

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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	<p>Initial Comments</p> <p>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.</p> <p>Number of tenants without cognitive disorder: 40 Number of tenants with cognitive disorder: 22 Total census of Assisted Living Program for People with Dementia: 62</p> <p>No regulatory insufficiencies were cited during the investigation of Complaint #91674-C or Incident #91962-I. There were no deficiencies cited during the onsite infection control survey completed 9-22-2020.</p> <p>The following regulatory insufficiencies were cited during the investigation of Complaint #90169-C.</p>	A 000	<p>See attached</p> <p>POC</p> <p>1/4/21</p>	
A 055	<p>481-67.9(1) Staffing</p> <p>481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to provide a sufficient number of staff to fully meet the identified needs of 8 of 8 tenants reviewed (Tenant #1, Tenant #2, Tenant #3, Tenant #4, Tenant #5, Tenant #6, Tenant #7, Tenant #8) and potentially affected all</p>	A 055		

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 1</p> <p>tenants residing in the dementia specific assisted living. Findings follow:</p> <p>1. Record review on 9-22-2020 of Monitoring Entrance Form revealed five staff were required for the a.m. shift and p.m. shift to meet the needs of tenants in a dementia specific program.</p> <p>Record review on 9-29-2020 of facility schedules for 8/2/20 to 9/22/20 revealed 20 days with five or more staff; 18 days with four staff; and 15 days with only three staff scheduled for the a.m. shift. Continued record review revealed 18 days with five or more staff on the p.m. shift; 16 days with four staff, 14 days with three staff, and four days with only two staff scheduled for the p.m. shift.</p> <p>Additional record review on 9-23-2020 revealed the Device Activity Report indicated the following:</p> <ul style="list-style-type: none"> a. On 9-15-2020 25% of personal response systems were not answered within 15 minutes. b. On 9-16-2020 32% of personal response systems were not answered within 15 minutes. c. On 9-17-2020 24% of personal response systems were not answered within 15 minutes. d. On 9-19-2020 35% of personal response systems were not answered within 15 minutes. e. On 9-20-2020 43% of personal response systems were not answered within 15 minutes. f. On 9-21-2020 24% of personal response systems were not answered within 15 minutes. <p>Further review of Device Activity Report revealed a response time of 44 minutes on 9-17-2020, response times of 43 and 47 minutes on 9-19-2020, response times of 52 and 95 minutes on 9-20-2020, and a response time of 62 minutes on 9-21-2020.</p> <p>Review of response times for Tenant #6 revealed</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 2</p> <p>25 and 27 minute wait times on 9-16-2020, a 38 minute wait time on 9-18-2020, a 26 minute wait time on 9-20-2020, and a 32 minute wait time on 9-21-2020. Response times for Tenant #4 revealed a 95 minute wait time on 9-20-2020 and a 62 minute wait time on 9-21-2020.</p> <p>When interviewed on 9-29-2020 at 9:52 a.m. Tenant #6 stated she required assistance to stand after toileting and waited over half an hour several times before staff arrived. She stated she became quite anxious knowing it could be a long time before staff arrived to help her up.</p> <p>When interviewed on 9-28-2020 at 3:22 p.m. Tenant #4 stated she required assistance to get off the toilet and waited almost two hours before staff person arrived to help. She reported this happened more than once.</p> <p>During an interview on 9-28-2020 at 1:43 p.m. Tenant #7 reported the overall service had gone "downhill" in the past year or so.</p> <p>An interview with Staff B on 9-28-2020 at 11:01 a.m. revealed two to four staff were scheduled most of the time. She reported staff could not answer personal response systems timely and failed to complete other responsibilities such as showers and scheduled toileting failed as required. She stated staff did the best they could, but they needed more help.</p> <p>When interviewed on 9-21-2020 at 2:19 p.m. Staff C confirmed three staff worked the a.m. shift and failed to complete required cares by the end of a.m. shift. Staff would stay late to ensure things were done. She stated a hydration station would be offered to tenants in between meals and medications when fully staffed. She reported they</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 3</p> <p>were unable to do this with the three staff working.</p> <p>When interviewed on 9-23-2020 at 10:09 a.m. Staff E reported three staff scheduled for the shift this particular day, with one training. She stated showers often did not get done and the management staff did not help much when help requested. She recalled a time she was the only staff on her shift and when she called the nurse she was instructed to find her own help. She stated neither the nurse nor the manager came in to assist. She stated one staff from 3rd shift stayed and she was able to find one staff to come in. She stated personal response systems would go unanswered, showers would not be completed, and toileting would be done when needed. She reported cleaning and laundry would be left for the housekeeper since there would not be enough time to do those tasks in addition to the required cares and medications.