IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

June 9, 2015

Mr. Caleb Walton, Administrator
Oak Estates Assisted Living
110 Alice Street
Conrad, IA 50621

RE: Final Recertification Monitoring Evaluation Report – Oak Estates AL, Conrad, IA

Dear Mr. Walton:

Enclosed is the **Final 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 **May 21 and 26, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Staffing, Evaluation of Tenant, 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.

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 **S0105** with effective dates of **January 17, 2015** through **January 16, 2017**.

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 Number of tenants without cognitive disorder: 13 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 15 TOTAL census of Assisted Living Program: 15 The following regulatory insufficiencies were cited during the recertfication visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	This shall serve as my credible alegation of compliance. All insufficiencies will be corrected by the date specified.	
A 061	481-67.9(4)d Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants ' health, cognitive or functional status. This REQUIREMENT is not met as evidenced	A 061	A061 An educational staff meeting was held for staff member C and all similarly situated staff on 6-15-2015; items discussed were the in-service program which includes annual dementia training. Proper make-up processes were discussed if an employee cannot attend the face-to-face training. This includes on-line training and completing a make-up training with the in-service facilitator. The program's registered nurse will monitor for compliance and ensure all similarly situated staff comply with the training program.	06/17/15

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 061	Continued From page 1 by: Based on review of tenant files, a staff interview and Program documents, the Program failed to provide staff training regarding service plan tasks in accordance with medical or nursing directives and the acuity of a tenant's health, functional and cognitive status for one staff (Staff C) regarding one tenant (Tenant #2). Tenant #2 had a diagnosis of dementia and the scored objective cognitive tool indicated moderate cognitive impairment. Review of Care Notes indicated Tenant #2 had paranoia and behaviors and Staff C provided reality orientation including to Tenant #2's diagnosis of dementia and the disease process. Staff C did not have any documented training regarding Tenant #2 cognitive status. 1. Tenant #2, an 88 year old, was admitted on 2-8-14 and diagnoses included: hyperlipidemia, hypertension, dementia, anxiety, hyperthyroidism, macular degeneration, gastroesophageal reflux disease and Charles Bonnet Syndrome. Tenant #2's score from the Mental Status Questionnaire indicated moderately advanced impairment. According to a Quarterly Registered Nurse Review document dated 5-4-15, Tenant #2 was having a difficult time. Tenant #2's paranoia had dramatically increased, word finding was extremely difficult and Tenant #2 had hallucinations. The Exelon patch was discontinued on 4-1-15. Tenant #2's behavior had increased and Tenant #2 no longer knew how to unlock Tenant #2's door, use Tenant #2's phone or television. According to Care Notes dated 4-27-15, Tenant #2 reported Tenant #2 had been robbed. Staff C	A 061		

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 061	Continued From page 2 counted the money to Tenant #2, all the money was accounted for and Tenant #2's credit card was found underneath the money. Staff C spent about 45 minutes with Tenant #2 talking about Tenant #2's disease (dementia) and how Tenant #2 forgot things. Tenant #2 broke down crying and said Tenant #2 did not know what to do and apologized. Staff C checked on Tenant #2 later and Tenant #2 showed Staff C missing clothing items that had reappeared. Tenant #2 said whoever had taken them brought them back as the items were not there before. Staff C explained maybe Tenant #2 had misplaced them and now remembered where they were as it was part of Tenant #2's disease. Tenant #2 became agitated and threw all the clothing items back in the drawer and kicked it shut with Tenant #2's foot. According to Care Notes dated 4-29-15, Tenant #2 said someone had come in and "messed all that up." Tenant #2's wallet and everything was scattered over the dresser. Tenant #2 also reported someone took Tenant #2's eyeglasses. Staff C went through all of Tenant #2's drawers and boxes looking for the eyeglasses with Tenant #2 present and found a key, perfume and a bottle of hairspray Tenant #2 had previously reported as stolen. Staff C explained to Tenant #2 about Tenant #2's disease. Tenant #2 questioned what dementia was and Staff C again explained it to Tenant #2. Staff C also told Tenant #2 that Tenant #2 should not accuse people of stealing and it could get someone in trouble. According to Care Notes dated 5-6-15, Tenant #2 asked Staff C to come to Tenant #2's apartment. Tenant #2 said there were children on the couch and Staff C told Tenant #2 there were no children on the couch. They talked, Tenant #2 calmed	A 061		

