IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

December 4, 2014

Complaint/Incident Intake #: 49899-C
50804-I

Ms. Annette Grochala, Executive Director
Vintage Hills Retirement Community
604 E. Hillcrest Avenue
Indianola, IA 50125-1759

RE: Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report – Vintage Hills Retirement Community, Indianola, IA

Dear Ms. Grochala:

Enclosed is the **Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following a survey by DIA on **November 19, 20 and 24, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Medications, Evaluation, Service Plans and Nurse Review.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

During the course of the recertification visit, a tenant meeting was held. Tenants expressed concern and confusion over fire evacuation procedures. The tenant concern was forwarded to the State Fire Marshall's office.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0314** with effective dates of **October 26, 2014** through **October 25, 2016**.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0314	A. BUILDING _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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	481-67 Initial Comments 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. General Population Program No. of tenants without cognitive disorder. 30 No. of tenants with cognitive disorder. 3 Total Population of Program at time of visit: 33 Dementia-Specific Program by Dedication No. of tenants without cognitive disorder: 1 No of tenants with cognitive disorder: 18 Total Population of Program at time of visit: 19 TOTAL census of Assisted Living Program: 52 The following insufficiencies were cited during the investigation of Complaint #49899-C, Incident #50804-I, and a recertification conducted to determine compliance with certification for an assisted living program:	A 000		
A 036	481-67.5(6)a Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted	A 036		

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A 036	Continued From page 1 by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on interviews and tenant file reviews the program did not administer medications as directed by the health care provider. (Complaint #49899-C alleged medications were not administered according to physician orders.) Six tenant files were reviewed and included a review of the physician orders and medication adminsitration records (MARs). Tenant #1, a 90 year-old was admitted on 6-30-13 and had diagnoses of heart disease, dementia, and hypertension. On 10-19-14 Tenant #1 was staged at six on the Global Deterioration Scale which indicated moderately severe dementia. Tenant #1 resided in the dementia unit A physician order sheet dated 1-27-14 documented the physician ordered Quetiapine 25 milligrams (mg) daily at bedtime. An order dated 2-19-14 documented Tenant #1 could have Quetiapine 25 mg twice a day as needed. The MAR for June 2014 was reviewed. The MAR indicated Quetiapine 25 mg had been placed in a pill planner for Tenant #1 and one pill was to be given at bedtime. The MAR also indicated Tenant #1 could have Quetiapine 25 mg one tablet twice a day as needed for agitation or anxiety. The MAR documented Tenant #1 had one dose of the "as needed" Quetiapine on 19 days in June 2014. Tenant #1 had two doses of the "as needed"	A 036		

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A 036	Continued From page 2 Quetiapine on one day, June 25. Fifteen of the doses were administered between 2:00 p.m. and 6:00 p m. The MAR also documented Tenant #1 had received the medication for agitation or anxiety and Tenant #1 had a positive result from the medication administered On 6-25-14 a fax was sent to the physician which indicated Tenant #1 had been experiencing increased behaviors during the afternoon The fax indicated Tenant #1 was taking Quetiapine 25 mg twice daily as needed and at bedtime. A request was made to the physician to change to a scheduled dose twice a day On 6-27-14 the physician responded and indicated an ok to change to Quetiapine 25 mg one pill twice a day According to the staff list provided by the program and the Executive Director (11-20-14 at 2:04 p.m.), the nurse who had written the fax request was no longer at the program. In an interview with RN A on 11-20-14 at 2:30 p.m , she stated the fax dated 6-25 and response of 6-27-14 did not discontinue the use of the "as needed" Quetiapine, but the order should have been clarified with the physician. A physician's order sheet dated 6-27-14 was signed by the physician and indicated an order for Quetiapine 25 mg to be given routinely twice a day. Another notation handwritten indicated Quetiapine 25 mg twice a day as needed. The "twice a day as needed" had a line through it and the notation of "q hs" was written above Progress notes dated 6-26-14 documented Tenant #1 was found on the floor and was without injury. Notes dated 7-3-14 documented the nurse	A 036		

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A 036	Continued From page 3 was called because Tenant #1 was unresponsive. According to the documentation, to the nurse, Tenant #1 appeared to be sleeping while sitting up and was slow to answer questions. Per family request Tenant #1 was taken to the hospital. The progress notes documented Tenant #1 returned to the program, had been treated for mental status change, and had no new orders. Progress notes dated 7-6-14 documented the nurse had been notified over the weekend Tenant #1 was short of breath and grey in color. Tenant #1 was taken to the hospital and returned the same day with no changes to medications. The progress notes documented Tenant #1 was treated for mental status change. In an interview on 11-20-14 at 2:04 p.m. with the Executive Director, she stated Tenant #1 was taken to the hospital as Tenant #1 was not responding. The Executive Director reported the Quetiapine was building up. A physician order sheet from a local hospital dated 7-5-14 and signed by a health care provider documented Tenant #1 was diagnosed with "increased somnolence." Direction was given to follow the Quetiapine prescription as directed, hold if sedated, and as needed for agitation only. The attached medication list from the hospital indicated Quetiapine 25 mg was taken twice a day. A physician's order dated 7-8-14 documented Quetiapine 25 mg at bedtime, and discontinued "as needed" doses. The July 2014 MAR was updated to reflect the changes A physician's order sheet dated 10-1-14 and signed by a physician documented Tenant #1 was	A 036		

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A 036	Continued From page 4 to receive Quetiapine 25 mg one tablet twice a day. According to the MAR for October 2014, Quetiapine was placed in a med planner equivalent to one tablet daily. In an interview with RN #A, she confirmed the order dated 10-1-14 was for two pills daily which was not on the MAR for October. Quetiapine was not administered as ordered during the month of October 2014. Medication Adminsitration Records (MAR) were reviewed for Tenant #2 The September 2014 MAR lacked documentation of the administration of morning medications on 9-13 and 9-14-14. There was no documentation as to why medications were not given. Medications not given included Metoprol for blood pressure, Pantoprazole for gastric reflux, and Sertraline for mood. The November 2014 MAR lacked documentation of the administration of morning medications on 11-18-14. There was no documentation as to why medications were not given. Medications not given included Metoprol for blood pressure, Pantoprazole for gastric reflux, and Sertraline for mood.	A 036		
A 037	481-69.22(2) Evaluation of Tenant 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 needed with significant change, but not less than annually, to determine the tenant ' s continued	A 037		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 037	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on interviews, tenant file and incident report reviews, evaluations were not completed with a significant change of condition. Six tenant files were reviewed. Tenant #1, a 90 year-old was admitted on 6-30-13 and had diagnoses of: heart disease, dementia, and hypertension. On 10-19-14 Tenant #1 was staged at six on the Global Deterioration Scale which indicated moderately severe dementia. Tenant #1 resided in the dementia unit On 6-25-14 a fax was sent to the physician which indicated Tenant #1 had been experiencing increased behaviors during the afternoon. The fax indicated Tenant #1 was taking Quetiapine 25 mg twice daily as needed and at bedtime. A request was made to the physician to change to a scheduled dose twice a day. On 6-27-14 the physician responded and indicated an ok to change to Quetiapine 25 mg one pill twice a day. In an interview with RN A on 11-20-14 at 2:30 p.m., she stated the fax dated 6-25 and response of 6-27-14 did not discontinue the use of the "as needed" Quetiapine, but the order should have	A 037		