</p> <p>When interviewed on 9-23-2020 at 9:13 a.m. Staff F reported she did the best she could to stay on top of the housekeeping. She stated additional cleaning and disinfecting was required due to COVID and she tried to complete the community areas in the morning and clean tenant apartments in the afternoon. She reported she often failed to complete cleaning of apartments and would put them off until the next day. She stated she had come in on Mondays and found several bathrooms with fecal matter on the toilet. She reported more staff was needed to complete cleaning as needed.</p> <p>An interview with Staff H on 9-28-2020 at 2:07 p.m. revealed several days there were only 2 or 3 staff working. She reported it was not enough staff to complete all cares as required. When she</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 4</p> <p>called the nurse for assistance she was told to "figure it out."</p> <p>When interviewed on 9-29-2020 at 6:26 a.m. Staff I stated at times only 2 to 3 staff worked the a.m. shift but most of the time there was four staff. She reported the manager answered personal response systems but did not complete any cares.</p> <p>When interviewed on 9-28-2020 at 3:54 p.m. the Registered Nurse (RN) reported staffing became an issue in July 2020. She confirmed more staff was needed to complete cares as required and stated she tried to assist when possible. She stated she worked a second job and that interfered with her ability to stay on top of her job duties. As a result, things were not done as they should have been. She reported staff had called her for assistance. She told them to prioritize and focus on medications and cares. She confirmed in the past month she only came in twice to assist staff when help was requested. She further confirmed the Program failed to provide showers as required due to not having enough staff. She also reported at times soiled laundry was not addressed as needed.</p> <p>When interviewed on 9-29-2020 at 1:20 p.m. the Community Relations Coordinator confirmed he worked 9-19-20 and 9-20-20 from between 8:00 and 9:00 a.m. to approximately 1:00 p.m. as the Manager on Duty. He reported he answered the phones and doors, and assisted with lunch. He stated he observed staff "going and going and going" but could not assist as he was not delegated to provide cares or administer medications.</p> <p>When interviewed on 9-22-2020 at 12:44 p.m. the</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 5</p> <p>Manager confirmed more staff was required to provide adequate care of the tenants. He stated he recently lost several staff to other businesses that paid more. He also reported some newly hired staff quit after 1-2 days on the job. He attempted to hire a part time person for housekeeping but had no luck filling the position. He stated he hoped to fill it now that it was changed to a full time position.</p> <p>When interviewed on 9-24-2020 the Clinical Quality Manager (QCM) confirmed 2 to 3 staff was unacceptable to provide adequate care and services to tenants residing the Program. She stated temporary staff would be contracted immediately. She further reported the call response system required an upgrade and stated the process to get it fixed had already been implemented.</p> <p>When interviewed on 9-29-2020 at 11:30 a.m. the QCM and the Manager confirmed housekeeping of approximately 12 apartments per day and cleaning/disinfecting of community areas in the building required more than one staff to ensure acceptable standards.</p> <p>2. Observations on 9-22-2020 at 11:53 p.m. during the noon meal revealed Tenant #3 asked why she hadn't received her 8:00 a.m. medications (meds) yet.</p> <p>On 9-22-2020 at 11:55 a.m. Staff A and Staff D were found in the staff office and when asked why Tenant #3 had not yet received her 8:00 a.m. medications administered, Staff B stated "We still have over twenty tenants that still need 8:00 a.m. meds administered because three staff isn't enough to get everything done." She stated this</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 6</p> <p>happened often due to a limited number of staff scheduled and a lack of assistance from the nurse.</p> <p>Record review on 9-22-2020 revealed the Monitoring Entrance Form indicated 59 of 62 tenants required the Program to administer their medications at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>Record review on 9-22-2020 revealed the Program's Medication Policy directed staff to follow the six rights for proper and accurate administration of medication. The six rights included, "... Right time - Specific timing may be important for certain drugs to be most effective. If a certain time is specified for the medication, it needs to be given only at that time."