

DEPARTMENT OF INSPECTIONS AND APPEALS

*J. Keller*  
*HS 5/20/17*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VISTA PRAIRIE AT KEELSON HARBOUR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2810 AURORA AVENUE SPIRIT LAKE, IA 51360</b>
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A 000	<p>481-67 Initial Comments</p> <p>Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site.</p> <p>General Population Program</p> <p>Number of tenants without cognitive disorder: 38 Number of tenants with cognitive disorder: 5 Total Population of Program at time of on-site: 43</p> <p>Dementia-Specific Program by Dedication</p> <p>Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 19 Total Population of Program at time of on-site: 19</p> <p>TOTAL census of Assisted Living Program: 62</p> <p>During the recertification to determine compliance with certification of an Assisted Living Program and Complaint Investigations 67398-C, 67007-C and 66743-C, the following regulatory insufficiencies were cited.</p>	A 000	<p><i>See attached Plan of Correction</i> <i>DD 5/05/17</i></p>	
A 013	<p>481-67.3(2) Tenant Rights</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to consistently ensure tenants</p>	A 013		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A 013	<p>Continued From page 1</p> <p>received care, treatment and services that were adequate and appropriate. This potentially affected all 19 tenants in the memory care unit but specifically Tenants #3 and #13, as well as 2 of 3 of tenants interviewed who resided in the general population program (Tenants #1 and #5). Findings follow:</p> <p>1. Record review on 4/25/17 revealed a document entitled Keelson Harbour Assisted Living MD Visit/Contact dated 2/3/17 which documented that staff reported Tenant #2 was scratching their private area after receiving a shower and there was a foul odor. This document was faxed to the primary care provider on 2/3/17, then re-faxed on 2/6/17, 2/13/17 and 2/15/17. No reply from the primary care provider could be located.</p> <p>When interviewed on 4/25/17 at 3:00 p.m. the Memory Care Nurse could not remember when the issue had been resolved but admitted she had not completed follow up until 4/14/17 when staff reported seeing blood in the tenant's stool/urine.</p> <p>According to a Progress Note dated 4/18/17 a Urinary Analysis was obtained and an order was received for Macrochantin (antibiotic to treat and prevent urinary tract infection). Tenant #2's diagnoses included dementia, depressive disorder and a score of 6 on the Global Deterioration Scale (GDS). According to Tenant #2's Master Care Plan the tenant could not speak and needed assistance to communicate and described the tenant's speech as garbled. The plan directed staff to ask the tenant to show them what may be needed.</p> <p>2. During an interview on 4/11/17 at 9:10 a.m., an</p>	A 013		

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A 013	<p>Continued From page 2</p> <p>interviewee expressed concern about Tenant #3 wandering in out of other tenant's apartments in the memory care unit. The interviewee described an instance when Tenant #3 wandered into Tenant #2's bathroom and had a bowel movement.</p> <p>Further interviews confirmed Tenant #3 also used Tenant #13's bathroom instead of the bathroom in his/her apartment or the common area bathroom. Review of Tenant #3's Service Notes revealed the following entries:</p> <ul style="list-style-type: none"> <li>a. 1/16/17 Tenant #3 defecated in the dining room on the floor</li> <li>b. 2/24/17 Tenant #3 voided in Tenant #13's room</li> <li>c. 3/1/17 Tenant #3 used the restroom in another tenant's room</li> <li>d. 3/5/17 Tenant #3 urinated in Tenant #13's shower</li> <li>e. 3/20/17 Tenant #3 voided in Tenant #13's shower</li> <li>f. 3/25/17 Tenant #3 "peed" in Tenant #13's shower</li> <li>g. 4/13/17 Tenant #3 had bowel movement (BM) on the bedroom floor of Tenant #13</li> </ul> <p>A notation in the Nurses Notes dated 4/12/17 revealed staff found Tenant #3 trying to get into bed with Tenant #13. According to an incident report dated 4/12/17 at 2:15 a.m. when staff redirected Tenant #3 the tenant became aggressive and pulled staff's hair and pushed her down.</p> <p>3. Review of the Assisted Living Entrance form completed on 4/11/17 revealed Tenant #5 had experienced theft of personal belongings. When interviewed on 4/11/17 the Director of Nursing (DON) said the Program had spoken to Tenant #5</p>	A 013		

