroom and her buttock was raw and reddened. A note was faxed to the PCP.

Additional Progress Notes indicated the following:
a. On 10/8/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 25 microgram (mcg) in the morning, but it was not in the pill pack.
b. On 10/9/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 25 mcg in the morning, but it was not in the pill box.
c. On 10/9/23 it was noted at 8:00 a.m. to give medications from medication planner (five tablets) D3 2000IU, aspirin 81 mg, B1 1000 mcg, amlodipine besylate 5 mg, but the medication needed to be filled.
d. On 10/28/23 it was noted to give 8:00 p.m. medications per med planner (one tablet), but medication planners were empty.
e. On 10/30/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning, but it was not in the pill box.
f. On 11/5/23 it was noted at 8:00 a.m. to give medications from medication planner (five tablets) D3 2000IU, aspirin 81 mg, B1 1000 mcg, amlodipine besylate 5 mg. It was charted as "N/A."
g. On 11/26/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning, but it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ____ B. WING ____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 285	Continued From page 22 not in the pill box. h. On 11/27/23 it was noted at 8:00 a.m. to give medications from medication planner (five tablets) D3 2000IU, aspirin 81 mg, B1 1000 mcg, amlodipine besylate 5 mg. The medication planner was empty. i. On 11/28/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning. There were no pills for 6:00 a.m. j. On 12/8/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning. There was no medication planner in the drawer. k. On 12/9/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning. There were no pills available. l. On 12/16/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning. There were no pills available. m. On 12/17/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning. There were no pills in the planner. n. On 12/18/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning. There were no pills in the planner. o. On 12/19/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning. There were no pills in the planner. p. On 12/20/23 it was noted at 6:00 a.m. to give medication from single medication planner, Levothyroxine 50 mcg in the morning. There were no pills in the planner. 2. When observed on 3/28/24 at 10:30 a.m. Staff	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ____ B. WING ____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 285	Continued From page 23	A 285		

D assisted Tenant #7 with taking his blood glucose. Staff D assisted with a finger stick to complete the blood glucose check and his blood glucose level was 192. It was noted during the medication pass there was a Dexcom reader in Tenant #7's apartment.

On 3/28/24 at 10:50 a.m. Staff D said she was going to replace Tenant #7's Dexcom sensor as the current sensor was old.

Review of Tenant #7's order on 4/4/24 indicated on 2/1/24 a continuous glucometer meter was ordered. The items ordered included one reader and one unit (one month of sensors and supplies).

Continued record review revealed the March 2024 MAR did not reflect the use of the Dexcom device.

3. When interviewed on 4/4/24 at the time of the exit meeting the Healthcare Coordinator indicated Tenant #6's family had been setting up her medications in the medication planner (during the time of the issues with medication availability). She said Tenant #6 currently had medications dispensed by the pharmacy.

When interviewed on 4/4/24 at 11:22 a.m. the Community Director confirmed all MARs and orders were provided for the tenants reviewed.

A 355	481-67.9(4)d Staffing	A 355		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 355	Continued From page 24	A 355		

shall, at a minimum, include the following:

d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the Program failed to provide training for 2 of 2 staff reviewed who assisted with a continuous glucometer (Staff D and Staff H). Findings follow:

1. When observed on 3/28/24 at 10:30 a.m. Staff D assisted Tenant #7 with taking his blood glucose. It was noted during the medication pass there was a Dexcom reader in Tenant #7's apartment.

When interviewed on 3/28/24 at 10:50 a.m. Staff D said she was going to replace Tenant #7's Dexcom sensor.

2. Record review on 4/4/24 of Tenant #7's orders indicated on 2/1/24 a continuous glucometer meter was ordered. The items ordered included one reader and one unit (one month of sensors and supplies).

3. When interviewed on 4/2/24 at 2:27 p.m. the Healthcare Coordinator indicated Tenant #7 had a Dexcom. She said Staff D and possibly Staff H had been trained on replacement of the sensor; however, it was not documented.