</p> <p>Record review of Medication Administration Records (MAR) from 9-22-2020 through 9-29-2020 revealed the following:</p> <p>a. Tenant #1's MARs indicated the Program failed to administer the following medication doses in August 2020:</p> <ul style="list-style-type: none"> 17 of 31 days - Citalopram Hydrobromide (antidepressant) 8 of 31 days - Senna tablet (stool softener) 9 of 31 days - 8:00 a.m. Keppra (anticonvulsant) 27 of 31 days - 8:00 p.m. Keppra (anticonvulsant) 13 of 31 days - Mirtazapine (antidepressant) <p>The Program also failed to administer the following medications as prescribed in September 2020:</p> <ul style="list-style-type: none"> 22 of 23 days - Citalopram Hydrobromide (antidepressant) 	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 7</p> <p>15 of 23 days - Senna tablet (stool softener) 10 of 23 days - 8:00 a.m. Kepra (anticonvulsant) 20 of 23 days - 8:00 p.m. Kepra (anticonvulsant) 11 of 23 days - Mirtazapine (antidepressant)</p> <p>b. Tenant #2's MAR indicated the Program failed to administer the following medications from 9-18-20 to 9-29-20 at 9:00 p.m.: Metoprolol Succinate (used to treat chest pain, high blood pressure, and heart failure) Xarelto (blood thinner)</p> <p>When interviewed on 9-24-2020 at 12:35 p.m. the spouse of Tenant #2 stated his wife had not received evening medications since they ran out about one week prior. He expressed concern since the medications were for her heart and blood pressure. He further reported staff were often late administering medications.</p> <p>c. According to the MAR, Tenant #5 did not receive the following medication doses in August 2020: 6 of 31 days - Cilostazol (used to increase blood flow) 2 of 31 days -Diltiazem (used to treat high blood pressure) 4 of 31 days - Ezetimibe (used to treat high cholesterol)</p> <p>The MAR further indicated the Program failed to provide Tenant #5 the following medications as ordered in September 2020: 15 of 23 days - Cilostazol (used to increase blood flow) 4 of 23 days - Ezetimibe (used to treat high cholesterol) 3 of 23 days - Lisinopril (used to treat high</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 8</p> <p>blood pressure)</p> <p>When interviewed on 9-24-2020 at 12:52 p.m. Tenant #5 stated medications were often administered late. She reporting having to delay eating meals, as some medications needed to be taken with food.</p> <p>d. Tenant #8's MAR indicated the Program failed to administer the following number of doses in August 2020:</p> <ul style="list-style-type: none"> 4 of 31 days - Carvedilol (used to treat high blood pressure and heart failure) 13 of 31 days - Folic Acid 4 of 31 days - Latanoprost (used to treat glaucoma) 2 of 31 days - Losartan (used to treat high blood pressure) 11 of 31 days - Simvastatin (used to treat high cholesterol) <p>The MAR further identified the Program's failure to administer Tenant #8 the following medications in September 2020:</p> <ul style="list-style-type: none"> 3 of 23 days - 8:00 p.m. Carbidopa/levodopa 7 of 23 days - 8:00 a.m. Carvedilol (used to treat high blood pressure and heart failure) 10 of 23 days - 8:00 p.m. Carvedilol (used to treat high blood pressure and heart failure) 8 of 23 days - Folic Acid 3 of 23 days - Losartan (used to treat high blood pressure) 3 of 23 days - Simvastatin (used to treat high cholesterol) <p>When interviewed on 9-28-2020 at 11:01 a.m. Staff D confirmed 8:00 a.m. meds were administered as late as 12:00 p.m. due to not enough staff. She stated refills did not arrive timely and tenants often went without</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 9</p> <p>medications. She stated the Medication Administration Record (MAR) was recorded as "not in stock" when this occurred. She further stated she failed to follow up with the nurse when this occurred.</p> <p>When interviewed on 9-28-2020 at 2:07 p.m. Staff H reported meds were usually given timely on 2nd shift. She stated tenants had gone without medications due to refills not arriving timely. When this occurred, she reported she documented as not available on the MAR. She confirmed she failed to follow up with the nurse when meds were not administered. She stated if the medication was an important one such as Coumadin, she would notify the nurse, otherwise meds were just not given as prescribed.</p> <p>When interviewed on 9-29-2020 at 6:26 a.m. Staff I confirmed staff failed to administer medications on time due to only 2-3 staff scheduled. She stated 2-3 staff was not enough to complete cares and administer meds. She reported medications took priority over showers and scheduled toileting but would attend to someone if soiled. She confirmed she failed to follow up with the nurse when a medication refill is not available.</p> <p>When interviewed on 9-29-2020 at 11:30 a.m. the Clinical Quality Manager and the Assisted Living Manager agreed medication administration would take approximately three hours if each med pass averaged three minutes. They confirmed failure to schedule sufficient staff to ensure timely medication administration. The Manager reported they immediately contracted with an agency to provide extra staff to address identified issues.</p> <p>When interviewed on 9-22-2020 at 12:44 p.m. the</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	<p>Continued From page 10</p> <p>Manager confirmed administration of medications would fall behind due to lack of staff.