DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0004	A. BUILDING: _____ B. WING _____	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MEADOW PLACE, L L C	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	Initial Comments Assisted Living Programs for People with Dementia are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 11 Number of tenants with cognitive disorder: 29 TOTAL census of Assisted Living Program for People with Dementia: 40 The following regulatory insufficiencies were cited during the investigation of Complaints #97246-C, #97326-C, #97465-C and the revisit conducted to determine progress toward correcting violations identified during the complaint visit completed on 12-31-2020. No regulatory insufficiencies were cited during the investigation of Complaints #95084-C, #97396-C, the onsite infection control survey. A revisit was conducted to determine progress toward correcting violations identified during the complaint visit completed on 11-16-2020. The revisit was determined to be MET.	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 160		

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A 160	Continued From page 1	A 160		

Program failed provide adequate and appropriate care, treatment, and services to 1 of 5 tenants reviewed (Tenant #1). Findings follow:

Review of Incident Report dated 5-2-21 documented two unwitnessed falls during the overnight shift. Tenant #1 complained of leg pain. The report documented the nurse became aware of the tenant's leg pain at 7:30 a.m. She documented, "...reports her leg "hurts a whole lot" Resident's typical level of mobility is up independently with walker, but with current pain level, resident is not willing to ambulate. Resident given acetaminophen, and ice applied to leg. After this failed to bring pain relief, resident was sent to ER for evaluation."

Continued record review revealed a progress note, dated 5/4/21, documented "... resident had a fractured hip that was surgically repaired with a rod and screws placed. The plan is for resident to discharge... for a skilled care stay for rehabilitation."

Additional review of progress notes revealed the following:

a. On 5/2/21 at 7:30 a.m. the Health Care Coordinator documented she received a call from staff regarding Tenant #1's leg pain. It was further documented, "...states it "hurts a whole lot" when pressing on leg, resident indicates the leg hurts on top of the thigh near the knee. Resident currently lying in bed and does not want to get out of bed or ambulate due to leg pain. Instructed (staff) to apply ice and given acetaminophen and call back if not effective."

b. On 5/2/21 at 8:30 a.m. the HCC noted a call received informing her the interventions were not

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A 160	Continued From page 2	A 160		

effective against Tenant #1's leg pain. She further noted, "... refusing to move it and doesn't want to attempt to ambulate on it. Instructed (staff) to call EMS for transport to ER to have resident evaluated. At this time resident still reporting pain on anterior thigh near the knee.

c. On 5/2/21 at 8:47 a.m. the HCC documented: "Call received from a 2nd day shift (staff) reporting that resident had been taken by EMS. It was at this time that writer was made aware that night shift had reported to 2nd day shift (staff) that resident had two falls in the night, the first was an unwitnessed fall with resident stating she just "sat down" in hallway, resident was assisted back up to standing with 2 assist per report, and shortly thereafter, wen resident was back in her room, she had an unwitnessed fall next to her bed. She was assisted up and back into her bed by (staff) and (complained of) leg pain at that time, which was 0145."

Record review on 5-27-21 of Tenant #1's Service Plan dated 4-2-21 revealed she resided in the locked memory care unit and required a 4-wheeled walker for ambulation and a wheelchair for longer distances. Further review revealed she had a recent history of falls. Tenant #1's diagnoses included: unspecified dementia with behavioral disturbance, age-related osteoporosis without current pathological fracture.

Record review of In-Service training for Staff Notification to Nurse revealed staff must notify the nurse when a resident has fallen, staff must contact the nurse prior to getting the resident up, and staff must notify the nurse anytime they complete an incident report. Staff A and Staff B attended the training on 12-11-2020.