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A 037	Continued From page 6 been clarified with the physician. A physician's order sheet dated 6-27-14 was signed by the physician and indicated an order for Quetiapine 25 mg to be given routinely twice a day. Another notation handwritten indicated Quetiapine 25 mg twice a day as needed. The "twice a day as needed" had a line through it and the notation of "q hs" was written above, meaning at bedtime. Progress notes dated 6-26-14 documented Tenant #1 was found on the floor and was without injury. Notes dated 7-3-14 documented the nurse was called because Tenant #1 was unresponsive. According to the documentation, to the nurse, Tenant #1 appeared to be sleeping while sitting up and was slow to answer questions. Per family request Tenant #1 was taken to the hospital. The progress notes documented Tenant #1 returned to the program, had been treated for mental status change, and had no new orders. Progress notes dated 7-6-14 documented the nurse had been notified over the weekend Tenant #1 was short of breath and grey in color. Tenant #1 was taken to the hospital and returned the same day with no changes to medications. The progress notes documented Tenant #1 was treated for mental status change. In an interview on 11-20-14 at 2:04 p.m with the Executive Director, she stated Tenant #1 was taken to the hospital as Tenant #1 was not responding. The Executive Director reported the Quetiapine was building up. A physician order sheet from a local hospital dated 7-5-14 and signed by a health care provider documented Tenant #1 was diagnosed with	A 037		

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A 037	Continued From page 7 "increased somnolence." Direction was given to follow the Quetiapine prescription as directed, hold if sedated, and as needed for agitation only. The attached medication list from the hospital indicated Quetiapine 25 mg was taken twice a day. Tenant #1 experienced somnolence and according to the Executive Director, a build up of Quetiapine, a change of condition. Evaluations were not completed following two trips to the hospital for mental status changes within three days, 7/3 and 7/5/14.	A 037		
A 083	481-69.26(1) Service Plans 481-69 26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and support documentation provided by the program, service plans were not based on evaluations and did not meet the specific needs of the tenants. 1. Tenant #1, a 90 year-old was admitted on 6-30-13 and had diagnoses of: heart disease, dementia, and hypertension On 10-19-14 Tenant	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 083	Continued From page 8 #1 was staged at six on the Global Deterioration Scale which indicated moderately severe dementia. Tenant #1 resided in the dementia unit. According to the 24-hour report for the dementia unit dated 11-15-14 for the night shift, Tenant #1 was found outside the dementia unit around 5:15 a.m. Tenant #1 did not exit the building Staff B was interviewed on 11-19-14 at 9.11 a.m. and stated over the weekend Tenant #1 was walking down the hall of the general population area of the program. Staff B stated it was about 6:00 a.m Staff D was interviewed on 11-20-14 at 10:30 a.m. and stated over the weekend she was giving report to the day shift when she looked and saw a walker. Staff D reported seeing Tenant #1 who reported being out for a walk. Staff D stated she was in the dining room at the time and Staff D reported Tenant #1's spouse brought Tenant #1 to the dining room for activities. The current service plan for Tenant #1 dated 10-21-14 identified Tenant #1 wandered and may wander at night. The service plan revealed staff members were to redirect Tenant #1. The service plan did not identify Tenant #1 as exit seeking and was not updated following the event of 11-15-14. The service plan did not identify specific interventions to direct staff in the care of Tenant # in the event of wandering and exit-seeking behavior. The service plan did not meet the specific service needs of Tenant #1. 2. Tenant #2, an 89 year-old, was admitted on 6-29-13 and had diagnoses of: dementia with behaviors, atrial fibrillation, hypertension,	A 083		

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A 083	Continued From page 9	A 083		

osteoarthritis, and gastroesophageal reflux disease. Tenant #2 was staged at three on the Global Deterioration Scale which indicated mild cognitive impairment. Tenant #2 resided in the general population.

A fax to the physician dated 6-11-14 documented Tenant #2 had an argument with one tenant and "lightly" pushed another tenant.

A fax to the physician dated 6-19-14 documented Tenant #2 had "another" confrontational unprovoked outburst in the dining room. Tenant #2 approached another tenant and accused the other tenant of stealing a newspaper.

A fax to the physician dated 6-23-14 documented Tenant #2 had angry outbursts with other tenants.

Progress notes dated 8-10-14 documented Tenant #2 was very agitated, hit a staff member with a cane several times on the arms and legs and hit the staff member in the head with a glass, breaking the glass. It was reported one-on-one interventions were tried and Tenant #2 was escorted to the apartment and away from other tenants. It was documented Tenant #2 would not stay in the apartment and came down the hallway cursing, shouting and waving a cane at staff members. According to the notes, the staff was instructed to call 911 and request Tenant #2 be taken to an emergency room for treatment. According to the notes, the hospital was not keeping Tenant #2, and Tenant #2 returned to the program later the same day. According to the notes, staff members were being advised of interventions to use to minimize agitation and aggression.

Progress notes dated 8-21-14 documented

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A 083	Continued From page 10 Tenant #2 returned to the program following hospitalization for increased agitation and aggressive behavior. Evaluations of function, cognition, and health were completed on 8-21-14 as well as a nurse review. The evaluations and nurse review indicated Tenant #2 had a recent increase in aggressive behavior and required interventions to address agitation. The nurse review also documented Tenant #2 did not consistently display good judgement and the examples provided by the program included joking with employees regarding sex and intimacy, becoming angry easily, becoming agitated and aggressive with staff as well as other tenants, and when left alone in an attempt to defuse the situation, Tenant #2 followed people down the hallway yelling. Staff B was interviewed on 11-19-14 at 9.11 a.m. and stated Tenant #2 "talks dirty" and tries to lift up staff member's shirts. Staff C was interviewed on 11-24-14 at 1:35 p.m and stated Tenant #2 makes dirty jokes. Staff C reported while in the dining room Tenant #2 said to her "I wish my face was between your legs." A service plan was created on 8-21-14 for Tenant #2. The service plan identified Tenant #2 became agitated, cursed, and made comments of a sexual nature. The service plan identified Tenant #2 was easily agitated with other tenants. The service plan identified Tenant #2 was to be reminded and encouraged about social events. The service plan did not identify specific interventions to direct staff in the care of Tenant #2 in the event of agitation, cursing, and sexual comments. The service plan did not meet the identified specific needs of Tenant #2.	A 083		