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A 013	<p>Continued From page 3</p> <p>and Tenant #4 (the spouse of Tenant #5) and they described the jewelry as costume and only worth sentimental value. According to Tenant #5 and #4 they asked the Program to make sure no staff were in their apartment unless they were present. They said they did not trust the staff and were very hurt/sad that someone had taken their belongings.</p> <p>4. Review of an Incident Report (IR) dated 1/28/17 revealed Program staff failed to apply Tenant #12's daily Exelon patch (cognition enhancing medication) that day. According to the IR, staff had forgotten. Tenant #12 resided in the memory care unit.</p> <p>5. When interviewed on 4/12/17 Tenant #1 said the Program failed to ensure he/she had prescribed medications. Tenant #1's daughter stated the tenant was out of their Levothyroxine for at least two days starting on 3/20/17. Review of the Med Administration Summary revealed a notation under Levothyroxine that said, "This medication is kept in a caddy on the bathroom counter. [He/she] will take on [his/her] own early morning. Please check to make sure [he/she] has taken it when giving 7:30 a.m. medications." The DON noted on the Med Administration Summary on 3/20/17 and 3/21/17 that the tenant had self-administered the medication. According to Tenant #1 and her/his daughter, the tenant could not have self-administered the medication as it was not in the pill caddy for those two days. Tenant #1 told the DON on 3/20/17 that the medication had not been taken because it wasn't available but the DON did not refill the pill caddy. According to Tenant #1 and her/his daughter when the Staff Development Registered Nurse (SDRN) was notified about the issue, she got the medication for the tenant.</p>	A 013		

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A 013	Continued From page 4  Review of the Program's Bill of Right document revealed the following statement, "To receive care, treatment and services which are adequate and appropriate."  When interviewed on 4/23/17 at 3:10 p.m. the DON and SDRN confirmed the Program had failed to ensure tenants had received care, treatment and services that were adequate and appropriate.	A 013		
A 019	481-67.3(8) Tenant Rights  481-67.3 Tenant rights. All tenants have the following rights: 67.3(8) To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination.  This REQUIREMENT is not met as evidenced by: Based on interviews the Program failed to ensure tenants felt able to express concerns or recommend changes without fear of reprisal. This potentially affected 42 of 42 assisted living general population tenants and/or legal representatives. Finding follows:  During a tenant meeting on 4/11/17 at 1:30 p.m. tenants and one family member expressed	A 019		

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A 019	<p>Continued From page 5</p> <p>concerns regarding staffing. They said staff often worked double shifts and were getting worn out. Tenants also said that recently a number of staff had resigned and they had expressed concerns about both issues to administration but didn't feel the concerns were taken seriously. Tenants expressed frustration that when they did bring concerns to the Program's administration they were often labeled "troublemakers" and treated differently. Tenants also said they had been told not to talk to other tenants.</p> <p>On 4/12/17 a tenant expressed frustration that the Program had not invited all tenants to the community meeting held on 4/11/17 by the monitor. According to the tenant the Program made an announcement regarding the meeting during lunch but did not attempt to inform tenants who had not been present. Observations revealed most apartments had a clip near the door to leave documents or notes for the tenant.</p> <p>During the exit interview on 4/24/17 the administrative staff acknowledged the Program had issues with tenants who felt targeted and/or unable to express concerns without fear.</p>	A 019		
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:</p>	A 055		