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 061	Continued From page 3 down and Staff C left. Tenant #2 paged later and Staff C responded. Tenant #2 said "there were no kids were there?" and Staff C told Tenant #2 no. Tenant #2 became agitated, upset and started to cry. Staff C explained that everything would be okay, it was part of the disease and the doctors were trying to help. Tenant #2 then became agitated about an extra pill and Staff C explained for the third time regarding Tenant #2's new orders and why there were extra pills. Tenant #2 began to cry again and Staff C reassured Tenant #2 everyone was doing what they could to help. Care Notes dated 5-11-15 indicated Tenant #2 reported the people who had been taking Tenant #2's things had been in Tenant #2's apartment. Staff C reminded Tenant #2 no one was coming into the apartment, stealing and then returning things. Staff C reminded Tenant #2 of all of the items Staff C found the week prior. Staff C explained to Tenant #2 that forgetfulness and misplacing things was part of the disease. Tenant #2 said the eyeglasses were not Tenant #2's eyeglasses and Staff C had Tenant #2 put on the eyeglasses. Staff C told Tenant #2 she felt they were the eyeglasses Tenant #2 had been missing and Tenant #2 had misplaced them. Tenant #2 became increasingly agitated, told Staff C to go and gestured for Staff C to leave. As Staff C and Tenant #2 got to the door Staff C said they were all just trying to help Tenant #2. Tenant #2 reached out and grabbed Staff C's arm in an agitated/angry manner. Care Notes dated 5-15-15 indicated Tenant #2 reported Tenant #2 had not received Tenant #2's medications. Staff C reminded Tenant #2 that Staff C had sat with Tenant #2 at supper and helped Tenant #2. Tenant #2 disagreed with Staff C numerous times and became extremely agitated. Staff C	A 061		

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 061	Continued From page 4 reminded Tenant #2 numerous times that Tenant #2 had taken them and where, when and how Tenant #2 had taken them. Each time Tenant #2 disagreed and the notes indicated Staff C had never seen Tenant #2 that agitated. The Nurse was called and said to have a charge nurse (from the nursing home) assess and check into getting an as needed medication to calm Tenant #2. Staff C again tried talking with Tenant #2 to help Tenant #2 understand that Tenant #2 did take the medications. Staff C showed Tenant #2 the pill container which was empty. The same conversation continued for about 45 minutes total, according to the notes. 2. Staff C, a certified medication aide, did not have documented training on dementia. There was a in-service document provided regarding dementia training. Review of the staff signature sheet for the in-service revealed Staff C did not attend the training. Online training records for dementia education were not provided for Staff C. Staff C did not have training regarding Tenant #2's cognitive status. 3. According to a Program document, it the Program's policy to hold regular in-services for all staff. Dementia training was offered annually. An all staff in-service was provided in January 2015, which covered dementia training. The Program utilized an online education service and staff could make up missed in-services through that arena. Staff could also view the video from the in-service where available. 4. According to an interview with the Nurse on 5-26-15 at 2:26 p.m., Tenant #2's doctor provided instructions to Tenant #2's family to tell Tenant #2 it was a part of Tenant #2's disease process.	A 061		