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A 083	Continued From page 11 3. Incident #50804-I. The program reported Tenant #4, admitted on 11-11-14, fell on 11-14-14 and fractured a hip. Tenant #4 was transferred to the hospital and died on 11-18-14. Based on interviews and review of the clinical records, the service plan did not meet the identified needs of Tenant #4 and was not based on evaluations Tenant #4, a 75 year-old, was admitted on 11-11-14 and had a diagnosis of: Lewy Body dementia with hallucinations, hypertension, and osteoporosis. Tenant #4 had nine errors on the Short Portable Mental Status Questionnaire completed on 11-11-14 which indicated severe intellectual functioning. Tenant #4 resided in the dementia unit. RN B was interviewed on 11-20-14 at 8:58 a.m. RN B confirmed the handwritten notes on an evaluation form were her notes used for the initial evaluations. The initial evaluations completed by RN B completed in handwriting indicated Tenant #4 revealed Tenant #4 had four falls in the week prior to admission. On three of those occasions, Tenant #4 hit the head during the fall. The handwritten form documented Tenant #4 had no vision in the right eye, and required continual assistance and supervision due to severe visual impairment. The handwritten form documented Tenant #4 was unable to understand the use of a walker, and required a schedule for toileting. The form indicated Tenant #4 had a history of falls and required a fall prevention program. Tenant #4 also required escorting and physical assist of one to attend meals and activities. The initial evaluation also indicated Tenant #4 wandered frequently and may wander at night. The admission summary written by RN B documented Tenant #4 had falls at home and	A 083		

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
	S0314	A. BUILDING _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 083	Continued From page 12 Tenant #4 could no longer be cared for at home. Tenant #4 mumbled answers when asked questions. Tenant #4 was asked to demonstrate using the walker. Tenant #4 had difficulty standing and "could not grasp the concept of hanging onto a walker." The spouse stated to RN #B Tenant #4 did not use a walker at home but due to recent falls the spouse thought the walker would be helpful. The spouse reported Tenant #4 was restless at wandered at night The spouse reported falls were new. Documentation in the progress notes dated 11-12-14 documented Tenant #4 had fallen during the night Tenant #4 sustained a skin tear to a finger and an abrasion to the back. The progress notes written by RN B documented Tenant #1 ambulated with the assistance of one. An incident report dated 11-14-14 and timed 4:55 a.m. documented a roommate's pendant was sounding and Tenant #4 was found lying on the floor. Tenant #4 complained of hip pain. Tenant #4 was transported to the hospital and did not return to the program. Staff D was interviewed on 11-20-14 at 10:30 a.m. Staff D reported she was working the night Tenant #4 fell and was transported to the hospital. Staff D reported Tenant #4 had been up and down most of the night and would not stay in bed. Staff D reported she tried offering fluids and toileted Tenant #4 without success. Staff D stated Tenant #4 did not walk well, had a shuffled gait, leaned, and didn't know what a walker was Tenant #4 remained restless, and used a shuffling gait when taken to the bathroom. Tenant #4 was returned to bed, and Tenant #4 scooted to the end of the bed. Staff D left the	A 083		

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
	S0314	A. BUILDING _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 083	Continued From page 13 apartment to care for another tenant. Staff D then heard a pendant sound, and it was the roommate of Tenant #4. Tenant #4 was found on the floor and complained of hip pain. Staff D reported she checked on Tenant #4 at least hourly, and when Tenant #4 was restless she checked every 15 to 30 minutes. The initial service plan dated 11-11-14 documented Tenant #4 was continent and needed reminders to use the bathroom. The service plan did not identify a toileting schedule as indicated in the initial evaluations. The service plan did not identify a fall prevention program other than to use an alarm at all times. The service plan identified Tenant #4 was independent with a walker but required the assist of one to transfer The service plan did not identify the need for escorts and physical assist to meals and activities. The service plan did not identify the risk for wandering or interventions to direct staff if Tenant #4 wandered. The service plan did not meet the identified needs of Tenant #4 and was not based on evaluations. 4. Tenant #6, an 82 year-old, was admitted on 4-26-14 and had diagnoses of: hypertension and senile dementia. Tenant #6 had two errors on the Short Mental Status exam Incident reports documented Tenant #6 sustained a fall on 8-19, two falls on 8-28, a fall on 9-5 and 9-7-14. Two of the falls resulted in trips to the emergency room due to injury. Evaluations of function, cognition, and health were completed on 9-6-14 with a change of condition. The service plan was updated with a signature date of 9-6-14. The service plan identified interventions for fall risk as "recommend safety techniques." The service plan	A 083		

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
	S0314	A. BUILDING _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 083	Continued From page 14 did not identify specific interventions related to the prevention of falls to direct staff in the care of Tenant #6. The service plan did not meet the identified needs of Tenant #6.	A 083		
A 094	481-69.27(1) 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 or a licensed practical nurse via nurse delegation: 69.27(1) 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 interviews and tenant file reviews the program did not complete a nurse review to monitor for adverse reactions to medications, and to make sure medication orders were current. (Complaint #49899-C alleged tenants were not assessed for medication side effects and received too much medication.) Six tenant files were reviewed and included a review of the physician orders and medication administration records (MARs)	A 094		

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
	S0314	A. BUILDING _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 094	Continued From page 15 1. Tenant #1, a 90 year-old was admitted on 6-30-13 and had diagnoses of: heart disease, dementia, and hypertension. On 10-19-14 Tenant #1 was staged at six on the Global Deterioration Scale which indicated moderately severe dementia. Tenant #1 resided in the dementia unit. A physician order sheet dated 1-27-14 documented the physician ordered Quetiapine 25 milligrams (mg) daily at bedtime. An order dated 2-19-14 documented Tenant #1 could have Quetiapine 25 mg twice a day as needed. The MAR for June 2014 was reviewed. The MAR indicated Quetiapine 25 mg had been placed in a pill planner for Tenant #1 and one pill was to be given at bedtime. The MAR also indicated Tenant #1 could have Quetiapine 25 mg one tablet twice a day as needed for agitation or anxiety. The MAR documented Tenant #1 had one dose of the "as needed" Quetiapine on 19 days in June 2014. Tenant #1 had two doses of the "as needed" Quetiapine on one day, June 25. Fifteen of the doses were administered between 2:00 p.m. and 6:00 p.m. The MAR also documented Tenant #1 had received the medication for agitation or anxiety and Tenant #1 had a positive result from the medication administered. On 6-25-14 a fax was sent to the physician which indicated Tenant #1 had been experiencing increased behaviors during the afternoon. The fax indicated Tenant #1 was taking Quetiapine 25 mg twice daily "as needed" and at bedtime. A request was made to the physician to change to a scheduled dose twice a day. On 6-27-14 the physician responded and indicated an ok to change to Quetiapine 25 mg one pill twice a day.	A 094		