4. Review of Staff D's training documents on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 355	Continued From page 25 4/1/24 revealed a Nurse Delegation Flowsheet indicating nurse delegated training was completed on 8/24/23 and 11/1/23. The training on 11/1/23 included glucometer testing; however, the nurse delegation completed did not include training on a continuous glucometer. Review of Staff H's training documents on 4/1/24 revealed a Nurse Delegation Flowsheet indicating nurse delegated training was completed on 1/10/24 and 2/8/24. The training on 2/8/24 included glucometer testing; however, the nurse delegation completed did not include training on a continuous glucometer. 5. When interviewed on 4/4/24 at 11:22 a.m. the Community Director confirmed all nurse delegation training was provided for the staff reviewed.	A 355		
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 complete a background check prior to employment. This pertained to 1 of 7 staff reviewed hired in 2023 (Staff F). Findings follow: 1. Review of Staff F's training information on	A 400		

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
	S0300	A. BUILDING: ______ B. WING ______	C **04/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 400	Continued From page 26 4/2/24 revealed a hire date of 3/16/23. A Single Contact License & Background Check was completed on 3/27/24 (date onsite visit was initiated). The background check revealed no results were found for the Abuse Registries Background Check or Criminal History Background Check. 2. When interviewed on 4/4/24 at 11:22 a.m. and on 4/4/24 at the time of exit interview the Community Director confirmed all background check information for the staff reviewed was provided and no additional background checks were found for Staff F.	A 400		
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 for 6 of 6 tenants reviewed (Tenant #1, #2, #3, #4, #5 and #6). Findings follow: 1. Review of Tenant #1's file on 4/1/24 revealed Progress Notes for the last three months revealed one entry dated 1/3/24. That entry indicated Tenant #1 tested positive for COVID-19.	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 290	Continued From page 27	A 290		

Continued From page 27

A fax was sent to the primary care provider (PCP). A nurse's note was not completed when Tenant #1 was no longer COVID-19 positive and was out of isolation.

2. Review of Tenant #2's file on 4/2/24 revealed Progress Notes indicating the following:
  a. On 1/3/24 Tenant #2 tested positive for COVID-19. A fax was sent to the PCP.
  b. On 2/12/24 a call was received from the PCP regarding urinalysis (UA) results. An antibiotic was ordered and the medication planner would be set up.
  c. On 2/12/24 Tenant #2 had diarrhea after starting the antibiotics.
  d. On 2/13/24 an order for a probiotic was sent to the pharmacy the previous night.

Nurse's notes were not completed when Tenant #2 was no longer COVID-19 positive and isolation had ended, or with the completion of the antibiotic and probiotic.

3. Review of Tenant #3's file on 4/3/24 revealed Progress Notes indicating the following:
  a. On 12/31/23 Tenant #3 tested positive for COVID-19 and fax was sent to the PCP.
  b. On 3/19/24 Tenant #3 had vomiting and diarrhea that afternoon. She was tested for COVID and was negative.

Nurse's notes were not completed when Tenant #3 was no longer COVID-19 positive and isolation had ended or to follow up to the vomiting and diarrhea noted on 3/19/24.