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A 160	Continued From page 3	A 160		

When interviewed on 6-2-21 at 3:04 p.m. Staff A stated on 5-2-21 Tenant #1 lowered herself to the floor and when asked if she fell, Tenant #1 stated she did not. Staff A stated she assumed Tenant #1 stated a fact and appeared to have not injuries. Staff A stated she called Staff B for assistance and they assisted her from the floor. Staff A stated she left to assist another tenant and a few minutes later Staff B joined her to assist. She stated she heard a crash and Staff B left to check it out. Staff A stated Staff B told her he found Tenant #1 on the floor and complained of some pain and was in bed. Staff A asked Staff B if he called the nurse and he informed her he had not and she failed to follow up to ensure the nurse was notified. Staff A stated she continued to check on Tenant #1 and found her sleeping and appeared comfortable. Staff A stated she informed the next shift Tenant #1 needed pain medication because she told Staff B earlier she was hurting. Staff A stated she could not explain why she assumed pain medication would be needed if Tenant #1 was sleeping and stated no further complaints. Staff A confirmed she attended the training on 12-11-2020 on when to contact the nurse and confirmed she failed to ensure the nurse was notified of Tenant #1's falls.

When interviewed on 6-2-21 at 1:27 p.m. Staff C stated Staff A asked her to check on Tenant #1 because she fell twice in the night and had complained of pain. Staff C stated she observed Tenant #1 and she appeared to be in pain and had trouble moving. Staff C stated she asked Staff A if she contacted the nurse and Staff A stated no because they were not bad falls. Staff C contacted the nurse and was told to apply ice and administer Tylenol. Staff C stated Tenant #1 continued to be in pain and contacted the nurse to let her know. Tenant #1 was sent to the

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A 160	Continued From page 4 hospital for further evaluation. When interviewed on 5-20-21 at 9:37 a.m. Staff B stated Staff A called him for assistance. He stated he finished assisting another tenant before going to the memory care side approximately 15 minutes later. He stated he observed Tenant #1 on the floor of her bathroom doorway. He stated Tenant #1 stood up and refused assistance and would not go back to her bed. He stated he and Staff A left her to assist another tenant and later walked by Tenant #1's room and observed her on the floor by her dresser. He stated he and Staff A assisted her to her knees and up into her bed. He stated he did not take vitals and did not know if Staff A completed them either time. He stated he assumed Staff A completed an incident report and contacted the nurse since she was assigned to the memory care unit. When interviewed on 6-2-21 at 1:17 p.m. the Director confirmed Tenant #1 suffered a hip fracture after her falls. He confirmed Staff A and Staff C attended the in-service on 12-11-20202 that included when staff are to notify the nurse and when to to write an incident report. He stated both staff received a final written warning for failing to follow the policy as trained. He confirmed both staff are no longer employed by the Program.	A 160		
A 361	481-67.9(4)f 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 361		

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A 361	Continued From page 5 f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review the Program failed provide services to tenants in accordance with the training provided. This pertained to 1 of 1 tenants (Tenant #1) reviewed with a major injury. Findings follow: Record review on 5-27-21 of Tenant #1's Service Plan dated 4-2-21 revealed she resided in the locked memory care unit and required a 4 wheeled walker for ambulation and a wheelchair for longer distances. Further review revealed she had a recent history of falls. Review of Incident Report dated 5-2-21 documented 2 unwitnessed falls during the overnight shift and Tenant #1 complained of leg pain. Further review revealed she was sent to the emergency room for further evaluation for continued leg pain. Tenant #1 was diagnosed with a hip fracture. Record review of In-Service training for Staff Notification to Nurse revealed staff must notify the nurse when a resident has fallen, staff must contact the nurse prior to getting the resident up, and staff must notify the nurse anytime they complete an incident report. Staff A and Staff B attended the training on 12-11-2020. When interviewed on 6-2-21 at 3:04 p.m. Staff A stated on 5-2-21 Tenant #1 lowered herself to the floor and when asked if she fell, Tenant #1 stated she did not. Staff A stated she assumed Tenant #1 stated a fact and appeared to have not injuries. Staff A stated she called Staff B for	A 361		

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A 361	Continued From page 6	A 361		

assistance and they assisted her from the floor. Staff A stated she left to assist another tenant and a few minutes later Staff B joined her to assist. She stated she heard a crash and Staff B left to check it out. Staff A stated Staff B told her he found Tenant #1 on the floor and complained of some pain and was in bed. Staff A asked Staff B if he called the nurse and he informed her he had not and she failed to follow up to ensure the nurse was notified. Staff A stated she continued to check on Tenant #1 and found her sleeping and appeared comfortable. Staff A stated she informed the next shift Tenant #1 needed pain medication because she told Staff B earlier she was hurting. Staff A stated she could not explain why she assumed pain medication would be needed if Tenant #1 was sleeping and stated no further complaints. Staff A confirmed she attended the training on 12-11-2020 on when to contact the nurse and confirmed she failed to ensure the nurse was notified of Tenant #1's falls.