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 063	481-67.9(4)f Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program 's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on observation, review of staff files, a staff interview and review of Program documents the Program failed to provide services in accordance with the training provided for one staff (Staff A). Staff A had nurse delegated training on medication administration; however, did not provide appropriate sanitation, documentation of medications or supervision of the medication cart during the medication pass observed. 1. Staff A, a certified medication aide, had nurse delegated training on medication administration. The most current medication administration delegation training was dated 4-3-15. Staff A also had documented training on hand hygiene technique which was dated 4-3-15. 2. A medication pass was observed on 5-21-15 at 12:20 p.m. with Staff A. The medications were administered in the dining room and the medication cart was located in the dining room. Staff A washed her hands prior to the start of the medication pass and then started coughing. Staff A left the dining room and went to the	A 063	A063 An educational staff meeting was held on 6-15-15 where proper medication pass procedures were reviewed. Staff member A and all similarly situated staff demonstrated the ability to perform a medication pass that is consistent with the programs policies. The program's nurse manager will conduct medication pass audits on all staff on a quarterly basis. This will ensure all current and future tenants medication will passed within the parameters of the Program's policies.	6/17/15

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 063	Continued From page 6 kitchen to wash her hands. The medication cart was unlocked and the cart was not in Staff A's view when she left to wash her hands. Staff A administered medications to Tenants #6 and #7 and signed out the medications prior to the administration of medications. Staff A did not wash her hands or use hand sanitizer after administering medications to Tenant #6 and before administering medications to Tenant #7. During the observation of the medication pass, Staff A left the unlocked medication cart unattended, signed out medications prior to administering the medications and did not sanitize her hands in between tenants when administering medications. 3. According to a Medication Pass Monitoring Tool (procedure checklist) for Staff A dated 4-3-15, the medication cart was locked when staff did not have the cart in view and/or the staff was away from the cart. It also indicated the administered medication was charted in the medication administration record immediately following administration. Correct use of hand sanitizer or hand washing was exhibited, according to the document. 4. According to an interview with the Nurse on 5-26-15 at 2:26 p.m., the medication cart was to be locked when staff was not beside the cart. Medications were to be documented after administration and hand sanitation was to be done in between administering medications to tenants.	A 063		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of	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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 037	Continued From page 7 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 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 review of tenant files and review of Program documents the Program failed to evaluate tenants' cognitive, health and functional status as needed with significant change for three of five tenant files reviewed (Tenants #1, #2 and #3). Three tenants had significant changes and cognitive, health and functional evaluations were not completed as needed. 1. Tenant #1, a 92 year old, was admitted on 12-29-14 and diagnoses included: hypertension (HTN), hyperthyroidism, memory disturbance, edema, osteoporosis, arthritis, irritable bowel syndrome and polymyalgia. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. According to Care Notes dated 3-16-15 to 5-18-15, Tenant #1 was incontinent of urine and	A 037	A037 The program's nurse manager will complete functional, cognitive and health status evaluations upon admission, within 30-days of admission and upon a significant change for tenants # 1, 2 and 3 on 6/15/15 and all similarly situated tenants. The program's nurse manager and the QAPI team will monitor on a quarterly basis for compliance.	6/17/15