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A 055	<p>Continued From page 6</p> <p>Based on observations, interviews and record reviews the Program failed to ensure sufficient numbers of staff trained to meet tenant needs. This potentially affected 62 of 62 tenants who received services. Findings follow:</p> <p>1. Observations on 4/11/17 and 4/12/17 revealed two staff worked on the first and second shifts in each of the two units (general population and memory care). One of the staff working in the general population area on the first shift had been placed on light duty. An interviewee expressed concern that staff were working double shifts to cover the care needs of tenants. Observations in the memory care unit on 4/10/17 revealed that although two staff were present, one administered/passed medications leaving one staff to attend to 18 of the 19 memory care tenants during preparation for the evening meal.</p> <p>During an interview on 4/11/17 at 10:15 a.m. the interviewee said two staff worked while the Director of Nursing (DON) administered/passed medications because the Program did not have enough staff to meet the tenant needs without assistance from the DON.</p> <p>Review of a document provided by the Vista Prairie Communities Care Coordinator(VPCCC) confirmed two direct care staff worked on the first and second shift while the DON administered/passed medications on 4/11/17. Further review revealed on 4/12/17 two direct care staff worked while Staff Development Registered Nurse (RN) administered/passed medications.</p> <p>According to information provided by the Program, staff administered medications to 20 of the 43 tenants on the general population unit, and</p>	A 055		
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A 055

Continued From page 7  
all 19 tenants in the memory care unit.

2. During a tenant meeting held at 1:30 p.m. on 4/11/17 attended by 12 tenants and one family member, concerns were expressed about staff working back to back shifts. According to the tenants, they were worried about their well-being due to the length of time staff were having to work. The tenants/family member also expressed concern about the competency of the staff. Two tenants who used oxygen said staff did not know how to change the oxygen tanks even though the Program had agreed to provide that service.

Review of information provided by the Program regarding staff resignations between the dates of 1/17/17 and 4/5/17 revealed 12 staff resignations/terminations (six occurred between the dates of 2/10/17 and 2/20/17). Of the 12 only one was terminated due to performance issues. The other 11 were all listed as personal/voluntary resignations.

3. When interviewed on 4/25/17 at 3:10 p.m. the DON and Staff Development RN confirmed nurse reviews and evaluations had not been completed and brought up to date since they were hired at the beginning of December 2016. According to the nurses, the Program had not kept current with assessments/nurse reviews. Review of a list provided by the Program noted 21 assessments/nurse reviews were past due with one being completed on 4/26/17. The nurses said the need for them to assist with medication administration, direct care services and training new staff had prevented them from being able to complete the needed assessments/nurse reviews. During further discussion the nurses expressed their lack of training and knowledge of the assisted living (AL) rules had contributed to

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A 055	Continued From page 8  nurse review and/or evaluations not being completed as required by the AL rules.	A 055		
A 057	481-67.9(3) Staffing  481-67.9(231B,231C,231D) Staffing. 67.9(3) Training documentation. The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to maintain documentation of training of nurse-delegated procedures for 5 of 5 staff reviewed (Staff A-E). Finding follows:  Record review on 4/11/17 revealed no documentation of delegation training for Staff A, B, C, D or E.  When interviewed on 4/11/17 at 12:50 p.m. the Director of Nursing (DON) admitted she could not find the documentation of nurse delegation trainings for the five staff.	A 057		
A 058	481-67.9(4)a Staffing  481-67.9(231B,231C,231D) 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:	A 058		

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A 058	<p>Continued From page 9</p> <p>a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of documentation the Program's Registered Nurse (RN) did not complete a review to ensure staff were sufficiently trained and competent to provide services within 60 days of beginning employment. Findings follow:</p> <p>According to information provided by the Program, the Director of Nursing (DON) began employment on 12/1/16. When interviewed on 4/11/17 at 12:50 p.m. the DON confirmed she had not completed a review with the 5 sample staff to ensure they had been sufficiently trained and competent to provide services to tenants within the first 60 days of her employment.</p>	A 058		
A 037	<p>481-69.22(2) Evaluation of Tenant</p> <p>481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as</p>	A 037		

