PRINTED: 07/13/2021 FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED	
AND CAN OF CONNECTION			A. BUILDING:		c	
		880682	B. WING		1	9/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CMY,	STATE, ZIP CODE		
CAREL	CAREUNITA 500 OPAL STREET					
		AFTON, IA		The state of the second of the		ner)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPROPERTY (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
R 000	Initial Comments		R 000	8-304 Staff have received	te	
		ciencies cited during the		activity inservice trai	ning	
		nplaints #95867-C and site infection control survey.		for this year. Mondai	e Mondatard	
	#80002-C or the on	site infection control survey.		inservices have resu	ured	
٠	The following defici	encles were cited during the		I THE LITT THUISON	uq i	
	survey conducted to	o determine compliance with Residential Care Facility,		of every month , ex	cept	
	incensing rules for a	Negliconial Calc / acinty.		November of this us	305	8-26-21
R 304	481-57.10(2)c(4) A	dministrator	R 304	His to Tranksaiving	416	0 26-21
•	57.10(2) Dutles of a	an administrator. The	,	ILL COMPOSE IN SENICE Y		
administrator shall:			2021 will be the sto	•		
	c. Provide in-service	e educational programming for		1 - Lacronace	FULL	
٠	all employees with	direct resident contact and				
	maintain records of	programs and participants.		Inservice will recei	400	
:	during each calenda	nal programming offered ar year shall include, at				
***	minimum, the follow			191177es reguest		
	(4) Decident cotiviti	0.7		Down inservices wi		
,	(4) Resident activiti	Q3.		continue on the 4th	7	
-		199)	4	Thursday of every mo	ottin	
t .	This REQUIREMENT by:	NT Is not met as evidenced	-	THUTSOMY OF ELECTION	- -	
!	Based on interview	and record review the facility		and include all the		
:	failed to ensure trail	ning for resident activities was		meerice education	ed	
	completed every ca	llendar year. Finding include:		programming require	וויט	
		a.m. review of Relias staff	7777	for coopies the the	ھ	
!	training records rev	ealed no course regarding		be recontrollesia	ree	
	resident activities.			programming require for chapter 5%. This was be monitored by the administrator design)	
1	The Administrator of 6/09/21 at 11:36 a.r	confirmed this finding on m.				
R 306	481-57.10(2)c(5) A	dministrator	R 306			
					######################################	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

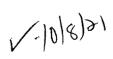
TITLE CARE Administrator (X6) DATE

Jara Dailey STATE FORM

LLIK11

5695

18-8-2021 If continuation sheet 1 of 13



DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 06/09/2021 B. WING 880682 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **500 OPAL STREET** CAREUNITA **AFTON, IA 50830** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SLIMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R-300 R 306 R 306 Continued From page 1 staff have received the 9.24-21 57.10(2) Duties of an administrator. The mental illress/behavior administrator shall: modification crisis intervention training c. Provide in-service educational programming for for this year. Mardofory all employees with direct resident contact and inservices have resumed maintain records of programs and participants. In-service educational programming offered on the 4th Thursday of during each calendar year shall include, at every month, except minimum, the following topics: November Of this year due to Thanksgiving. The (5) Mental illness/behavior modification/crisis Intervention. November inservice in 2021 will be the 3rd Thursday in November. Any staff not attending This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility will receive the training failed to ensure training for mental illness/behavior modification/crisis intervention information/quizzes was completed every calendar year. Finding requested. The 2022 include: inservices will continue On 6/09/21 at 11:27 a.m. review of Relias staff on the 4th Thursday training records revealed no course regarding mental Illness/behavlor modification/crisis of every month and intervention include all the inservice required for Chapter 57 The Administrator confirmed this finding on 6/09/21 at 11:36 a.m. R 308 This will be monitored R 308 481-57.10(2)c(6) Administrator by the administrator 57.10(2) Duties of an administrator. The administrator shall: designee. c. Provide in-service educational programming for all employees with direct resident contact and

maintain records of programs and participants.