4. Review of Tenant #4's file on 4/3/24 revealed Progress Notes indicating the following:
  a. On 1/6/24 Tenant #4 complained of a stuffy nose and tested positive for COVID-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 290	Continued From page 28 b. On 1/19/24 Tenant #4 as sent to the emergency department (ED) after an unwitnessed fall that resulted in large bump to backside of her head. c. On 1/20/24 Tenant #4 returned at 12:45 a.m. from the ED. Discharge paperwork indicated she was seen including for acute cystitis with hematuria. An antibiotic was ordered. Nurse's notes were not documented by exception when Tenant #4 was no longer COVID-19 positive and isolation had ended and with the completion of the antibiotic to ensure there were no further signs or symptoms. 5. Review of Tenant #5's file on 4/3/24 revealed Progress Notes for the last three months revealed one entry dated 1/2/24. That entry indicated Tenant #1 tested positive for COVID-19. A fax was sent to the PCP. A nurse's note was not completed when Tenant #5 was no longer COVID-19 positive and was out of isolation. 6. Review of Tenant #6's file on 4/3/24 revealed Progress Notes indicating the following: a. On 1/2/24 Tenant #6 tested positive for COVID-19 and a fax was sent to the PCP. b. On 3/19/24 it was noted Tenant #6 had diarrhea that morning. She was tested for COVID and was negative. c. On 3/26/24 it was noted Tenant #6 was assisted to the bathroom and her buttock was raw and reddened. A note was faxed to the PCP. Nurse's notes were not completed when Tenant #6 was no longer COVID-19 positive and isolation had ended or to follow up to the vomiting and diarrhea noted on 3/19/24. A note was also not completed as a follow up to the raw and reddened appearance of Tenant #6's buttock.	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ____ B. WING ____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 290	Continued From page 29 7. When interviewed on 4/4/24 at 11:22 a.m. the Community Director confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have service plans based on evaluations, failed to update service plans as needed and failed to have service plans reflect the service needs of the tenants. This pertained to 5 of 6 current (Tenants #2, #3, #4, #5 and #6) tenants reviewed. Findings follow: 1. Review of Tenant #2's file on 4/2/24 revealed Progress Notes indicating the following: a. On 8/12/23 there were multiple episodes of physical and verbal aggression towards staff. Tenant #2 slapped a staff in the face, punched a staff in the head and hit a staff across the face with a tablecloth. Tenant #2 threw a full glass of water at staff when she came out of the laundry room. She also tried to jump on another tenant and tried to hit another tenant but staff	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 350	Continued From page 30	A 350		

intervened.
b. On 8/13/23 Tenant #2 continued to pace from her apartment to the lounge. She thought staff were talking about her. She approached staff, would get up to her face and call her a name. She would also clap her hands or make gestures at staff.
c. On 8/14/23 a sign was put on her door not to hit other people, to keep her hands to herself and no kissing other people.
d. On 8/30/23 a call was placed to the primary care provider (PCP) regarding behaviors of calling names and throwing things at staff.
e. On 1/18/24 Tenant #2 started punching another tenant. Staff separated both tenants.
f. On 2/5/24 Tenant #2 attempted to push another tenant's chair over from behind numerous times. She showed the other tenant a hand gesture and then slapped the other tenant in the face with an open palm. She then hit staff in the stomach and pushed them against the wall. The tenants were separated.
g. On 3/5/24 Tenant #2 was seated at the table with staff members and she took a glass of water and threw the water in the staff's face. The staff member stood up, made physical contact her with her and yelled at her to go to apartment.
h. On 3/12/24 a change of condition was completed related to Tenant #2's discharge (30 day) notice given.

Tenant #2's service plan with an activation date of 12/13/23 reflected she had occasional behavior issues as well as occasional disruptive behaviors. On 1/17/24 it was updated to reflect Tenant #2 had physical aggressive to another tenant. On 2/4/24 the plan was revised to have Tenant #2 sit at different table from another tenant with their backs to each other. The service plan was not updated to reflect the behaviors, both physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ____ B. WING ____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 350	Continued From page 31	A 350		

and verbal towards staff and interventions.

2. Review of Tenant #3's file on 4/3/24 revealed Progress Notes indicating the following:
a. On 1/24/24 Tenant #3 had an unwitnessed fall.
b. On 2/13/24 Tenant #3 was found sitting on the floor.
c. On 2/22/24 at 12:06 a.m. it was noted staff completed a visual check and found Tenant #3 on the floor.
d. On 2/22/24 at 7:01 p.m. Tenant #3 stood up from the dining room table and fell backwards. She hit her head hard on the floor. Tenant #3 was sent to the emergency department (ED) for evaluation.
e. On 2/23/24 a change of condition was required for the falls and ED visit
f. On 3/7/24 physical therapy (PT) was started with Tenant #3.
g. On 3/21/24 staff found Tenant #3 sitting on the floor.
h. On 3/25/24 staff found Tenant #3 sitting on the floor. She was later observed ambulating in the common area. Staff then saw her on the floor.