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A 037	<p>Continued From page 10</p> <p>needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to complete evaluations within 30 days of admission and/or a significant change. This affected 3 of 7 sample tenants reviewed (Tenant #6, Tenant #10 and Tenant #11). Findings follow:</p> <p>1. Record review on 4/12/17 and 4/23/17 revealed Tenant #6 was admitted to Hospice on 3/7/17. Record review revealed the Program completed a nurse review 2/22/17 but failed to complete a nurse review and evaluation with Tenant #6's significant change of condition on 3/7/17 when Hospice services began.</p> <p>When interviewed on 4/23/17 at 3:10 p.m. the Director of Nursing (DON) and Staff Development Registered Nurse (SDRN) admitted the Program failed to complete evaluations with a significant change of condition for Tenant #6.</p> <p>2. Record review on 4/12/17 revealed the Program admitted Tenant #10 on 2/21/17. The Program completed functional, cognitive and</p>	A 037		
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A 037	<p>Continued From page 11</p> <p>health evaluations on 4/4/17.</p> <p>When interviewed on 4/23/17 at 3:10 p.m. the DON and SDRN admitted the Program failed to complete the functional, cognitive and health assessments within 30 days as required.</p> <p>3. Record review on 4/12/17 and 4/23/17 revealed Tenant #11 had an increase in falls as documented by Incident Reports dated 2/9/17, 3/2/17, 3/11/17, 3/13/17, 3/15/17, 3/18/17, 3/24/17 and on 3/27/17 at 9:00 a.m. and 9:30 p.m. Review of Resident Notes revealed an entry on 3/13/17 which stated the tenant's son reported a fracture to Tenant #10's right hand and a brace would be used for treatment. The Program completed a Nurse Review (Assessment Summary) on 3/21/17 but failed to complete a functional, cognitive and health evaluation.</p> <p>When interviewed on 4/23/17 at 3:10 p.m. the DON and SDRN admitted the Program failed to complete the functional, cognitive and health assessments as required.</p>	A 037		
A 077	<p>481-69.25(1)o Tenant Documents</p> <p>481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record)</p>	A 077		

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NAME OF PROVIDER OR SUPPLIER  <b>VISTA PRAIRIE AT KEELSON HARBOUR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2810 AURORA AVENUE SPIRIT LAKE, IA 51360</b>
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A 077	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete incident reports as required for 2 of 7 sample tenants reviewed (Tenants #1, #2). Findings follows:</p> <p>1. When interviewed on 4/12/17 Tenant #1 said the Program failed to ensure he/she had prescribed medications. Tenant #1's daughter stated the tenant was out of their Levothyroxine for at least two days starting on 3/20/17. Review of the Med Administration Summary revealed a notation under Levothyroxine that said, "This medication is kept in a caddy on the bathroom counter. [He/she] will take on [his/her] own early morning. Please check to make sure [he/she] has taken it when giving 7:30 a.m. medications. The Director of Nursing (DON) noted on the Med Administration Summary on 3/20/17 and 3/21/17 that the tenant had self-administered the medication. According to Tenant #1 and her/his daughter, the tenant could not have self-administered the medication as it was not in the pill caddy for those two days. Tenant #1 told the DON on 3/20/17 that the medication had not been taken because it wasn't available but the DON did not refill the pill caddy. According to Tenant #1 and her/his daughter when the Staff Development Registered Nurse (SDRN) was notified about the issue, she got the medication for the tenant.</p> <p>When interviewed on 4/12/17 at 12:55 p.m. the SDRN confirmed the omission of a medication would be considered a medication error therefore an incident report should have been completed.</p> <p>Record review on 4/12/17 revealed no incident report completed for the omission of Tenant #1's</p>	A 077		
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A 077	<p>Continued From page 13</p> <p>Levothyroxine.</p> <p>2. Record review on 4/25/17 revealed a document entitled Keelson Harbour Assisted Living MD Visit/Contact dated 2/3/17 which stated staff reported Tenant #2 was scratching their private area after receiving a shower and there was a foul odor. This document was faxed to the primary care provider on 2/3/17, then re-faxed on 2/6/17, 2/13/17 and 2/15/17. No reply from the primary care provider could be located.</p> <p>When interviewed on 4/25/17 at 3:00 p.m. the Memory Care Nurse could not remember when the issue had been resolved but admitted she had not completed follow-up until 4/14/17 when staff reported seeing blood in the tenant's stool/urine.</p> <p>According to a Progress Note dated 4/18/17 a Urinary Analysis was obtained and an order was received for Macrochantin (antibiotic to treat and prevent urinary tract infection).</p> <p>Record review revealed no incident report completed for the behavior displayed by Tenant #2.</p> <p>On 4/24/17 at 10:00 a.m. the DON confirmed no further documentation existed regarding this issue for Tenant #2.</p>	A 077		
A 085	<p>481-69.26(3) Service Plans</p> <p>481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not</p>	A 085		