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
	S0314	A. BUILDING. _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 094	Continued From page 16 According to the staff list provided by the program and the Executive Director, the nurse who had written the fax request was no longer at the program. In an interview with RN #A, she stated the fax dated 6-25 and response of 6-27-14 did not discontinue the use of the "as needed" Quetiapine, but the order should have been clarified with the physician. A nurse review was not completed to ensure physician orders were current. A physician's order sheet dated 6-27-14 was signed by the physician and indicated an order for Quetiapine 25 mg to be given routinely twice a day. Another notation handwritten on the order sheet indicated Quetiapine 25 mg twice a day as needed. The "twice a day as needed" had a line through it and the notation of "q hs" was written above. A nurse review was not completed to to ensure medications were administered consistent with the orders. Progress notes dated 6-26-14 documented Tenant #1 was found on the floor and was without injury. Notes dated 7-3-14 documented the nurse was called because Tenant #1 was unresponsive. According to the documentation, to the nurse, Tenant #1 appeared to be sleeping while sitting up and was slow to answer questions. Per family request Tenant #1 was taken to the hospital. The progress notes documented Tenant #1 returned to the program, had been treated for mental status change, and had no new orders. Progress notes dated 7-6-14 documented the nurse had been notified over the weekend Tenant #1 was short of breath and grey in color. Tenant #1 was taken to the hospital and returned the	A 094		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0314	A. BUILDING _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 094	Continued From page 17 same day with no changes to medications. The progress notes documented Tenant #1 was treated for mental status change. In an interview with the Executive Director, she stated Tenant #1 was taken to the hospital as Tenant #1 was not responding. The Executive Director reported the Quetiapine was building up. A physician order sheet from a local hospital dated 7-5-14 and signed by a health care provider documented Tenant #1 was diagnosed with "increased somnolence." Direction was given to follow the Quetiapine prescription as directed, hold if sedated, and as needed for agitation only The attached medication list from the hospital indicated Quetiapine 25 mg was taken twice a day. A physician's order dated 7-8-14 documented Quetiapine 25 mg at bedtime, and discontinued "as needed" doses The July 2014 MAR was updated to reflect the changes. After two trips to the hospital documented as treatment for mental status changes, a change of condition, a nurse review was not completed to determine any adverse reactions to medications, and to clarify physician orders to make sure medications were being administered consistent with the orders. A physician's order sheet dated 10-1-14 and signed by a physician documented Tenant #1 was to receive Quetiapine 25 mg one tablet twice a day. According to the MAR for October 2014, Quetiapine was placed in a med planner equivalent to one tablet daily. In an interview with RN #A, she confirmed the order dated 10-1-14 was for two pills daily which was not on the MAR	A 094		

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
	S0314	A. BUILDING _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 094	Continued From page 18 for October. Quetiapine was not administered as ordered during the month of October 2014. The program did not ensure medications were being administered consistent with the orders. 2. Tenant #3 an 89 year-old, was admitted on 7-24-14 and had diagnoses of: Macular Degeneration, Senile Dementia, and Schizophrenia. Tenant #3 was staged at six on the GDS which indicated severe cognitive decline. Tenant #3 resided in the dementia unit Tenant #3 had a physician's order dated 8-29-14 for an antibiotic for seven days to treat a urinary tract infection, a change in physical status. A nurse review was not completed with a change of condition that required a standard disease related intervention, an antibiotic. There was no documentation at the end of the seven days to indicate Tenant #3's response to the medication, or whether the infection was resolved. 3. Tenant #3 had a physician's order dated 10-20-14 for an antibiotic for seven days A nurse review completed on 10-24-14 documented the antibiotic was for an ear infection. There was no documentation at the end of the seven days to indicated Tenant #3's response to the medication or whether the medication was effective in treating the condition for which it was prescribed.	A 094		

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 000	481-67 Initial Comments 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. General Population Program No. of tenants without cognitive disorder: 30 No. of tenants with cognitive disorder: 3 Total Population of Program at time of visit: 33 Dementia-Specific Program by Dedication No. of tenants without cognitive disorder: 1 No. of tenants with cognitive disorder: 18 Total Population of Program at time of visit: 19 TOTAL census of Assisted Living Program: 52 The following insufficiencies were cited during the investigation of Complaint #49899-C, Incident #50804-I, and a recertification conducted to determine compliance with certification for an assisted living program:	A 000		
A 036	481-67.5(6)a Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted	A 036		

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 036	Continued From page 1	A 036		

by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).

This REQUIREMENT is not met as evidenced by:
Based on interviews and tenant file reviews the program did not administer medications as directed by the health care provider. (Complaint #49899-C alleged medications were not administered according to physician orders.)

Six tenant files were reviewed and included a review of the physician orders and medication adminsitration records (MARs).

Tenant #1, a 90 year-old was admitted on 6-30-13 and had diagnoses of: heart disease, dementia, and hypertension. On 10-19-14 Tenant #1 was staged at six on the Global Deterioration Scale which indicated moderately severe dementia. Tenant #1 resided in the dementia unit.

A physician order sheet dated 1-27-14 documented the physician ordered Quetiapine 25 milligrams (mg) daily at bedtime. An order dated 2-19-14 documented Tenant #1 could have Quetiapine 25 mg twice a day as needed.

The MAR for June 2014 was reviewed. The MAR indicated Quetiapine 25 mg had been placed in a pill planner for Tenant #1 and one pill was to be given at bedtime. The MAR also indicated Tenant #1 could have Quetiapine 25 mg one tablet twice a day as needed for agitation or anxiety. The MAR documented Tenant #1 had one dose of the "as needed" Quetiapine on 19 days in June 2014. Tenant #1 had two doses of the "as needed"

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
	S0314	A. BUILDING _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 036	Continued From page 2	A 036		

Quetiapine on one day, June 25. Fifteen of the doses were administered between 2:00 p.m. and 6:00 p.m. The MAR also documented Tenant #1 had received the medication for agitation or anxiety and Tenant #1 had a positive result from the medication administered.

On 6-25-14 a fax was sent to the physician which indicated Tenant #1 had been experiencing increased behaviors during the afternoon. The fax indicated Tenant #1 was taking Quetiapine 25 mg twice daily as needed and at bedtime. A request was made to the physician to change to a scheduled dose twice a day.
On 6-27-14 the physician responded and indicated an ok to change to Quetiapine 25 mg one pill twice a day.