PRINTED: 07/13/2021 FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 880682 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 OPAL STREET** CARFUNITA **AFTON. IA 50830** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (¥4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) R-30B R 308 · Continued From page 2 R 308 Staff have received the 9-24-21 resident safety/supervision training this calendar In-service educational programming offered during each calendar year shall include, at minimum, the following topics: year. Marchitory inservices have resumed on the 4th (6) Resident safety/supervision. Thursday of every month, except November of this year due to Tranksgimmy This REQUIREMENT is not met as evidenced by: The November inservice in Based on interview and record review the facility 2021 will be the 3rd failed to ensure training for resident safety/supervision was completed every calendar Thursday in Novemberyear. Finding include: Any staff not attending the inservice will receive On 6/09/21 at 11:27 a.m. review of Relias staff training records revealed no course regarding the training information resident safety/supervision. and return all information The Administrator confirmed this finding on quizzes requested. The 6/09/21 at 11:36 a.m. 2022 inservices will R 310 continue on the 4th R 310I 481-57.10(2)c(7) Administrator Thursday of every month 57.10(2) Dutles of an administrator, The administrator shall: and include all the inservice educational c. Provide In-service educational programming for all employees with direct resident contact and programming required maintain records of programs and participants. Or Chapter 57. This will be monitored by the administrator designe. In-service educational programming offered during each calendar year shall include, at

(7) Resident rights.

minimum, the following topics:

This REQUIREMENT is not met as evidenced

R-310

Staff have received the

Continued

resident rights training for this year. Mardatury 8-26-21

DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 06/09/2021 B. WING 880682 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 500 OPAL STREET CAREUNITA **AFTON, IA 50830** (X6) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R-310 continued: R 310 R 310 Continued From page 3 on the 4th Thursday of 82621 Based on interview and record review the facility every month, except failed to ensure training for resident rights was November of this year completed every calendar year. Finding include: due to Thanks giving. The November inservice On 6/09/21 at 11:27 a.m. review of Rellas staff in 2021 will be the 3rd training records revealed no course regarding Thursday in November. resident rights. Any staff not attending the inservice will receive the The Administrator confirmed this finding on 6/09/21 at 11:36 a.m. training information and return all information R 312 R 312: 481-57.10(2)c(8) Administrator quittes requested. The 2022 inservices will 57.10(2) Duties of an administrator. The continue on the 4th administrator shall: Thursday of every months c. Provide in-service educational programming for and include all the inservice educational all employees with direct resident contact and maintain records of programs and participants. programming required In-service educational programming offered for Chapter 57. This will be resigned monitored by the administrator designed during each calendar year shall include, at minimum, the following topics: (8) Medication education, to include R-312 Staff hove received the 8-26-21 administration, storage and drug interactions. medication education training for this year. Mandatory inservices have resumed on the 4th Thursday of every month, This REQUIREMENT is not met as evidenced except November of this year due to Thanksgiving Based on interview and record review the facility The November Inscrike falled to ensure training for medication education in 2021 will be the third was completed every calendar year. Finding Thursday of November. R-312 continued: On 6/09/21 at 11:27 a.m. review of Relias staff