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A 085	<p>Continued From page 14 less than annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were updated within 30 days of occupancy and with significant changes. This affected 3 of 7 sample tenants reviewed (Tenants #6, Tenant #7 and Tenant #11). Findings follow:</p> <p>1. Record review on 4/12/17 and 4/23/17 revealed Tenant #6 was admitted to Hospice on 3/7/17. Program staff failed to update the service plan to reflect the admission to Hospice care.</p> <p>When interviewed on 4/23/17 at 3:10 p.m. the Director of Nursing (DON) and Staff Development Registered Nurse (SDRN) admitted the Program failed to update the service plan with a significant change of condition when Hospice care services began for Tenant #6.</p> <p>2. Record review on 4/12/17 revealed the Program admitted Tenant #10 on 2/21/17. The Program completed a service plan on 4/4/17.</p> <p>When interviewed on 4/23/17 at 3:10 p.m. the DON and SDRN admitted the Program failed to update/develop a service plan within 30 days of admission as required.</p> <p>3. Record review on 4/12/17 and 4/23/17 revealed Tenant #11 had an increase in falls as documented by Incident Reports dated 2/9/17, 3/2/17, 3/11/17, 3/13/17, 3/15/17, 3/18/17, 3/24/17, 3/27/17 at 9:00 a.m. and 9:30 p.m.</p>	A 085		

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A 085	Continued From page 15  Review of Resident Notes revealed an entry on 3/13/17 which stated, Tenant #10's son reported a fracture to Tenant #10's right hand and a brace would be used for treatment. The Program completed a Nurse Review (Assessment Summary) on 3/21/17 but failed to update Tenant #11's service plan with a significant change in condition.  When interviewed on 4/23/17 at 3:10 p.m. the DON and SDRN admitted the Program failed to update Tenant #11's service plan with a significant change in condition.	A 085		
A 094	481-69.27(1)a Nurse Review  481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: 69.27(1)a To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 094		

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A 094	<p>Continued From page 16</p> <p>Program failed to complete nurse reviews at least every 90 days or with a significant change of condition for 2 of 7 sample tenants reviewed (Tenant #6 and #7). Findings follow:</p> <p>1. Record review on 4/12/17 revealed Tenant #6 had a significant change of condition when Hospice admitted the tenant on 3/7/17. The most recent noted nurse review completed by the Program was dated 2/22/17.</p> <p>When interviewed on 4/23/17 at 3:10 p.m. the Director of Nursing (DON) and Staff Development Registered Nurse (SDRN) confirmed no nurse review had been completed when Hospice admitted Tenant #6 on 3/7/17.</p> <p>2. Record review on 4/12/17 revealed Tenant #7's most recent nurse review dated 11/29/16.</p> <p>When interviewed on 4/23/17 the DON and SDRN admitted they had not completed a 90 day nurse review for Tenant #7.</p>	A 094		
A 121	<p>481-69.30(1) Dementia Specific Education for Personnel</p> <p>481-69.30(231C) Dementia-specific education for program personnel.</p> <p>69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	A 121		