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 037	Continued From page 8 bowel, staff found a sandwich wrapped in napkins underneath protective undergarments, found crackers behind the bath towels and found socks and washcloths mixed in with garbage in a trash can. Tenant #1's protective undergarment was on inside out, Tenant #1 had torn apart a protective undergarment, Tenant #1 was unable to figure out how to put on the protective undergarment and a soiled protective undergarment was found in the refrigerator. Tenant #1 had 4+ edema and Tenant #1's feet were reddish purple in color. Tenant #1 went to the doctor due to a decrease in activity, inability to get out of chairs without assistance, increased incontinence episodes and increased confusion. Tenant #1 had scrambled words and showed confusion when staff conversed with Tenant #1. According to a Quarterly Registered Nurse Review document dated 4-24-15, Tenant #1 had significant dementia and staff helped Tenant #1 with showering, dressing and grooming. Tenant #1 had significant incontinence. It was discussed with Tenant #1's family that further placement was needed due to incontinence and Tenant #1's difficulty getting out of the chair. Tenant #1 had 4+ edema in Tenant #1's feet and lower legs. According to a Quarterly Registered Nurse Review document dated 5-18-15, looking for alternate placement was discussed with Tenant #1's family and Tenant #1's family was agreeable. Cognitive, health and functional evaluations were completed on 1-26-15. Evaluations were not completed as needed with Tenant #1's incontinence of urine and bowel, edema, difficulty getting out of chairs without assistance and confusion. Evaluations were not completed	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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 037	Continued From page 9 as needed with significant change for Tenant #1. 2. Tenant #2, an 88 year old, was admitted on 2-8-14 and diagnoses included: hyperlipidemia, HTN, dementia, anxiety, hyperthyroidism, macular degeneration, gastroesophageal reflux disease and Charles Bonnet Syndrome. Tenant #2's score from the Mental Status Questionnaire indicated moderately advanced impairment. Care Notes from 3-11-15 to 5-15-15 identified behaviors with Tenant #2. The behaviors included: Tenant #2 reported someone pushed Tenant #2 from behind into the refrigerator and Tenant #2 almost blacked out. Tenant #2 said someone had come into Tenant #2's apartment and taken items. Tenant #2 said someone had drugged Tenant #2 and taken Tenant #2's instructions for the television. Tenant #2 reported seeing children run past Tenant #2 when there were no children present. Tenant #2 had paranoid thoughts including: Tenant #2 thought things were missing and thought someone had used Tenant #2's personal items. Tenant #2 had gone through Tenant #2's garbage and thrown it on the floor. Tenant #2 reported someone broke into Tenant #2's apartment and ate Tenant #2's food. Tenant #2 was found in Tenant #2's apartment visibly shaking, the thermostat read above 80 degrees and the heat was on. Tenant #2 was very flustered and was unable to do anything alone. Tenant #2 had always been able to unlock Tenant #2 door and was no longer able to understand the concept. According to a Quarterly Registered Nurse Review document dated 5-4-15, Tenant #2 was having a difficult time. Tenant #2's paranoia had dramatically increased, word finding was	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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 037	Continued From page 10 extremely difficult and Tenant #2 had hallucinations. The Exelon patch was discontinued on 4-1-15. Tenant #2's behavior had increased and Tenant #2 no longer knew how to unlock Tenant #2's door, use Tenant #2's phone or television. Tenant #2 had an injection for macular degeneration on 4-22-15 and Tenant #2 said Tenant #2 could not see. Tenant #2's family reported an eye test showed Tenant #2 could see. Tenant #2 required assistance with Tenant #2's shower and staff spent a lot of one to one time with Tenant #2. Cognitive, health and functional evaluations were completed on 2-6-15. Evaluations were not completed as needed with an increase in Tenant #2's behaviors and inability to complete routine daily tasks. Evaluations were not completed as needed with significant change for Tenant #2. 3. Tenant #3, an 88 year old, was admitted on 12-13-14 and diagnoses included: congestive heart failure, dementia, atrial fibrillation and renal insufficiency. According to Quarterly Registered Nurse Review document dated 3-11-15, Tenant #3 was admitted to the attached nursing home. According to a Quarterly Registered Nurse Review document dated 5-1-15, Tenant #3 returned to the Program with Tenant #3's spouse. According to the service plan dated 1-6-15, Tenant #3 had oxygen at 2 liters, Tenant #3's family set up medications and staff administered. The service plan dated 5-1-15 indicated the oxygen was discontinued at the nursing home. The service plan indicated pharmacy set up medications and staff administered. Tenant #3 was admitted to the nursing home on 3-11-15	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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 037	Continued From page 11 and returned on 5-1-15. The service plan reflected changes with oxygen and medication administration. Cognitive, health and functional evaluations were not completed as needed. Evaluations were not completed as needed with significant change for Tenant #3.	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 review of tenant files and review of Program documents the Program failed to develop service plans that were based on evaluations, were updated as needed with changes and reflected the identified needs of the tenants for four of five tenant files reviewed (Tenants #1, #2, #3 and #4). The service plans were not based on evaluations, were not updated as needed and did not reflect the needs of the tenants. 1. Tenant #1, a 92 year old, was admitted on 12-29-14 and diagnoses included: hypertension (HTN), hyperthyroidism, memory disturbance, edema, osteoporosis, arthritis, irritable bowel	A 083	A 083 The program's nurse manager will develop the tenant service plan based on the evaluation process and will be completed upon admission, within 30-days of admission and with any significant change, and at a minimum of annually for tenants #1, 2, 3, 4 on 6/15/15 and all similarly situated tenants. The nurse manager and the program;s QAPI team will monitor for compliance on a quarterly basis.	6/17/15