</p> <p>When interviewed on 9-29-2020 at 11:30 a.m. the Clinical Quality Manager and the Assisted Living Manager agreed medication administration would take approximately three hours if each med pass averaged three minutes. They confirmed failure to schedule sufficient staff to ensure timely medication administration. The Manager reported they immediately contracted with an agency to provide extra staff to address identified issues.</p> <p>When interviewed on 9-28-2020 at 1:43 p.m. Tenant #7 stated the Program failed to begin new prescriptions timely and overall services had gone downhill in the past year.</p> <p>When interviewed on 9-24-2020 at 10:16 a.m. the Clinical Quality Manager confirmed the Program failed to administer medications as ordered. She reported one of the pharmacies used failed to deliver refills timely and the nurse failed to follow up due to improper documentation by staff.</p> <p>When interviewed on 9-28-2020 at 3:54 p.m. the Registered Nurse (RN) confirmed medications had been administered after scheduled times on several occasions. She confirmed more staff was needed to ensure medications were administered as required. She stated staff failed to inform her when refills had not arrived and she was not aware tenants had missed several days of medications.</p> <p>Additional review of the Program's Medication Administration Policy revealed, "Ordering of new medications and refills will be the sole responsibility of the Community Nurse, lead Resident Assistant or delegate by Community</p>	A 055		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 055	Continued From page 11 Nurses' discretion... The Community Nurse will be responsible to review and verify that the correct medications were delivered the next time he/she is in the building..."	A 055		
A 147	<p>481-67.5(6)d Medications</p> <p>481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to administer medications as prescribed by a physician. This pertained to 5 of 8 tenants reviewed (Tenant #1, Tenant #2, Tenant #3, Tenant #5, and Tenant #8), and potentially affected 59 tenants requiring assistance with medication administration. Findings follow:</p> <p>1. Observations on 9-22-2020 at 11:53 p.m. during the noon meal revealed Tenant #3 asked why she hadn't received her 8:00 a.m. medications (meds) yet.</p> <p>On 9-22-2020 at 11:55 a.m. Staff A and Staff D were found in the staff office and when asked why Tenant #3 had not yet received her 8:00 a.m. medications administered, Staff B stated "We still have over twenty tenants that still need 8:00 a.m.</p>	A 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 147	<p>Continued From page 12</p> <p>meds administered because three staff isn't enough to get everything done." She stated this happened often due to a limited number of staff scheduled and a lack of assistance from the nurse.</p> <p>Record review on 9-22-2020 revealed the Monitoring Entrance Form indicated 59 of 62 tenants required the Program to administer their medications at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>Record review on 9-22-2020 revealed the Program's Medication Policy directed staff to follow the six rights for proper and accurate administration of medication. The six rights included, "... Right time - Specific timing may be important for certain drugs to be most effective. If a certain time is specified for the medication, it needs to be given only at that time."</p> <p>2. Record review of Medication Administration Records (MAR) from 9-22-2020 through 9-29-2020 revealed the following:</p> <p>a. Tenant #1 had diagnoses including: essential (primary) hypertension; unspecified dementia without behavioral disturbance; orthostatic hypotension; syncope and collapse; transient cerebral ischemic attack, unspecified; major depressive disorder, single episode, unspecified; other chest pain; unspecified convulsions.</p> <p>Tenant #1's MARs indicated the Program failed to administer the following medication doses in August 2020: 17 of 31 days - Citalopram Hydrobromide (antidepressant) 8 of 31 days - Senna tablet (stool softener) 9 of 31 days - 8:00 a.m. Kepra</p>	A 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 147	<p>Continued From page 13</p> <p>(anticonvulsant) 27 of 31 days - 8:00 p.m. Kepra</p> <p>(anticonvulsant) 13 of 31 days - Mirtazapine (antidepressant)</p> <p>The Program also failed to administer the following medications as prescribed in September 2020:</p> <p>22 of 23 days - Citalopram Hydrobromide (antidepressant) 15 of 23 days - Senna tablet (stool softener) 10 of 23 days - 8:00 a.m. Kepra (anticonvulsant) 20 of 23 days - 8:00 p.m. Kepra (anticonvulsant) 11 of 23 days - Mirtazapine (antidepressant)</p> <p>b. Tenant #2 had diagnoses including: heart failure, unspecified; paroxysmal atrial fibrillation; acute and chronic respiratory failure with hypoxia; disseminated intravascular coagulation (defibrillation syndrome); essential hypertension; chronic lymphocytic leukemia of b-cell type not having achieved remission; non-Hodgkin lymphoma, unspecified.