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A 121	<p>Continued From page 17</p> <p>Based on interview and record review the Program failed to ensure staff received eight hours of dementia-specific education within 30 days of beginning employment. This affected 3 of 5 staff reviewed (Staff A, B and E). Finding follows:</p> <p>Record review on 4/12/17 revealed the Program hired Staff A on 11/8/16. According to available documentation Staff A had not completed the required eight hours within 30 days of employment.</p> <p>Record review on 4/12/17 revealed the Program hired Staff B on 11/21/16. According to available documentation Staff B had not completed the required eight hours within 30 days of employment.</p> <p>Record review on 4/12/17 revealed the Program hired Staff E on 8/17/16. According to available documentation Staff E had not completed the required eight hours within 30 days of employment.</p> <p>When interviewed on 4/12/17 the Executive Assistant and Director of Nursing confirmed no documentation existed to prove Staff A, B and E had completed the required training.</p>	A 121		
A 123	<p>481-69.30(3)a Dementia Specific Education for Personnel</p> <p>481-69.30(231C) Dementia-specific education for program personnel.</p> <p>69.30(3)a Except as otherwise provided in this subrule, all personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of</p>	A 123		

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A 123	<p>Continued From page 18</p> <p>dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually.</p> <p>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 training annually. This affected 2 of 2 staff reviewed employed more than one year (Staff C and D). Findings follows:</p> <p>Review of staff files on 4/12/17 revealed Staff C and D, direct-contact staff, had not received eight hours of dementia-specific education annually.</p> <p>When interviewed on 4/12/17 the Executive Assistant and Director of Nursing confirmed the Program did not have documentation to confirm Staff C and D had received the needed eight hours of dementia-specific education.</p>	A 123		
A 151	<p>481-69.34(3) Activities</p> <p>481-69.34(231C) Activities. 69.34(3) A written schedule of activities shall be developed at least monthly and made available to tenants and their legal representatives.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program's memory care unit failed to develop a written schedule of activities at least monthly and</p>	A 151		

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A 151	<p>Continued From page 19</p> <p>make available to tenants and legal representatives. This potentially affected 19 of 19 tenants. Finding follows:</p> <p>When interviewed on 4/11/17 an interviewee expressed concerns regarding activities offered in the memory care unit. The concerns expressed included very few activities to keep people engaged were offered especially on the weekends. When the staff played music it was often modern day which the tenants had no interest in it.</p> <p>Review of documents provided by the Program during the visit revealed no written schedule of monthly activities for the memory care unit.</p> <p>During the exit on 4/26/17 at 1:00 p.m. the Director of Nursing confirmed even though an activity staff had been assigned to the memory care unit a written monthly schedule had not been developed and made available to tenants and/or legal representatives.</p>	A 151		

K. Keller  
5/30/17

W. Starling

## Plan of Correction

### Tag 013 Tenant Rights

- Elements detailing how the Program will correct each regulatory insufficiency.
  - Tenant #2 has received treatment
  - Evaluate Tenant #3's current status and update Service Plan interventions as needed to address potential wandering.
  - Tenant #5's Service Plan was updated to instruct staff to not enter the apartment unless the Tenant was in the apartment
  - Clarify wording in Tenant #12's order for Exelon patch
  - The medication was provided to Tenant #1
  
- What measures will be taken to ensure the problem does not recur.
  - Policy and Procedure reviews and revisions as needed:
    - Assisted Living Tenant Rights
    - Complaints and Investigation of Complaints
    - Dependent Adult Abuse Reporting
    - Initial and Ongoing Evaluation of Tenants
    - Content of Service Plans
    - Medication Administration – administration, documentation and training
  
  - Registered Nurses and Resident Assistants, training regarding:
    - Communication with primary care providers when a Tenant experiences a potential change in condition and following up on communication concerns not yet addressed
    - The need to identify Memory Care Tenants who may wander in and out of other Tenant rooms and to develop interventions to prevent wandering
    - Policies and procedures regarding Tenant complaints and the potential dependent adult reporting process
    - Entering a Tenant's apartment when the Tenant is not in the apartment – the process to determine whether or not the Tenant has given permission for staff to enter an apartment when the Tenant is not there
    - Medication Administration policy and procedures review regarding proper actions for medication administration and documentation. The process for filling of medication caddies was reviewed.
  