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

DEPARTMENT OF INSPECTIONS AND APPEALS (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING_ 06/09/2021 880682 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 500 OPAL STREET CAREUNITA **AFTON, IA 50830** PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID REACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R-812 continued; 8-26-21 R 312 R 312 Continued From page 4 Any stoff not attending the training records revealed no course regarding inserve will receive the training information and medication education. and return all information The Administrator confirmed this finding on quizzes requested. The 6/09/21 at 11:36 a.m. 2022 inservices will continue on the 4th Thursday of R 314 every month and include R 314 481-57.10(2)c(9) Administrator all the educational programmin 57.10(2) Dutles of an administrator. The required for chapted 5% administrator shall: This will be monitored low the administrator/designer c. Provide in-service educational programming for all employees with direct resident contact and maintain records of programs and participants. R-314 9-24-21 staff-take received the In-service educational programming offered resident source plans! during each calendar year shall include, at programming goals traini minimum, the following topics: for this year. Mandatory inservices have resumed (9) Resident service plans/programming/goals. on the 4th Thursday of every month, except Hoverber of this year due to Tranksgiving The November inservice in 2021 WILL loe the third Thursday This REQUIREMENT Is not met as evidenced of Hovernoer. Any staff no attending the meetrice will receive the training by: Based on interview and record review the facility falled to ensure training for resident service information and returnal plans/organming/goals was completed every the information quietess
requested. The 2022 inservices calendar year. Finding include: will continue on the 4th On 6/09/21 at 11:27 a.m. review of Relias staff: training records revealed no course regarding Thursday of every month and include on the educational resident service plans/programming/goals. programming required br pronitored by the administrator/ The Administrator confirmed this finding on 6/09/21 at 11:36 a.m.

designee.

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
880682		B. WING		C 06/09/2021		
NAME OF PROVIDER OR SUPPLIES		DDRESS, CITY, STATE, ZIP CODE				
	500 OPAL					
CAREUNITA	AFTON, IA	A 50830				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE	
R 358 Continued From p	age 5	R 358		210		
R 358: 481-57.11(3) Personnel 57.11(3) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in lowa Code section 135C.33 as amended by 2014 lowa Acts, chapter 1040, and rule 481-50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I,II, III)		R 358	R-35B - Refer to C-3 on page 13 and powers of fine 8-9 2021.	nt	୫-ଅ	
by: Based on interview the facility failed to related to employed lowa Administrative Findings include:: A review of personr failed to ensure crir completed as requi Administrative Code	e rule 481-50.9(3). The med this finding. See					

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

PRINTED: 07/13/2021 FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 8. WING 880682 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 OPAL STREET** CAREUNITA **AFTON, IA 50830** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X6)(X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R-470 R 470. Continued From page 6 R 470 The administrator, LAN, or trained designee R 470i 481-57.13(2)a Admission, Transfer, Discharge R 470 5-21 will renew all recessary 8-21 notifications prior to 481-57.13(135C) Admission, transfer and the transfer or discharges 21 discharge. of any resident. The 57.13(2) Discharge or transfer. physician orders, nurses rotes, and any other a. Notification shall be made to the legal representative, primary care provider, and required notifications sponsoring agency, if any, prior to the transfer or will be documented discharge of any resident, (III) in the physician order nurses notes, sponsorur agency if any and This REQUIREMENT is not met as evidenced communicated to any bv: other required agencies or providers. Any staff tandling any admission, Based on interview and record review the facility failed to ensure the notification of the primary care provider had been completed and documented prior to discharge for 1 of 3 former residents reviewed (Resident C-2). Findings discharge ortransfer include: will be trained prior · On 6/09/21 at 1:25 p.m. record review revealed to admission, discharge or transfer. This will Resident C-2 discharged from the facility on 4/15/21. Record of Resident C-2's physician being contacted prior to this discharge could not be monitored by the be located. administrator, LAN, ortrained designée On 6/09/21 at 1:45 p.m. the Administrator confirmed this finding. R 622 R 622' 481-57.17(1)r Records

: 481-57.17(135C) Records.

57.17(1) Resident record. The licensee shall keep a permanent record on every resident admitted to the residential care facility, and all