According to the staff list provided by the program and the Executive Director (11-20-14 at 2:04 p.m.), the nurse who had written the fax request was no longer at the program.

In an interview with RN A on 11-20-14 at 2:30 p.m., she stated the fax dated 6-25 and response of 6-27-14 did not discontinue the use of the "as needed" Quetiapine, but the order should have been clarified with the physician.

A physician's order sheet dated 6-27-14 was signed by the physician and indicated an order for Quetiapine 25 mg to be given routinely twice a day. Another notation handwritten indicated Quetiapine 25 mg twice a day as needed. The "twice a day as needed" had a line through it and the notation of "q hs" was written above.

Progress notes dated 6-26-14 documented Tenant #1 was found on the floor and was without injury. Notes dated 7-3-14 documented the nurse

A036

1. Clarification of medication orders for tenant #1 with physician was received by Program Director/RN on 12/12/2014.

2. Education was completed with Program Director and RN's by the Executive Director on 12/12/2014. All physician orders will be reviewed and noted by the Program Director/RN to ensure whether or not clarification is needed by 12/24/2014.

3. Random audits will be completed by the Program Manager/RN to ensure all new physician orders have been clarified that are on the medication administration record as of 12/24/2014.

4. The findings will be taken to the QI Committee monthly at such a time when the committee determines that there is no longer a need to review. The insufficiency will be corrected by 12/24/2014.

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 036	Continued From page 3	A 036		

was called because Tenant #1 was unresponsive. According to the documentation, to the nurse, Tenant #1 appeared to be sleeping while sitting up and was slow to answer questions. Per family request Tenant #1 was taken to the hospital. The progress notes documented Tenant #1 returned to the program, had been treated for mental status change, and had no new orders.

Progress notes dated 7-6-14 documented the nurse had been notified over the weekend Tenant #1 was short of breath and grey in color. Tenant #1 was taken to the hospital and returned the same day with no changes to medications. The progress notes documented Tenant #1 was treated for mental status change.

In an interview on 11-20-14 at 2:04 p.m. with the Executive Director, she stated Tenant #1 was taken to the hospital as Tenant #1 was not responding. The Executive Director reported the Quetiapine was building up.

A physician order sheet from a local hospital dated 7-5-14 and signed by a health care provider documented Tenant #1 was diagnosed with "increased somnolence." Direction was given to follow the Quetiapine prescription as directed, hold if sedated, and as needed for agitation only. The attached medication list from the hospital indicated Quetiapine 25 mg was taken twice a day.

A physician's order dated 7-8-14 documented Quetiapine 25 mg at bedtime, and discontinued "as needed" doses. The July 2014 MAR was updated to reflect the changes.

A physician's order sheet dated 10-1-14 and signed by a physician documented Tenant #1 was

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 036	Continued From page 4 to receive Quetiapine 25 mg one tablet twice a day. According to the MAR for October 2014, Quetiapine was placed in a med planner equivalent to one tablet daily. In an interview with RN #A, she confirmed the order dated 10-1-14 was for two pills daily which was not on the MAR for October. Quetiapine was not administered as ordered during the month of October 2014. Medication Adminsitration Records (MAR) were reviewed for Tenant #2. The September 2014 MAR lacked documentation of the administration of morning medications on 9-13 and 9-14-14. There was no documentation as to why medications were not given. Medications not given included Metoprol for blood pressure, Pantoprazole for gastric reflux, and Sertraline for mood. The November 2014 MAR lacked documentation of the administration of morning medications on 11-18-14. There was no documentation as to why medications were not given. Medications not given included Metoprol for blood pressure, Pantoprazole for gastric reflux, and Sertraline for mood.	A 036	1. All current medication orders for tenant #1 have been clarified by the Program Director/RN as of 12/12/2014. 2. Education with the Program Director and RN's was completed by Executive Director on 12/12/2014. All new physician orders will be reviewed and noted on the physician order sheet 12/24/2014. 3. Physician Order Sheets will be received monthly from the pharmacy and updated with new orders beginning 1/1/2015. 4. The findings will be taken to the QI committee monthly at such a time when the committee determines that there is no longer a need to review. The insufficiency will be corrected by 12/24/2014. 1. Physician notified of tenant #2 not receiving medications on 9/13-9/14/2014 and 11/18/2014 on 12/11/2014. 2. Education with the care associates was completed by the Executive Director on 12/12/2014. All care associates will review the previous shift medication administration records to ensure all medication was received and documented prior to the end of the shift beginning 12/9/2014. 3. Random weekly audits will be completed by the Program Director/RN to ensure all medication administration documentation is completed beginning 12/24/2014. 4. The findings will be taken to the QI committee monthly at such a time when the committee determines that there is no longer a need to review. This insufficiency will be corrected by 12/24/2014.	
A 037	481-69.22(2) Evaluation of Tenant 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 needed with significant change, but not less than annually, to determine the tenant ' s continued	A 037		

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 037	Continued From page 5	A 037		

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.

This REQUIREMENT is not met as evidenced by:
Based on interviews, tenant file and incident report reviews, evaluations were not completed with a significant change of condition.

Six tenant files were reviewed.

Tenant #1, a 90 year-old was admitted on 6-30-13 and had diagnoses of: heart disease, dementia, and hypertension. On 10-19-14 Tenant #1 was staged at six on the Global Deterioration Scale which indicated moderately severe dementia. Tenant #1 resided in the dementia unit.

On 6-25-14 a fax was sent to the physician which indicated Tenant #1 had been experiencing increased behaviors during the afternoon. The fax indicated Tenant #1 was taking Quetiapine 25 mg twice daily as needed and at bedtime. A request was made to the physician to change to a scheduled dose twice a day.
On 6-27-14 the physician responded and indicated an ok to change to Quetiapine 25 mg one pill twice a day.

In an interview with RN A on 11-20-14 at 2:30 p.m., she stated the fax dated 6-25 and response of 6-27-14 did not discontinue the use of the "as needed" Quetiapine, but the order should have

A037

1. Nurse review completed for tenant #1 on 12/12/14, all assessments updated on 12/12/14 and service plan reviewed and updated 12/12/14 by Program Director/ RN.

2. Education was completed with Program Director and RN's by the Executive Director on 12/12/2014. All tenants returning from the hospital will be reviewed by Program Director/RN for any significant change by 12/1/2014.

3. Random weekly audits by the Program Director/RN to ensure evaluations are completed by 12/1/2014.

4. The findings will be taken to the QI committee monthly at such a time when the committee determines that there is no longer a need to review. This insufficiency will be corrected by 12/24/2014.

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

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A 037	Continued From page 6	A 037		

been clarified with the physician.

A physician's order sheet dated 6-27-14 was signed by the physician and indicated an order for Quetiapine 25 mg to be given routinely twice a day. Another notation handwritten indicated Quetiapine 25 mg twice a day as needed. The "twice a day as needed" had a line through it and the notation of "q hs" was written above, meaning at bedtime.