</p> <p>Tenant #2's MAR indicated the Program failed to administer the following medications from 9-18-20 - 9-29-20: 9:00 p.m.:</p> <p>Metoprolol Succinate (used to treat chest pain, high blood pressure, and heart failure) Xarelto (blood thinner)</p> <p>When interviewed on 9-24-2020 at 12:35 p.m. the spouse of Tenant #2 stated his wife had not received evening medications since they ran out about one week prior. He expressed concern since the medications were for her heart and blood pressure. He further reported staff were often late administering medications.</p>	A 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 147	<p>Continued From page 14</p> <p>c. Tenant #5 had diagnoses including: arthropathy, unspecified and peripheral vascular disease, unspecified.</p> <p>According to the MAR, Tenant #5 did not receive the following medication doses in August 2020: 6 of 31 days - Cilostazol (used to increase blood flow) 2 of 31 days -Diltiazem (used to treat high blood pressure) 4 of 31 days - Ezetimibe (used to treat high cholesterol)</p> <p>The MAR further indicated the Program failed to provide Tenant #5 the following medications as ordered in September 2020: 15 of 23 days - Cilostazol (used to increase blood flow) 4 of 23 days - Ezetimibe (used to treat high cholesterol) 3 of 23 days - Lisinopril (used to treat high blood pressure)</p> <p>When interviewed on 9-24-2020 at 12:52 p.m. Tenant #5 stated medications were often administered late. She reporting having to delay eating meals, as some medications needed to be taken with food.</p> <p>d. Tenant #8 had diagnoses including: essential hypertension, Parkinson's disease; other bursitis, not elsewhere classified; presence of cardiac pacemaker, glaucoma.</p> <p>Tenant #8's MAR indicated the Program failed to administer the following number of doses in August 2020: 4 of 31 days - Carvedilol (used to treat high blood pressure and heart failure)</p>	A 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 147	<p>Continued From page 15</p> <p>13 of 31 days - Folic Acid 4 of 31 days - Latanoprost (used to treat glaucoma) 2 of 31 days - Losartan (used to treat high blood pressure) 11 of 31 days - Simvastatin (used to treat high cholesterol)</p> <p>The MAR further identified the Program's failure to administer Tenant #8 the following medications in September 2020: 3 of 23 days - 8:00 p.m. Carbidopa/levodopa 7 of 23 days - 8:00 a.m. Carvedilol (used to treat high blood pressure and heart failure) 10 of 23 days - 8:00 p.m. Carvedilol (used to treat high blood pressure and heart failure) 8 of 23 days - Folic Acid 3 of 23 days - Losartan (used to treat high blood pressure) 3 of 23 days - Simvastatin (used to treat high cholesterol)</p> <p>3. When interviewed on 9-28-2020 at 11:01 a.m. Staff D confirmed 8:00 a.m. meds were administered as late as 12:00 p.m. due to not enough staff. She stated refills did not arrive timely and tenants often went without medications. She stated the Medication Administration Record (MAR) was recorded as "not in stock" when this occurred. She further stated she failed to follow up with the nurse when this occurred.</p> <p>When interviewed on 9-28-2020 at 2:07 p.m. Staff H reported meds were usually given timely on 2nd shift. She stated tenants had gone without medications due to refills not arriving timely. When this occurred, she reported she documented as not available on the MAR. She confirmed she failed to follow up with the nurse</p>	A 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 147	<p>Continued From page 16</p> <p>when meds were not administered. She stated if the medication was an important one such as Coumadin, she would notify the nurse, otherwise meds were just not given as prescribed.</p> <p>When interviewed on 9-29-2020 at 6:26 a.m. Staff I confirmed staff failed to administer medications on time due to only 2-3 staff scheduled. She stated 2-3 staff was not enough to complete cares and administer meds. She reported medications took priority over showers and scheduled toileting but would attend to someone if soiled. She confirmed she failed to follow up with the nurse when a medication refill is not available.</p> <p>When interviewed on 9-29-2020 at 11:30 a.m. the Clinical Quality Manager and the Assisted Living Manager agreed medication administration would take approximately three hours if each med pass averaged three minutes. They confirmed failure to schedule sufficient staff to ensure timely medication administration. The Manager reported they immediately contracted with an agency to provide extra staff to address identified issues.</p> <p>When interviewed on 9-22-2020 at 12:44 p.m. the Manager confirmed administration of medications would fall behind due to lack of staff.</p> <p>When interviewed on 9-28-2020 at 1:43 p.m. Tenant #7 stated the Program failed to begin new prescriptions timely and overall services had gone downhill in the past year.</p> <p>When interviewed on 9-24-2020 at 10:16 a.m. the Clinical Quality Manager confirmed the Program failed to administer medications as ordered. She reported one of the pharmacies used failed to deliver refills timely and the nurse failed to follow</p>	A 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY MEADOW PLACE, L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 17396 KINGBIRD AVE MASON CITY, IA 50401
--	---