  - Develop a tracking method to review faxes sent to primary care providers and to track until a response is received and/or the RN takes other action to prompt a response
  
- How the Program plans to monitor performance to ensure compliance.
  - An auditing process will be developed that includes:
    - Review of Tenant's potential condition changes and the actions of the Registered Nurse
    - A review of the Evaluation and interventions for each Memory Care Tenant who shows the potential for wandering
    - Asking Tenants about their preferences regarding staff entering apartments for garbage pick up, laundry delivery, etc. Entering those preferences into the Service Plan

**Tag 013 Tenant Rights continued:**

- RNs (including the Vista Prairie Communities corporate Director of Home Care, an RN) will periodically observe/audit staff who provide medication administration services as they perform their duties
- The date by which the regulatory insufficiency will be corrected.
  - June 7, 2017

**Tag 019 Tenant Rights**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - Development of an Interview Tool and process that will guide Leadership staff in regular 1:1 Tenant discussion. Staff will be assigned a group of Tenants. The process will include training for staff on follow up of concerns addressed. The program will be called a 'Guardian Angel' program; every Assisted Living Tenant will be assigned a Guardian Angel.
  - Regulatory visit preparation tools were updated to include providing written notice to all Tenants and staff when a person representing the Department of Inspections and Appeals plans to meet with a group of Tenants.
- What measures will be taken to ensure the problem does not recur.
  - The Guardian Angel program will be an ongoing program intended to foster a Tenant's relationship with at least one Keelson Harbour leader to share concerns and ideas for improvement. New Tenants will be assigned their Guardian Angel on Move-In.
- How the Program plans to monitor performance to ensure compliance.
  - Staff will review Tenant responses at a Monthly Quality Council meeting and action plan accordingly. Quality Council meeting minutes are reviewed by the VPC Director of Home Care
- The date by which the regulatory insufficiency will be corrected.
  - June 7, 2017

### **Tag 055 Staffing**

- Elements detailing how the Program will correct each regulatory insufficiency
  - Keelson Harbour has been interviewing and hiring staff who are qualified to work with and provide care for Assisted Living Program Tenants
  - The Orientation and Onboarding process for new staff has been revised. The Staff Development Nurse will implement orientation policies and processes under the direction of the Director of Health Services and the VPC Director of Home Care.
- What measures will be taken to ensure the problem does not recur.
  - An evaluation of the orientation process will be completed with staff at 2 weeks from start date, again reviewing competency of skills needed to provide care and services to Tenants. This will also be an opportunity for staff feedback on the orientation process.
- How the Program plans to monitor performance to ensure compliance.
  - The Quality Council will review information regarding staff hiring and turnover identifying trends and developing orientation process improvements.
- The date by which the regulatory insufficiency will be corrected.
  - June 7, 2017

### **Tag 057 Staffing    Tag 058 Staffing (each has the same Plan of Correction)**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - The Director of Health Services will re-complete competency testing with all the current staff who were employed at the DOHS' employment start date of 12/1/16.
  - This competency testing will be documented and documentation will be placed in the employee's personnel file.
- What measures will be taken to ensure the problem does not recur.
  - The requirement to completed this training and the required documentation supporting completion has been added to the DOHS orientation checklist
  - Forms to record this competency testing will be completed and placed in employee files
- How the Program plans to monitor performance to ensure compliance.
  - The Business Office Manager will audit each record to assure the documentation is in place
- The date by which the regulatory insufficiency will be corrected.
  - June 7, 2017

### **Tag 037 Evaluation of Tenant**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - Tenant #6 has discharged from the Program related to increasing level of care needs while on Hospice care.
  - Tenant #10's Evaluation has been completed
  - Tenant #11 has discharged from the Program related to increasing level of care needs
- What measures will be taken to ensure the problem does not recur.
  - Registered Nurse training regarding the regulatory requirements for Tenant Evaluation when the Tenant experiences a change in condition
  - All Tenants will receive an Evaluation within 30 days of occupancy using software (electronic health record) Evaluation/Assessment scheduler to prompt completion.
  - All Tenants will receive an Evaluation that addresses the function, cognitive and health needs of the Tenant when a change of condition is noted
- How the Program plans to monitor performance to ensure compliance.
  - An audit of each Tenants' health record will be completed using EHR Report features to determine those Tenants with condition changes.
- The date by which the regulatory insufficiency will be corrected.
  - May 26, 2017