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 syndrome and polymyalgia. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. According to Care Notes dated 3-16-15 to 5-18-15, Tenant #1 was incontinent of urine and bowel, staff found a sandwich wrapped in napkins underneath protective undergarments, found crackers behind the bath towels and found socks and washcloths mixed in with garbage in a trash can. Tenant #1's protective undergarment was on inside out, Tenant #1 had torn apart a protective undergarment, Tenant #1 was unable to figure out how to put on the protective undergarment and a soiled protective undergarment was found in the refrigerator. Tenant #1 had 4+ edema and Tenant #1's feet were reddish purple in color. Tenant #1 went to the doctor due to a decrease in activity, inability to get out of chairs without assistance, increased incontinence episodes and increased confusion. Tenant #1 had scrambled words and showed confusion when staff conversed with Tenant #1. According to a Quarterly Registered Nurse Review document dated 4-24-15, Tenant #1 had significant dementia and staff helped Tenant #1 with showering, dressing and grooming. Tenant #1 had significant incontinence. It was discussed with Tenant #1's family that further placement was needed due to incontinence and Tenant #1's difficulty getting out of the chair. Tenant #1 had 4+ edema in Tenant #1's feet and lower legs. According to a Quarterly Registered Nurse Review document dated 5-18-15, looking for alternate placement was discussed with Tenant #1's family and Tenant #1's family was agreeable.	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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 13 The service plan dated 4-10-15 reflected Tenant #1 wore protective undergarments and at times put them over Tenant #1's pants. The service plan reflected Tenant #1's legs were weak. The service plan was not updated as needed and did not reflect Tenant #1's incontinence of urine and bowel, edema, difficulty getting out of chairs without assistance and confusion. The service plan was not updated as needed with significant change and did not reflect the needs of Tenant #1. 2. Tenant #2, an 88 year old, was admitted on 2-8-14 and diagnoses included: hyperlipidemia, HTN, dementia, anxiety, hyperthyroidism, macular degeneration, gastroesophageal reflux disease and Charles Bonnet Syndrome. Tenant #2's score from the Mental Status Questionnaire indicated moderately advanced impairment. Care Notes from 3-11-15 to 5-15-15 identified behaviors with Tenant #2. The behaviors included: Tenant #2 reported someone pushed Tenant #2 from behind into the refrigerator and Tenant #2 almost blacked out. Tenant #2 said someone had come into Tenant #2's apartment and taken items. Tenant #2 said someone had drugged Tenant #2 and taken Tenant #2's instructions for the television. Tenant #2 reported seeing children run past Tenant #2 when there were no children present. Tenant #2 had paranoid thoughts including: Tenant #2 thought things were missing and thought someone had used Tenant #2's personal items. Tenant #2 had gone through Tenant #2's garbage and thrown it on the floor. Tenant #2 reported someone broke into Tenant #2's apartment and ate Tenant #2's food. Tenant #2 was found in Tenant #2's	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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 apartment visibly shaking, the thermostat read above 80 degrees and the heat was on. Tenant #2 was very flustered and was unable to do anything alone. Tenant #2 had always been able to unlock Tenant #2 door and was no longer able to understand the concept. According to a Quarterly Registered Nurse Review document dated 5-4-15, Tenant #2 was having a difficult time. Tenant #2's paranoia had dramatically increased, word finding was extremely difficult and Tenant #2 had hallucinations. The Exelon patch was discontinued on 4-1-15. Tenant #2's behavior had increased and Tenant #2 no longer knew how to unlock Tenant #2's door, use Tenant #2's phone or television. Tenant #2 had