Continued record review revealed an order was found dated 2/28/24 for PT services to evaluate and treat for weakness/balance and the right middle finger contracture.

Two service plans were provided for Tenant #3. One service plan had an activation date of 12/13/23 and had been updated on 2/22/24, 3/14/24 and 3/25/24. Health and functional evaluations were completed on 2/22/24 and 3/7/24; however, cognitive evaluations were not completed at those intervals. The service plan was updated when a change of condition was noted on 2/22/24 and 3/25/24; however, it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ____ B. WING ____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 350	Continued From page 32	A 350		

not based on cognitive evaluations as they were not completed. The plan was not updated to reflect the addition of physical therapy on 2/28/24. Another service plan with an activation date of 4/2/24 was provided. The service plan reflected PT services; however, again it was not based on a cognitive evaluation as one had not yet been completed.

3. Review of Tenant #4's file on 4/3/24 revealed Progress Notes indicating the following:
a. On 12/24/23 Tenant #4 was admitted to the hospital for a urinary tract infection (UTI).
b. On 12/26/23 Tenant #4 returned from the hospital.
c. On 1/12/24 staff was walking Tenant #4 back to her apartment. Staff opened the door and turned to let Tenant #4 in and she turned and fell.
d. On 1/19/24 Tenant #4 had an unwitnessed fall which staff heard. She had a large bump on the middle back of her head and a skin tear to her left wrist. Tenant #4 was sent to the ED.
e. On 1/20/24 Tenant #4 returned from the ED about 12:45 a.m. Discharge paperwork indicated she had a contusion of the scalp, neck pain, acute skin tear to the left forearm and acute cystitis with hematuria. She returned with an order for a 3 day course of an antibiotic.
f. On 3/3/24 staff was walking with Tenant #4 with a gait belt and she was using her walker. When she turned she fell onto her left side.
h. On 3/11/24 staff was walking Tenant #4 back to her apartment and she got weak, sat down on the floor and then laid back. Tenant #4 had a skin tear on the left wrist/hand.
i. On 3/17/24 Tenant #4 had an unwitnessed fall. Tenant #4 reported her head hurt and she was sent out to the hospital.
j. On 3/17/24 it was noted Tenant #4 returned from the hospital, she had a sprained left wrist,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: ______ B. WING ______	C **04/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57** **PARKERSBURG, IA 50665**

(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 350	Continued From page 33	A 350		

Continued From page 33

contusion of the head and contusion to the right hip

Tenant #4's service plan was not updated post hospitalization on 12/26/23. The service plan was updated on 2/5/24; however, was not based on evaluations as none were completed on 2/5/24. The service plan dated 2/5/24 was updated on 3/11/24 to reflect staff to assist Tenant #4 when she was tired. The update that occurred on 3/11/24 indicated an increase in assistance for mobility related to when Tenant #4 was tired. Evaluations were not completed when the service plan was updated to reflect the increase in assistance with mobility.

4. Review of Tenant #5's file on 4/3/24 revealed the service plan signed 2/5/24 reflected a history of wandering within the building.

When observed on 4/2/24 at the time of the lunch meal (approximately 11:00 a.m.) Tenant #5 was not out at lunch. Staff reported to the Healthcare Coordinator that two tenants, including Tenant #5, were sleeping as they were awake all night.

When interviewed on 4/2/24 at the time of the lunch meal, the Healthcare Coordinator said sometimes they (including Tenant #5) slept and sometimes they did not sleep. They wandered at night and were roommates.

When interviewed on 3/27/24 at 1:45 p.m. and 2:17 p.m. Staff B said Tenant #5 went into other tenant's apartments and took things. Staff redirected him and he sometimes displayed physical and verbal behaviors. It generally occurred twice per week and there were no physical injuries.

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
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 350	Continued From page 34	A 350		

Continued From page 34

Continued record review revealed Tenant #5's service plan did not reflect the behavior as noted above related to wandering at night, sleep patterns, or entering other's apartments.