### **Tag 077 Tenant Documents**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - A Medication Error Report for Tenant #1 has been completed
  - Tenant #2 was treated 4/18/17
- What measures will be taken to ensure the problem does not recur.
  - All staff training re: need to complete incident reports – Medication Error Reports
  - Develop a tracking method to review faxes sent to primary care providers and to track until a response is received and/or the RN takes other action to prompt a response
- How the Program plans to monitor performance to ensure compliance.
  - Audits of documentation regarding medication delivery utilizing EHR Reports will be completed by the VPC Director of Home Care.
  - Audits of staff reports of Tenant potential changes in condition and the follow up actions taken by the RN
- The date by which the regulatory insufficiency will be corrected.

- June 7, 2017

#### **Tag 085 Service Plans**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - The Service Plan for Tenant #6 was revised.
  - The Service Plan for Tenant #10 was completed.
- What measures will be taken to ensure the problem does not recur.
  - Registered Nurse training regarding the regulatory requirements for Service Plan implementation and updates when the Tenant experiences a change in condition.
- How the Program plans to monitor performance to ensure compliance.
  - The VPC Director of Home Care will audit Tenant Service Plans when there has been a Tenant change of condition.
- The date by which the regulatory insufficiency will be corrected.
  - May 26, 2017

#### **Tag 094 Nurse Review**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - Tenant #6 has discharged from the Program related to increasing level of care needs while on Hospice care.
  - Tenant #7's Nurse Review has been completed.
- What measures will be taken to ensure the problem does not recur.
  - Registered Nurse training regarding the regulatory requirements for Nurse Review when the Tenant experiences a change in condition and at least every 90 days.
  - Utilization of the electronic health record software Report that lists due dates for Tenant Reviews.
- How the Program plans to monitor performance to ensure compliance.
  - VPC Director of Home Care will audit RN's documentation in the health record when a Tenant experiences a change in condition and at least every 90 days.
- The date by which the regulatory insufficiency will be corrected.
  - May 26, 2017

**Tag 121 Dementia Specific Education for Personnel – 8 hours orientation**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - All staff hired will complete 8 hours of Dementia Specific Education
- What measures will be taken to ensure the problem does not recur.
  - The orientation checklist has been updated to reflect methods of training and the method of documentation to show the 8 hours of orientation have been completed.
- How the Program plans to monitor performance to ensure compliance.
  - The Business Office Manager will audit each new employee file to assure the 8 hours of training is documented.
- The date by which the regulatory insufficiency will be corrected.
  - May 26, 2017

**Tag 123 – Dementia Specific Education for Personnel – Annual requirement**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - All current staff are completing 8 hours of training for the year 2017
- What measures will be taken to ensure the problem does not recur.
  - The Staff Development Nurse will receive training on developing Dementia training content and the recording of completed Dementia training.
- How the Program plans to monitor performance to ensure compliance.
  - The VPC Director of Home Care will audit records of current staff to assure 8 hours of training is documented.
- The date by which the regulatory insufficiency will be corrected.
  - June 7, 2017

### **Tag 151 Activities**

- Elements detailing how the Program will correct each regulatory insufficiency.
  - The Memory Care Manager will develop a written schedule of monthly activities for those Tenant's residing in the Memory Care community. This monthly schedule will be provided to Tenants and Tenant legal representatives.
  
- What measures will be taken to ensure the problem does not recur.
  - The Memory Care Manager will continue to develop this monthly schedule.
  - Staff working in Memory Care will be trained on the use and implementation of the monthly schedule.
  - The Memory Care Manager will provide a copy of each month's schedule to each Tenant and to the Tenant's legal representative
  
- How the Program plans to monitor performance to ensure compliance.
  - The VPC Memory Care Manager will review the written schedule of monthly activities with the Keelson Harbour Memory Care Manager
  
- The date by which the regulatory insufficiency will be corrected.
  - June 7, 2017