LLIK11

PRINTED: 07/13/2021 FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ 08/09/2021 B. WING 880682 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **500 OPAL STREET** CAREUNITA **AFTON, IA 50830** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R. 622 R 622 R 622 Continued From page 7 8-2021 The administrator, UPN, entries in the permanent record shall be current, or trained designee will dated, and signed. (III) The record shall include: keep the permanent record of every resident admitted r. A notation of disposition of personal property and medications upon the resident's transfer, to the residential care discharge or death. (III) facility including record of the disposition of the resident's personal property whether sent This REQUIREMENT is not met as evidenced or donated and signed by the resident or Based on interview and record review the facility residents designees. falled to ensure the disposition of property and The resident's medication medications was documented for 1 of 3 former will be returned to the residents reviewed (Resident C-2). Findings pharmacy per unit bose policy and noted in the include: On 6/09/21 at 1:25 p.m. record review revealed nurse's notes. If the Resident C-2 discharged from the facility on resident is discharged 4/15/21. Record of the disposition of the resident's valuables and medications could not be home a physician's located. order will be obtained to send medications On 6/09/21 at 1:45 p.m. the Administration confirmed these findings. as ordered by physician home or documented R 780 R 780: 481-57,21(1)c Dietary returned to prammau 481-57.21(135C) Dietary. IREL POLICY 57.21(1) Dietary staffing. c. In addition to the regulrement of paragraph 57.21(1)"a," personnel who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service

PRINTED: 07/13/2021 FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B, WING 880682 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 OPAL STREET** CAREUNITA **AFTON, IA 50830** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 780 Continued From page 8 R 780 R780 All current staff have training on food protection, (III) 7-29-21 received the annual trammed on sanitation and safe food handling of food and food protection The orientation-training packet This REQUIREMENT is not met as evidenced for cooks will include written and hands on training Based on interview and record review the facility for food preparation and failed to ensure personnel responsible for food service. Staff working 117 preparation or service had orientation on the food preparation clean sanitation and safe food handling of food prior to will complete the SERVSAF handling of food as well as annual inservice class or work under the training on food protection for 4 of 4 staff supervision of staff who reviewed (Staff D, E, F, G). Findings include: have completed the On 6/09/21 at 9:08 a.m. personnel record review SERVSAF CIASS. Add Aimal revealed Staff D was hired on 1/06/21 to work as training and supernision will be required and ongoing for any staff an administrative assistant, Record of Staff D's orientation on sanitation and safe food handling who has not completed of food could not be located. THE SERV SAF CLOSS OF On 6/09/21 at 9:18 a.m. personnel record review food Preparation and revealed Staff E was hired on 2/11/21 to work as food Sanitation classes. a cook. Record of Staff E's orientation on This will be monitored sanitation and safe food handling of food could by the administrator not be located. designee who has completed the SERV SAT On 6/09/21 at 9:25 a.m. personnel record review Staff F was hired on 5/04/20 to work as a class. medication manager. Record of Staff F's orientation on sanitation and safe food handling of food could not be located.

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

of food could not be located.

On 6/09/21 at 9:41 a.m. personnel record review Staff G was hired on 1/07/21 to work as a medication manager, Record of Staff G's orientation on sanitation and safe food handling