5. Review of Tenant #6's file on 4/3/24 revealed a Physician's Report/Orders document dated 2/1/24 indicating the reason for the visit was regarding the tenant's paranoia of everyone in her apartment taking things. Tenant #6 went out to meals with encouragement. An order was received to start Seroquel 12.5 mg, twice daily.

A fax sent to the PCP dated 2/20/24 indicated Tenant #6 sat in her apartment and "mumbled" continuously. Tenant #6 believed everyone was out to get her and trying to steal her belongings. She also sat in wet protective undergarments and would only change them when she wanted to. Staff offered but she refused. An order was received for an A & D ointment, twice daily and as needed.

Further record review revealed a Progress Note dated 3/26/24 indicated Tenant #6 was assisted to the toilet and her buttocks was raw and reddened.

Tenant #6's service plan with an activation date of 12/13/23 reflected minimal assistance was needed for toileting. The service plan reflected she had occasional behavior issues. The service plan was not updated to reflect the paranoid behaviors as noted above and interventions, the refusals with toileting, and reddened and raw buttocks and treatment.

6. When interviewed on 4/4/24 at 11:22 a.m. the Community Director confirmed all service plans were provided for the tenants reviewed.

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
	S0300	A. BUILDING: ______ B. WING ______	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	**707 HWY 57 PARKERSBURG, IA 50665**

(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 556	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received eight hours of dementia-specific continuing education annually for 1of 3 staff reviewed for dementia training (Staff B). Findings follow: Review of Staff B's record on 4/2/24 revealed a hire date of 9/6/22. A training transcript revealed she had her inital 8 hour training completed in September 2022. Her record contained documentation of only 6 hours of dementia training in 2023. When interviewed on 4/4/24 at 11:22 a.m. the Community Director confirmed all dementia training was provided for the staff reviewed.	A 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0300	DATE SURVEY COMPLETED: 4/4/2024

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Regulation and Reg Number** 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 established policies and procedures related to door alarms, elopement and visual checks. This pertained 1 of 7 current (Tenant #1) and 1 of 2 former (Tenant C1) tenants reviewed.	**A150**	**What initial correction was made?** Education was completed with all staff on 7/3/23 & 9/26/23 Staff counseling's were completed with Staff C, J F, A, B, and K. Elopement Drills were completed on 7/7/23, 09/27/23, and 2/29/24.	**How will we ensure and maintain compliance going forward?** Elopement drills are completed quarterly and as needed as determined by the Director or Designee. Elopement policy education is completed upon hire and annually with all staff.	**Implementation Date: 7/3/2024** **Completion Date:** Ongoing **Responsible Party:** **Director or Designee**

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Tag #2	**Tenant Rights** 481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure tenants were treated with consideration, respect, dignity and autonomy regarding 1 of 1 tenants involved in incident 119442-I (Tenant #2).	**A155**	**What initial correction was made?** Staff Counseling were completed with Staff B, I, and E on 3/8/2024. Staff E was Suspended on 3/6/2024 and then terminated on 3/12/2024. Education on abuse policy was completed with staff on 3/7/2024.	**How will we ensure and maintain compliance going forward?** Upon hire all staff will receive education on the Abuse and Reporting policy. Abuse Training will be completed with All staff Quarterly, Annually, as needed, as determined by the Director/Designee	**Implementation Date:** 3/6/2024 **Completion Date:** Ongoing **Responsible Party:** Director or Designee
Tag #3	**Tenant Rights** 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: Based on interview and record review the Program	**A160**	**What initial correction was made?** All staff were educated about when to notify the nurse and use of the Staff to Nurse Communication form by 4/30/2024. Direct care staff was educated on the importance of timely and complete task record documentation by 4/30/2024.	**How will we ensure and maintain compliance going forward?** Upon hire, Care Delegated staff will receive training on the importance of timely task documentation. An Audit of task charting will be completed daily, weekly, monthly as needed, as determined by the nurse/director, or designee.	**Implementation Date:** **4/11/2024** **Completion Date:** Ongoing **Responsible Party:** Director or designee