(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 147	<p>Continued From page 17</p> <p>up due to improper documentation by staff.</p> <p>When interviewed on 9-28-2020 at 3:54 p.m. the Registered Nurse (RN) confirmed medications had been administered after scheduled times on several occasions. She confirmed more staff was needed to ensure medications were administered as required. She stated staff failed to inform her when refills had not arrived and she was not aware tenants had missed several days of medications.</p> <p>4. Additional review of the Program's Medication Administration Policy revealed, "Ordering of new medications and refills will be the sole responsibility of the Community Nurse, lead Resident Assistant or delegate by Community Nurses' discretion... The Community Nurse will be responsible to review and verify that the correct medications were delivered the next time he/she is in the building..."</p>	A 147		

Country Meadow Place
17369 Kingbird Ave, Mason City, IA 50401

Date: 1/4/2021

Investigation Intake #:

#91962-I, #91674-C, #90169-C and onsite Infection Control Survey

Plan of Correction (POC) Submitted For:

- Investigation Date: Between 9/21/20 and 11/16/20

POC:

A. 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

i. Program POC:

1. Elements detailing how this was corrected for residents:
 - a. The program manager is now responsible for scheduling of direct care staff
2. Actions program taking to protect tenants in similar situations:
 - a. Contracts with staffing agencies were executed related to COVID emergency staffing model
 - b. Community has upgraded to a digital scheduling system that provides up to date schedules to all staff in real times.
 - c. Attendance policy reviewed with individual employees at Inservice on 12/11/202
3. Measures taken to ensure problem does not recur:
 - a. Program Coordinator staff were delegated on cares in addition to the care staff to be able to provide direct care if needed
 - b. Agency staff will be utilized to supplement staffing numbers as needed
4. Program plans to monitor performance to ensure compliance:
 - a. Program Manager and/or designee will monitor staffing levels daily, weekly monthly and as needed basis and increase staffing levels to meet residents needs as needed

B. 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications

shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.

i. Program POC:

1. Elements detailing how this was corrected for residents:
 - a. Community has implemented routine procedures regarding notification to pharmacy on refills needed for medications
2. Actions program taking to protect tenants in similar situations:
 - a. Community switched from “On Demand” fill system to monthly routine fill system for medications received from Community Pharmacy
 - b. Manager is now doing staff scheduling to ensure sufficient amount of staff on site to give medications timely
 - c. All Staff Inservice held on 12/11/2020 to provide re-education to staff on medication administration, notifications to pharmacy and notifications to nurse about medications not available or questions
 - d. Tenants who were using a retail pharmacy were given the education about and option to switch to Community Pharmacy as their provider to ensure timely communication and delivery of medications
3. Measures taken to ensure problem does not recur:
 - a. Nurse or designee to review pharmacy refill binder, three times weekly or as needed, for requests sent to pharmacy for refills to ensure medications have been received or follow up communication to the pharmacy has been done
 - b. Nurse or designee to perform weekly audit of medication documentation compliance to ensure that medications are documented appropriately
 - c. Tenants who are new to the program will be given education and the option to use Community Pharmacy as their provider to ensure timely communication and delivery of medications
4. Program plans to monitor performance to ensure compliance:
 - a. Community manager and/or designee will verify compliance during QA audits

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.