When interviewed on 6-2-21 at 1:27 p.m. Staff C stated Staff A asked her to check on Tenant #1 because she fell twice in the night and had complained of pain. Staff C stated she observed Tenant #1 and she appeared to be in pain and had trouble moving. Staff C stated she asked Staff A if she contacted the nurse and Staff A stated no because they were not bad falls. Staff B contacted the nurse and was told to apply ice and administer Tylenol. Staff C stated Tenant #1 continued to be in pain and contacted the nurse to let her know. Tenant #1 was sent to the hospital for further evaluation.

When interviewed on 5-20-21 at 9:37 a.m. Staff B stated Staff A called him for assistance. He stated he finished assisting another tenant before going to the memory care side approximately 15

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A 361	Continued From page 7 minutes later. He stated he observed Tenant #1 on the floor of her bathroom doorway. He stated Tenant #1 stood up and refused assistance and would not go back to her bed. He stated he and Staff A left her to assist another tenant and later walked by Tenant #1's room and observed her on the floor by her dresser. He stated he and Staff A assisted her to her knees and up into her bed. He stated he did not take vitals and did not know if Staff A completed them either time. He stated he assumed Staff A completed an incident report and contacted the nurse since she was assigned to the memory care unit. When interviewed on 6-2-21 at 1:17 p.m. the Director confirmed Tenant #1 suffered a hip fracture after her falls. He confirmed Staff A and Staff B attended the in-service on 12-11-20202 that included when staff are to notify the nurse and when to to write an incident report. He stated both staff received a final written warning for failing to follow the policy as trained. He confirmed both staff are no longer employed by the Program.	A 361		
A 386	67.13(4) Monitoring Revisit 67.13(4) Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. This REQUIREMENT is not met as evidenced	A 386		

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A 386	Continued From page 8 by: Based on interviews and record review, the Program failed to adequately implement plans of correction to ensure on-going compliance. Finding follows: Record review revealed a regulatory insufficiency cited at Iowa Administrative Code (IAC) 481 Chapter 69.3(2) on 12/31/20 due to failure to provide tenants adequate and appropriate care; specifically, failure to notify the nurse in a timely manner of change in tenant condition. The Program submitted a plan of correction indicating the deficient practice would be corrected by 4/2/21. A revisit completed 6/21/21 resulted in a deficiency cited at IAC 481-67.3(2) due to failure to tenants adequate and appropriate care; specifically, staff failed to notify the nurse in a timely manner following a significant incident per Program policy.	A 386		

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

Iowa Department of Inspection & Appeals
Catie Campbell
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

To Whom It May Concern,

Please consider this our plan of correction for the regulatory insufficiency cited during May 17 through June 8, 2021complaint visit completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapter 481-69, pertaining to regulatory insufficiencies.

Date: 7/28/2021
Complaint Intake #: Complaint #94196-C and #94966-C And Re-Visit for Compliance

Plan of Correction (POC) Submitted For:
- Investigation Date: May 17 through June 8, 2021
- Monitors: Mary Hildreth

POC: 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. Based on interview and record review the Program failed provide adequate and appropriate care, treatment, and services to 1 of 5 tenants reviewed (Tenant #1).

Program POC:

1. Elements detailing how this was corrected for residents:
    a. Community has completed re-training for all staff- regarding communications needed to the nurse, notifications to the Nurse on Resident Illnesses/Incidents, Nurse Assessment following Incidents, and Incident Reporting between June 4th-July 28th 2021.
2. Actions program taking to protect tenants in similar situations:
    a. JSL team re-educated the nursing staff on incident reports and timely reporting to the nurse for unusual resident occurrences/assessments needed on 6/4/2021.
    b. 6/4/2021 to 7/28/2021 the community provided education to direct care staff on when to call nurse, Incident Reporting of resident illnesses and incidents.

c. 6/4/2021 to 7/28/2021 the community re-educated staff on the "Staff to RN Communication" form being used versus Incident Reporting, and Notifications to the Nurse.