an injection for macular degeneration on 4-22-15 and Tenant #2 said Tenant #2 could not see. Tenant #2's family reported an eye test showed Tenant #2 could see. Tenant #2 required assistance with Tenant #2's shower and staff spent a lot of one to one time with Tenant #2. The service plan dated 2-6-15 reflected to observe for changes in mental status and Tenant #2 had paranoia and anxiety. The service plan was not updated as needed and did not reflect the extent of Tenant #2's paranoia, behavior and interventions related to the behavior. The service plan was not updated as needed with significant change and did not reflect the needs of Tenant #2. 3. Tenant #3, an 88 year old, was admitted on 12-13-14 and diagnoses included: congestive heart failure, dementia, atrial fibrillation and renal insufficiency.	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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 15 According to Quarterly Registered Nurse Review document dated 3-11-15, Tenant #3 was admitted to the attached nursing home. According to a Quarterly Registered Nurse Review document dated 5-1-15, Tenant #3 returned to the Program with Tenant #3's spouse. According to the service plan dated 1-6-15, Tenant #3 had oxygen at 2 liters, Tenant #3's family set up medications and staff administered. The service plan dated 5-1-15 indicated the oxygen was discontinued at the nursing home. The service plan indicated pharmacy set up medications and staff administered. The service plan was updated on 5-1-15; however, was not based on evaluations. The service plan dated 5-1-15 reflected changes from the previous service plan and was not based on evaluations. The service plan dated 5-1-15 indicated pharmacy set up Tenant #3's medications and staff administered the medications. Tenant #3 had an order for Nitrostat 0.4 milligram (mg) tablet sublingual (SL) every five minutes up to three doses as needed for chest pain. According to an interview with the Nurse on 5-26-15 at 2:26 p.m., Tenant #3's spouse kept the Nitrostat at bedside. The May 2015 medication administration record (MAR) reflected Nitrostat 0.4 mg tablet SL one tablet every five minutes for three doses as needed for chest pain. The May 2015 MAR did not reflect any doses of Nitrostat administered by staff. The medication was reflected on the MAR where staff documented medications administered despite Tenant #3's spouse keeping the medication at bedside. The service plan did not reflect Tenant #3 had Nitrostat, where it was stored and who administered it as needed. The service plan did not reflect the needs of Tenant #3 related to 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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 16 administration and storage of Nitrostat. The service plan was not based on evaluations and did not reflect the needs of Tenant #3. 4. Tenant #4, a 93 year old, was admitted on 2-27-15 and diagnoses included: recent fall with a subdural hematoma, Parkinson's disease, HTN, hyperlipidemia, past cerebral vascular accident and glaucoma. Tenant #4's cognitive, health and functional evaluations within 30 days of taking occupancy were dated 3-30-15. The service plan was dated 3-18-15. The service plan was developed prior to the completion of the evaluations. The service plan was not based on the evaluations. Tenant #4 had an order for compression hose. The service plan did not reflect the compression hose. The service plan was not based on evaluations and did not reflect the needs of Tenant #4.	A 083		
A 092	481-69.26(4)d Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant ' s abilities and personal interests This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to develop service that reflected at a minimum: planned and spontaneous activities for tenants	A 092	A 092 Service plans were updated by the nurse manager to reflect individualized and spontaneous activities for tenant #1 and 5 and all similarly situated tenants on 6/15/15. The nurse manger and the Program's QAPI team will monitor for compliance on a quarterly basis.	6/17/15