Progress notes dated 6-26-14 documented Tenant #1 was found on the floor and was without injury. Notes dated 7-3-14 documented the nurse was called because Tenant #1 was unresponsive. According to the documentation, to the nurse, Tenant #1 appeared to be sleeping while sitting up and was slow to answer questions. Per family request Tenant #1 was taken to the hospital. The progress notes documented Tenant #1 returned to the program, had been treated for mental status change, and had no new orders.

Progress notes dated 7-6-14 documented the nurse had been notified over the weekend Tenant #1 was short of breath and grey in color. Tenant #1 was taken to the hospital and returned the same day with no changes to medications. The progress notes documented Tenant #1 was treated for mental status change.

In an interview on 11-20-14 at 2:04 p.m. with the Executive Director, she stated Tenant #1 was taken to the hospital as Tenant #1 was not responding. The Executive Director reported the Quetiapine was building up.

A physician order sheet from a local hospital dated 7-5-14 and signed by a health care provider documented Tenant #1 was diagnosed with

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 037	Continued From page 7 "increased somnolence." Direction was given to follow the Quetiapine prescription as directed, hold if sedated, and as needed for agitation only. The attached medication list from the hospital indicated Quetiapine 25 mg was taken twice a day. Tenant #1 experienced somnolence and according to the Executive Director, a build up of Quetiapine, a change of condition. Evaluations were not completed following two trips to the hospital for mental status changes within three days, 7/3 and 7/5/14.	A 037		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and support documentation provided by the program, service plans were not based on evaluations and did not meet the specific needs of the tenants. 1. Tenant #1, a 90 year-old was admitted on 6-30-13 and had diagnoses of: heart disease, dementia, and hypertension. On 10-19-14 Tenant	A 083		

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
	S0314	A. BUILDING. _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 083	Continued From page 8	A 083		

#1 was staged at six on the Global Deterioration Scale which indicated moderately severe dementia. Tenant #1 resided in the dementia unit.

According to the 24-hour report for the dementia unit dated 11-15-14 for the night shift, Tenant #1 was found outside the dementia unit around 5:15 a.m. Tenant #1 did not exit the building.

Staff B was interviewed on 11-19-14 at 9:11 a.m. and stated over the weekend Tenant #1 was walking down the hall of the general population area of the program. Staff B stated it was about 6:00 a.m.

Staff D was interviewed on 11-20-14 at 10:30 a.m. and stated over the weekend she was giving report to the day shift when she looked and saw a walker. Staff D reported seeing Tenant #1 who reported being out for a walk. Staff D stated she was in the dining room at the time and Staff D reported Tenant #1's spouse brought Tenant #1 to the dining room for activities.

The current service plan for Tenant #1 dated 10-21-14 identified Tenant #1 wandered and may wander at night. The service plan revealed staff members were to redirect Tenant #1. The service plan did not identify Tenant #1 as exit seeking and was not updated following the event of 11-15-14. The service plan did not identify specific interventions to direct staff in the care of Tenant # in the event of wandering and exit-seeking behavior. The service plan did not meet the specific service needs of Tenant #1.

2. Tenant #2, an 89 year-old, was admitted on 6-29-13 and had diagnoses of: dementia with behaviors, atrial fibrillation, hypertension,

A083

1. Tenant #1 Service plan updated to include exit seeking behaviors and interventions on 12/12/2014 by Program Director/RN.

2. Education was completed with the Program Director and RN's by the Executive Director on 12/12/2014. All tenants who are at risk for exit seeking behavior will have their service plans updated to identify that behavior with intervention strategies completed by Program Director by 12/24/2014.

3. Program Director/RN will complete random monthly audits to ensure individualized intervention strategies are on the service plan beginning 12/24/2014.

4. The findings will be taken to the QI committee monthly at such time when the committee determines there is no longer a need to review. This insufficiency will be corrected by 12/24/2014.

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 083	Continued From page 9	A 083		

osteoarthritis, and gastroesophageal reflux disease. Tenant #2 was staged at three on the Global Deterioration Scale which indicated mild cognitive impairment. Tenant #2 resided in the general population.

A fax to the physician dated 6-11-14 documented Tenant #2 had an argument with one tenant and "lightly" pushed another tenant.

A fax to the physician dated 6-19-14 documented Tenant #2 had "another" confrontational unprovoked outburst in the dining room. Tenant #2 approached another tenant and accused the other tenant of stealing a newspaper.

A fax to the physician dated 6-23-14 documented Tenant #2 had angry outbursts with other tenants.

Progress notes dated 8-10-14 documented Tenant #2 was very agitated, hit a staff member with a cane several times on the arms and legs and hit the staff member in the head with a glass, breaking the glass. It was reported one-on-one interventions were tried and Tenant #2 was escorted to the apartment and away from other tenants. It was documented Tenant #2 would not stay in the apartment and came down the hallway cursing, shouting and waving a cane at staff members. According to the notes, the staff was instructed to call 911 and request Tenant #2 be taken to an emergency room for treatment. According to the notes, the hospital was not keeping Tenant #2, and Tenant #2 returned to the program later the same day. According to the notes, staff members were being advised of interventions to use to minimize agitation and aggression.

Progress notes dated 8-21-14 documented

1. The Program Director/RN updated Tenant #2's service plan to address agitation and sexual comments with redirection strategies on 12/10/2014.

2. Education with the Program Director and RN's was completed by the Executive Director on 12/10/2014. Any resident with identified inappropriate behavior will be reviewed by the Program Director/RN to ensure behaviors are addressed on the service plan with redirection strategies by 12/24/2014.

3. Random monthly audits of service plans will be completed by the Program Director/RN to ensure service plans are individualized to meet tenant needs beginning 12/1/2014.

4. The findings will be taken to the QI Committee monthly at such a time when the committee determines that there is no longer a need to review. All insufficiencies will be corrected by 12/24/2014.

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 083	Continued From page 10	A 083		

Tenant #2 returned to the program following hospitalization for increased agitation and aggressive behavior. Evaluations of function, cognition, and health were completed on 8-21-14 as well as a nurse review. The evaluations and nurse review indicated Tenant #2 had a recent increase in aggressive behavior and required interventions to address agitation. The nurse review also documented Tenant #2 did not consistently display good judgement and the examples provided by the program included joking with employees regarding sex and intimacy, becoming angry easily, becoming agitated and aggressive with staff as well as other tenants, and when left alone in an attempt to defuse the situation, Tenant #2 followed people down the hallway yelling.

Staff B was interviewed on 11-19-14 at 9:11 a.m. and stated Tenant #2 "talks dirty" and tries to lift up staff member's shirts.