3. Measures taken to ensure problem does not recur:
    a. Nurse/Director or designee reviews "Staff to RN Communication" forms and incident reports routinely and as needed
    b. Direct Care staff completed education between 6/4/2021 to 7/28/2021 on when to call nurse, Incident Reporting of resident illnesses and incidents.
    c. Director, Nurse, or designee will review incident reports as they occur and address any areas of concern as needed.
4. Program plans to monitor performance to ensure compliance:
    a. Continued training will be completed on communicating with the nurse during onboarding of new staff, annually and as needed.

POC: 481-67.9(4)f 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:
f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review the Program failed provide services to tenants in accordance with the training provided. This pertained to 1 of 1 tenants (Tenant #1) reviewed with a major injury.

Program POC:

1. Elements detailing how this was corrected for residents:
    a. Community has completed re-training for all staff- regarding communications needed to the nurse, notifications to the Nurse on Resident Illnesses/Incidents, Nurse Assessment following Incidents, and Incident Reporting between June 4th-July 28th 2021.
2. Actions program taking to protect tenants in similar situations:
    a. A Skills Fair was completed July 15th and 16th with most direct care staff reviewing all delegations and skills. The remaining staff will have their skills fair training July 28th.
    b. 6/4/2021 to 7/28/2021 the community provided education to direct care staff on when to call nurse, Incident Reporting of resident illnesses and incidents.
    c. 6/4/2021 to 7/28/2021 the community re-educated staff on the "Staff to RN Communication" form being used versus Incident Reporting, and Notifications to the Nurse.
3. Measures taken to ensure problem does not recur:
    a. Nurse/Director or designee reviews "Staff to RN Communication" forms and incident reports routinely and as needed

b. Direct Care staff completed education between 6/4/2021 to 7/28/2021 on when to call nurse, Incident Reporting of resident illnesses and incidents.
c. Director, Nurse, or designee will review incident reports as they occur and address any areas of concern as needed.

4. Program plans to monitor performance to ensure compliance:
   a. Continued training/delegations will be completed on communicating with the nurse during training of new staff, annually and as needed.

POC: 67.13(4) Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. Based on interviews and record review, the Program failed to adequately implement plans of correction to ensure on-going compliance. Finding follows: Record review revealed a regulatory insufficiency cited at Iowa Administrative Code (IAC) 481 Chapter 69.3(2) on 12/31/20 due to failure to provide tenants adequate and appropriate care; specifically, failure to notify the nurse in a timely manner of change in tenant condition. The Program submitted a plan of correction indicating the deficient practice would be corrected by 4/2/21. A revisit completed 6/21/21 resulted in a deficiency cited at IAC 481-67.3(2) due to failure to tenants adequate and appropriate care; specifically, staff failed to notify the nurse in a timely manner following a significant incident per Program policy.

Program POC:

1. Elements detailing how this was corrected for residents:
   a. Community has completed re-training for all staff-regarding communications needed to the nurse, notifications to the Nurse on Resident Illnesses/Incidents, Nurse Assessment following Incidents, and Incident Reporting between June 4th-July 28th 2021.
2. Actions program taking to protect tenants in similar situations:
   a. 6/4/2021 to 7/28/2021 the community provided education to direct care staff on when to call nurse, Incident Reporting of resident illnesses and incidents.
   b. 6/4/2021 to 7/28/2021 the community re-educated staff on the "Staff to RN Communication" form being used versus Incident Reporting, and Notifications to the Nurse.
   c. A Skills Fair was completed July 15th and 16th with most direct care staff reviewing all delegations and skills. The remaining staff will have their skills fair training July 28th.
3. Measures taken to ensure problem does not recur:
   a. Nurse/Director or designee reviews "Staff to RN Communication" forms and incident reports routinely and as needed

b. Direct Care staff completed education between 6/4/2021 to 7/28/2021 on when to call nurse, Incident Reporting of resident illnesses and incidents.
c. Director, Nurse, or designee will review incident reports as they occur and address any areas of concern as needed.

4. Program plans to monitor performance to ensure compliance:
    a. Continued training will be completed on communicating with the nurse during onboarding of new staff, annually and as needed

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.

Thank you for your time and consideration in correcting these important matters.

Sincerely,

John Joyner, Community Director