On 6/09/21 at 11:42 a.m. the Administrator

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 9:	(X3) DATE SURVEY COMPLETED		
	880682	B, WING		C 06/09/2021		
NAME OF PROVIDER OR SUPPLIES C A R E UNIT A	500 OPA	DDRESS, CITY, STATE, ZIP CODE L STREET IA 50830				
PREFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETE		
food preparation of On 6/09/21 at 11:2 training records resanitation and safe On 6/09/21 at 11:3 confirmed these first R 836 481-57.22(3) d Ories 57.22(3) Service pradmission, the administrator's des resident, the reside interdisciplinary tea works with or serve written, individually for the resident. The developed and impresident's priorities activities of daily lives social, behavioral, the health. (I, II, III) d. The service plant quarterly by relevar appropriate others, case manager and shall include a writt summary of the residents.	e staff were involved in either or service. 7 a.m. review of Relias staff vealed no course regarding a food handling. 6 a.m. the Administrator addings. entation and Service Plan lan. Within 30 days of	R 780	An audit scredule of a plans, quarterly reports to the scrike plan meeting activity residents residents responsible interdisciplinary teams and any organization that works with orse expected to the residents responsible interdisciplinary teams and any organization that works with orse expensible interdisciplinary teams and any organization that works with orse exicult the audits a review the administrator of resident care proports with the discuss with the plans and complete the staff responsible to the scrike plan quarterly reports will be operated to have completed in required timely manner. Service plans and quarterly reports will be reported by the administrator design administrator design administrator design	THE STATE OF THE S		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	D WING			C 06/09/2021		
		880682	<u> </u>		1 00/01	8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE		
CARE	UNIT A	AFTON, IA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	DBE	(X6) COMPLETE DATE
R 836		ge 10 NT is not met as evidenced	R 836	<u>R836</u> Completed on Previous	a Rage	
	failed to ensure ser	and record review the facility vice plans were reviewed at of 2 residents reviewed Findings include:		Bids have been obtated about the wind about to the wind is being	ained The ,	7-2021
	Resident #1's last s 3/31/21. Prior to the was dated 1/14/20. On 6/09/21 at 3:35 Resident #2's last s	replaced. Additional replaced. Additional replaced. Additional replaced. Additional replaced for other doors bids for other doors to at 3:35 p.m. record review revealed is last service plan was dated.		id.		
	be located.	p.m. the Director of Resident		by the administrator des	l rota Sigree Hodh	7 2021
R1058	481-57.36(2) Mainte	enance	R1058	The women's central shower stall floor ux	15	,,
		ng, grounds, and other saintained in a clean, orderly	cleaned thoroughly grout was applied. will be monitored the maintenance me	this by		
. ,	by: Based on observational falled to maintain the Findings include: During the environment between 2:26 p.m. a	on and Interview the facility e building in good repair. nental tour on 6/08/21 and 2:47 p.m. while a Administrator the following		and grout applied as recessory. Staff give showers will report to maintenance and administrator when cleaning any areas and or cracks.	ing	

DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C 06/09/2021 R WING 880682 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 500 OPAL STREET CAREUNITA **AFTON, IA 50830** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R1058 -R1058 R1058 Continued From page 11 See Revious Page concerns were noted: - Metal door to the women's east wing was C210 rusted through at the bottom of the door. The employee who was 8-21 - The women's central bath shower stall floor hired to work part-time was cracked with mold in the corners. The corners of the surround tile were also moldy. in maintenance bookground checks The Administrator confirmed these findings during the tour. were completed. unfortunately, the C 210 C 210 01-50.9(5) Background Checks criminal background check was overlooked. 481-50.9(135C) Criminal, dependent adult abuse, and child abuse record checks. and then completed. The DHS hit form had 50.9(5) Employment prohibition. A person who has committed a crime or has a record of been completed had founded child or dependent adult abuse shall not not been sent or be employed in a facility unless an evaluation has report misplaced. been performed by the department of human The DHS report was services completed and amployee could work. This REQUIREMENT is not met as evidenced The administrative assistant/administrator Based on interview and record review the facility designee will double falled to have the Department of Human Services (DHS) perform an evaluation of an employee's check all criminal criminal history to determine whether the crime history, dependent warranted prohibition from employment for 1 of 2 adult abuse checks staff reviewed with a criminal history (Staff C). with the administrator prior to hire. This will Findings include: be completed with each On 6/09/21 at 10:01 a.m. personnel record review revealed Staff C was employed with the facility on hire and a review of 10/21/20 to work in maintenance. Further review all hores at the end revealed checks were completed for the child abuse, dependent adult abuse and sex offender of each month. registries on 10/1/21 with no concerns noted. A

PRINTED: 07/13/2021 FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION S:	(X3) DATE	(X3) DATE SURVEY COMPLETED	
	880682 B. WING		1	C 06/09/2021		
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
CAREUNITA	500 OPAL AFTON, I.	.STREET A 50830				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETE DATE	
until 10/24/21 which hired. The check ca required an evaluati whether or not the faindividual. Although requesting an evaluation from DHS of	rd check was not completed 3 days after Staff C was me back with a hit which on from DHS to determine acility could employ the the form to submit to DHS ation was in the file, a could not be located.	C 210				

LLIK11