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	failed to provide care, treatment and services that were adequate and appropriate for 3 of 6 of current (Tenants #1, #5 and #6) and 2 of 2 discharged (Tenant C1 and Tenant C2) tenants reviewed.				
Tag #4	**Medications** 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 and treatments as ordered for 2 of 7 tenants reviewed (Tenant #6, Tenant #7).	**A285**	**What initial correction was made?** RN audited medication orders for accuracy, completed on 5/6/24.	**How will we ensure and maintain compliance going forward?** Nurse will complete monthly and/or as needed medication order audits to verify accuracy of orders.	**Implementation Date:** 4/4/2024 **Completion Date:** Ongoing **Responsible Party:** Nurse, or Designee

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Tag#5	Regulation and Reg Number	A355	What initial correction was made?	How will we ensure and maintain compliance going forward?	Implementation Date: 4/4/2024
	Staffing: nurse delegation 481-67.9(4)d 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: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide training for 2 of 2 staff reviewed who assisted with a continuous glucometer (Staff D and Staff H).		Delegations completed with all Medication Managers for Dexcom use by 4/17/2024.	Upon hire, appropriate delegations will be completed with all new resident assistants as needed, as determined by the RN or Designee.	**Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or Designee

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Tag#6	**Record Checks** 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 complete a background check prior to employment. This pertained to 1 of 7 staff reviewed hired in 2023 (Staff F).	**A400**	**What initial correction was made?** An employee file audit was completed by the Director, completed, 4/19/2024, to ensure all background checks are completed. Background checks completed on Staff F on 03/27/2024, when it was discovered that it had not been completed upon hire.	**How will we ensure and maintain compliance going forward?** Upon hire, the Orientation Checklist will be utilized to ensure all training and background checks are completed as required.	**Implementation Date:** 4/4/2024 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or Designee
Tag #7	**Regulation and Reg Number** 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	**A290**	**What initial correction was made?** Education provided to the RN regarding tenant documentation and follow up documentation required on 4/23/24.	**How will we ensure and maintain compliance going forward?** The Director and RN will meet daily, weekly, monthly, as needed, as determined by the Director or	**Implementation Date: 4/23/2024** **Completion Date:** Ongoing

	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 for 6 of 6 tenants reviewed (Tenant #1, #2, #3, #4, #5 and #6).			Designee to ensure Documentation is complete and appropriate.	**Responsible Party:** Director or designee
Tag#8	**Regulation and Reg Number** 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.	**A350**	**What initial correction was made?** Assessments will be completed including evaluations of Health, Functional, and Cognitive status with service plans revisions and appropriate signatures for all residents by 5/9/2024, by the RN.	**How will we ensure and maintain compliance going forward?** The RN will complete Health, Cognitive and Functional assessments upon admission, within 30-days of move in, annually and with any significant change. An audit of residents Service Plans will be completed daily, weekly, monthly as needed, as determined, by the nurse or designee.	**Implementation Date**: 4/10/2024 **Completion Date:** Ongoing 4/4/2024 **Responsible Party:** Nurse, or designee

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have service plans based on evaluations, failed to update service plans as needed and failed to have service plans reflect the service needs of the tenants. This pertained to 5 of 6 current (Tenants #2, #3, #4, #5 and #6) tenants reviewed.				
Tag#9	**Regulation and Reg Number** 481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received eight hours of dementia-specific	**A556**	**What initial correction was made?** An employee file audit was completed by the Director, completed on 4/19/2024 to ensure all appropriate Dementia Trainings are completed for all staff members.	**How will we ensure and maintain compliance going forward?** An Audit of all newly hired employee files will be completed monthly, quarterly, as needed, as determined by the Director or Designee.	**Implementation Date:** 4/4/2024 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or Designee

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	continuing education annually for 1of 3 staff reviewed for dementia training (Staff B).				

Compliance Date:_6/07/2024

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