Staff C was interviewed on 11-24-14 at 1:35 p.m. and stated Tenant #2 makes dirty jokes. Staff C reported while in the dining room Tenant #2 said to her "I wish my face was between your legs "

A service plan was created on 8-21-14 for Tenant #2. The service plan identified Tenant #2 became agitated, cursed, and made comments of a sexual nature. The service plan identified Tenant #2 was easily agitated with other tenants. The service plan identified Tenant #2 was to be reminded and encouraged about social events. The service plan did not identify specific interventions to direct staff in the care of Tenant #2 in the event of agitation, cursing, and sexual comments. The service plan did not meet the identified specific needs of Tenant #2.

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 083	Continued From page 11	A 083		

3. Incident #50804-I. The program reported Tenant #4, admitted on 11-11-14, fell on 11-14-14 and fractured a hip. Tenant #4 was transferred to the hospital and died on 11-18-14. Based on interviews and review of the clinical records, the service plan did not meet the identified needs of Tenant #4 and was not based on evaluations.

Tenant #4, a 75 year-old, was admitted on 11-11-14 and had a diagnosis of: Lewy Body dementia with hallucinations, hypertension, and osteoporosis. Tenant #4 had nine errors on the Short Portable Mental Status Questionnaire completed on 11-11-14 which indicated severe intellectual functioning. Tenant #4 resided in the dementia unit.

RN B was interviewed on 11-20-14 at 8:58 a.m. RN B confirmed the handwritten notes on an evaluation form were her notes used for the initial evaluations. The initial evaluations completed by RN B completed in handwriting indicated Tenant #4 revealed Tenant #4 had four falls in the week prior to admission. On three of those occasions, Tenant #4 hit the head during the fall. The handwritten form documented Tenant #4 had no vision in the right eye, and required continual assistance and supervision due to severe visual impairment. The handwritten form documented Tenant #4 was unable to understand the use of a walker, and required a schedule for toileting. The form indicated Tenant #4 had a history of falls and required a fall prevention program. Tenant #4 also required escorting and physical assist of one to attend meals and activities. The initial evaluation also indicated Tenant #4 wandered frequently and may wander at night.

The admission summary written by RN B documented Tenant #4 had falls at home and

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 083	Continued From page 12	A 083		

Tenant #4 could no longer be cared for at home. Tenant #4 mumbled answers when asked questions. Tenant #4 was asked to demonstrate using the walker. Tenant #4 had difficulty standing and "could not grasp the concept of hanging onto a walker." The spouse stated to RN #B Tenant #4 did not use a walker at home but due to recent falls the spouse thought the walker would be helpful. The spouse reported Tenant #4 was restless at wandered at night. The spouse reported falls were new.

Documentation in the progress notes dated 11-12-14 documented Tenant #4 had fallen during the night. Tenant #4 sustained a skin tear to a finger and an abrasion to the back. The progress notes written by RN B documented Tenant #1 ambulated with the assistance of one.

An incident report dated 11-14-14 and timed 4:55 a.m. documented a roommate's pendant was sounding and Tenant #4 was found lying on the floor. Tenant #4 complained of hip pain. Tenant #4 was transported to the hospital and did not return to the program.

Staff D was interviewed on 11-20-14 at 10:30 a.m. Staff D reported she was working the night Tenant #4 fell and was transported to the hospital Staff D reported Tenant #4 had been up and down most of the night and would not stay in bed. Staff D reported she tried offering fluids and toileted Tenant #4 without success. Staff D stated Tenant #4 did not walk well, had a shuffled gait, leaned, and didn't know what a walker was.

Tenant #4 remained restless, and used a shuffling gait when taken to the bathroom. Tenant #4 was returned to bed, and Tenant #4 scooted to the end of the bed. Staff D left the

1. Resident #4 discharged on 11/14/2014.
2. Education was completed with RN B on assessments and service plan by the current Program Director/RN on 12/12/2014.
3. Monthly audits of assessments and service plans will be completed by the Program Director/RN beginning 12/24/2014.
4. The finding will be taken to the QI committee monthly at such a time when the committee determines that there is no longer a need to review. The insufficiency will be corrected by 12/24/2014.

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

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A 083	Continued From page 13	A 083		

apartment to care for another tenant. Staff D then heard a pendant sound, and it was the roommate of Tenant #4. Tenant #4 was found on the floor and complained of hip pain. Staff D reported she checked on Tenant #4 at least hourly, and when Tenant #4 was restless she checked every 15 to 30 minutes.

The initial service plan dated 11-11-14 documented Tenant #4 was continent and needed reminders to use the bathroom. The service plan did not identify a toileting schedule as indicated in the initial evaluations. The service plan did not identify a fall prevention program other than to use an alarm at all times. The service plan identified Tenant #4 was independent with a walker but required the assist of one to transfer. The service plan did not identify the need for escorts and physical assist to meals and activities. The service plan did not identify the risk for wandering or interventions to direct staff if Tenant #4 wandered. The service plan did not meet the identified needs of Tenant #4 and was not based on evaluations.

4. Tenant #6, an 82 year-old, was admitted on 4-26-14 and had diagnoses of: hypertension and senile dementia. Tenant #6 had two errors on the Short Mental Status exam. Incident reports documented Tenant #6 sustained a fall on 8-19, two falls on 8-28, a fall on 9-5 and 9-7-14. Two of the falls resulted in trips to the emergency room due to injury.

Evaluations of function, cognition, and health were completed on 9-6-14 with a change of condition. The service plan was updated with a signature date of 9-6-14. The service plan identified interventions for fall risk as "recommend safety techniques." The service plan

1. Resident #6 discharged on 9/8/2014.

2. Education was completed with the Program Director and RN;s on 12/12/2014 by the Executive Director. Current residents at risk for falls will be reviewed for specific interventions and will be updated on the service plans by the Program Director/RN beginning 12/24/2014.

3. Monthly audits will be completed by the Program Director/RN to ensure all interventions are placed on tenant service plans beginning 12/24/2014.

4. The findings will be taken to the QI committee monthly at such time the committee determines there is no longer a need to review. This insufficiency will be corrected by 12/24/2014.

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 083	Continued From page 14 did not identify specific interventions related to the prevention of falls to direct staff in the care of Tenant #6. The service plan did not meet the identified needs of Tenant #6.	A 083		
A 094	481-69.27(1) 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 or a licensed practical nurse via nurse delegation: 69.27(1) 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 interviews and tenant file reviews the program did not complete a nurse review to monitor for adverse reactions to medications, and to make sure medication orders were current. (Complaint #49899-C alleged tenants were not assessed for medication side effects and received too much medication.) Six tenant files were reviewed and included a review of the physician orders and medication administration records (MARs).	A 094		

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS RETIREMENT COMMUNITY	604 EAST HILLCREST AVENUE INDIANOLA, IA 50125

(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 094	Continued From page 15	A 094		

1. Tenant #1, a 90 year-old was admitted on 6-30-13 and had diagnoses of: heart disease, dementia, and hypertension. On 10-19-14 Tenant #1 was staged at six on the Global Deterioration Scale which indicated moderately severe dementia. Tenant #1 resided in the dementia unit.