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 092	Continued From page 17 unable to plan their own activities, including those tenants with dementia, for two of five tenant files reviewed (Tenants #1 and #5). Planned and spontaneous activities were not reflected on the service plans for two tenants with moderate to moderately severe cognitive decline. 1. Tenant #1, a 92 year old, was admitted on 12-29-14 and diagnoses included: hypertension (HTN), hyperthyroidism, memory disturbance, edema, osteoporosis, arthritis, irritable bowel syndrome and polymyalgia. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. The service plan dated 4-10-15 indicated Tenant #1 was able to participate as desired in activities in and out of the Program. It indicated Tenant #1 would participate as desired and staff would remind Tenant #1 of activities. According to a Quarterly Registered Nurse Review document dated 4-24-15, Tenant #1 had significant dementia and significant incontinence. The document indicated the need for alternate placement was discussed with Tenant #1's family. The service plan did not reflect planned and spontaneous activities for Tenant #1. 2. Tenant #5, an 85 year old, was admitted on 5-19-13 and diagnoses included: HTN, hyperlipidemia, hyperthyroidism, osteopenia, Alzheimer's disease and glaucoma. Tenant #5 was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan dated 4-17-15 did not reflect any planned or spontaneous activities. The	A 092		

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
	S0105	A. BUILDING:_____ B. WING_____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 092	Continued From page 18 service plan reflected Tenant #5 had a companion Monday through Friday. The service plan did not reflect planned and spontaneous activities for Tenant #5. 3. According to the Program's policy regarding service plans, the service plan would be individualized and would indicated at a minimum: for tenants who were unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on tenant's abilities and personal interests.	A 092		
A 095	481-69.27(2) 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(2) To ensure that health care professionals ' orders are current for tenants who receive health care professional-directed care from the program This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to ensure health care professionals' orders were current for tenants who received health care professional-directed care from the Program for two of five tenant files reviewed (Tenants #3 and #4). The Program's policy indicated documentation of physician orders would be noted with time, date and signature. Two tenant	A 095	A 095 The program educated staff at 6-15-15 in-service on physician orders and reviewed that all physician orders have a date, time and signature. This will ensure compliance for tenants # 3 and 4 and all similarly situated tenants. The nurse manager and the program's QAPI team will monitor for compliance on a quarterly basis.	6/17/15

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 095	Continued From page 19 files reviewed did not have physician orders noted with appropriate documentation. 1. Tenant #3, an 88 year old, was admitted on 12-13-14 and diagnoses included: congestive heart failure, dementia, atrial fibrillation and renal insufficiency. Tenant #3 had orders for wound dressing changes and edema control that were not noted with time, date or signature. The date of service was 1-23-15. A summary document from a healthcare visit dated 3-5-15, which included medications, was not noted with with time, date or signature. A medication history list dated 5-8-15 was not noted with time or signature. A handwritten note at the top of the document indicated it was a current medication list per the doctor and it was dated 5-8-15. The medication list indicated oxygen at 2 liters (L) per nasal cannula was ordered. The service plan dated 5-1-15 indicated Tenant #3's oxygen was discontinued at the nursing home. A clarification was received on 5-26-15, which indicated oxygen at 2 L as needed was ordered. The order was not noted appropriately. Tenant #3 went to the emergency room (ER) and returned with orders for Tramadol 50 milligram tablet and Silvadene 1% cream. The orders had a handwritten note that indicated the time Tenant #3 went to and returned from the ER. The orders were not noted appropriately. Physician orders were not noted with appropriate documentation. 2. Tenant #4, a 93 year old, was admitted on 2-27-15 and diagnoses included: recent fall with a subdural hematoma, Parkinson's disease, hypertension, hyperlipidemia, past cerebral vascular accident and glaucoma.	A 095		

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
	S0105	A. BUILDING: _____ B. WING _____	05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK ESTATES	110 ALICE STREET CONRAD, IA 50621

(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 095	Continued From page 20 Tenant #4 had orders for wound care and edema control that were not noted with time, date or signature. The date of service was 3-18-15. Tenant #2 had orders for wound care and edema control that were not noted with time, date or signature. The date of service was 4-1-15. A summary document from a healthcare visit dated 3-16-15 included a medication list, orders for a wound clinic consult and compression hose. The document was not noted with with time, date or signature. Physician orders were not noted with appropriate documentation. 3. According to the Program's Nurse Review policy, the nurse would ensure the health care professional orders, for health-care professional directed care delivered by the Program were current. Documentation of the above would include time, date and signature.	A 095		