A physician order sheet dated 1-27-14 documented the physician ordered Quetiapine 25 milligrams (mg) daily at bedtime. An order dated 2-19-14 documented Tenant #1 could have Quetiapine 25 mg twice a day as needed.

The MAR for June 2014 was reviewed. The MAR indicated Quetiapine 25 mg had been placed in a pill planner for Tenant #1 and one pill was to be given at bedtime. The MAR also indicated Tenant #1 could have Quetiapine 25 mg one tablet twice a day as needed for agitation or anxiety. The MAR documented Tenant #1 had one dose of the "as needed" Quetiapine on 19 days in June 2014. Tenant #1 had two doses of the "as needed" Quetiapine on one day, June 25. Fifteen of the doses were administered between 2:00 p.m. and 6:00 p.m. The MAR also documented Tenant #1 had received the medication for agitation or anxiety and Tenant #1 had a positive result from the medication administered.

On 6-25-14 a fax was sent to the physician which indicated Tenant #1 had been experiencing increased behaviors during the afternoon. The fax indicated Tenant #1 was taking Quetiapine 25 mg twice daily "as needed" and at bedtime. A request was made to the physician to change to a scheduled dose twice a day. On 6-27-14 the physician responded and indicated an ok to change to Quetiapine 25 mg one pill twice a day.

A094

1. Nurse review completed for tenant #1 on 7/22/2014 by Program Director.

2. Education was completed with the Program Director and RN/s on 12/12/2014. A nurse review will be completed by the Program Director/RN on new medication orders to ensure orders are current,, no adverse reactions and to ensure orders are being administered consistent with the physician orders beginning 12/24/2014

3. Random weekly audits will be completed by the Program Director/RN to ensure nurse reviews are completed on all new medication orders as prescribed by 12/24/2014

4. All findings will be taken to the QI committee monthly at such a time the committee determines there is no need to review. The insufficiency will be corrected by 12/24/2014.

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
	S0314	A. BUILDING: _____ B. WING _____	C 11/24/2014

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A 094	Continued From page 16	A 094		

According to the staff list provided by the program and the Executive Director, the nurse who had written the fax request was no longer at the program.

In an interview with RN #A, she stated the fax dated 6-25 and response of 6-27-14 did not discontinue the use of the "as needed" Quetiapine, but the order should have been clarified with the physician. A nurse review was not completed to ensure physician orders were current.

A physician's order sheet dated 6-27-14 was signed by the physician and indicated an order for Quetiapine 25 mg to be given routinely twice a day. Another notation handwritten on the order sheet indicated Quetiapine 25 mg twice a day as needed. The "twice a day as needed" had a line through it and the notation of "q hs" was written above. A nurse review was not completed to to ensure medications were administered consistent with the orders.

Progress notes dated 6-26-14 documented Tenant #1 was found on the floor and was without injury. Notes dated 7-3-14 documented the nurse was called because Tenant #1 was unresponsive. According to the documentation, to the nurse, Tenant #1 appeared to be sleeping while sitting up and was slow to answer questions. Per family request Tenant #1 was taken to the hospital. The progress notes documented Tenant #1 returned to the program, had been treated for mental status change, and had no new orders.

Progress notes dated 7-6-14 documented the nurse had been notified over the weekend Tenant #1 was short of breath and grey in color. Tenant #1 was taken to the hospital and returned the

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A 094	Continued From page 17	A 094		

same day with no changes to medications. The progress notes documented Tenant #1 was treated for mental status change.

In an interview with the Executive Director, she stated Tenant #1 was taken to the hospital as Tenant #1 was not responding. The Executive Director reported the Quetiapine was building up.

A physician order sheet from a local hospital dated 7-5-14 and signed by a health care provider documented Tenant #1 was diagnosed with "increased somnolence." Direction was given to follow the Quetiapine prescription as directed, hold if sedated, and as needed for agitation only. The attached medication list from the hospital indicated Quetiapine 25 mg was taken twice a day.

A physician's order dated 7-8-14 documented Quetiapine 25 mg at bedtime, and discontinued "as needed" doses. The July 2014 MAR was updated to reflect the changes.

After two trips to the hospital documented as treatment for mental status changes, a change of condition, a nurse review was not completed to determine any adverse reactions to medications, and to clarify physician orders to make sure medications were being administered consistent with the orders.

A physician's order sheet dated 10-1-14 and signed by a physician documented Tenant #1 was to receive Quetiapine 25 mg one tablet twice a day. According to the MAR for October 2014, Quetiapine was placed in a med planner equivalent to one tablet daily. In an interview with RN #A, she confirmed the order dated 10-1-14 was for two pills daily which was not on the MAR

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A 094	Continued From page 18 for October. Quetiapine was not administered as ordered during the month of October 2014. The program did not ensure medications were being administered consistent with the orders. 2. Tenant #3 an 89 year-old, was admitted on 7-24-14 and had diagnoses of: Macular Degeneration, Senile Dementia, and Schizophrenia. Tenant #3 was staged at six on the GDS which indicated severe cognitive decline. Tenant #3 resided in the dementia unit. Tenant #3 had a physician's order dated 8-29-14 for an antibiotic for seven days to treat a urinary tract infection, a change in physical status. A nurse review was not completed with a change of condition that required a standard disease related intervention, an antibiotic. There was no documentation at the end of the seven days to indicate Tenant #3's response to the medication, or whether the infection was resolved. 3. Tenant #3 had a physician's order dated 10-20-14 for an antibiotic for seven days. A nurse review completed on 10-24-14 documented the antibiotic was for an ear infection. There was no documentation at the end of the seven days to indicated Tenant #3's response to the medication or whether the medication was effective in treating the condition for which it was prescribed.	A 094	1. Nurse review completed for tenant #3 on 12/12/2014 by Program Director. 2. Education was completed with the Program Director and RN/s on 12/12/2014 by the Executive Director. A nurse review will be completed by the Program Director/RN on new medication orders to ensure orders are current,, no adverse reactions and to ensure orders are being administered consistent with the physician orders beginning 12/24/2014 3. Random weekly audits will be completed by the Program Director/RN to ensure nurse reviews are completed on all new medication orders as prescribed by 12/24/2014 4. All findings will be taken to the QI committee monthly at such a time the committee determines there is no need to review. This insufficiency will be corrected by 12/24/2014.	