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

DEMAND LETTER
Complaint Intake #:
55341-I
55591-I
54723-C
55348-C

October 28, 2015

Mr. Ryan Stephenitch, Executive Director
Prairie Hills at Clinton
1701 13th Avenue North
Clinton, IA 52732

RE: I. *NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - PRAIRIE HILLS AT CLINTON*
II. *Reduction of Civil Penalty*
III. Informal Conference
IV. Conclusion

Dear Mr. Stephenitch:

I. Final Complaint/Incident Investigation Report – Prairie Hills at Clinton, Clinton, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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 an investigation by DIA on **October 7 - 14, 2015.**

Incident #55341-I, Incident #55591-I, Complaint #54723-C and Complaint #55348-C were investigated. There were regulatory insufficiencies cited related to both incidents and both complaints. There were also regulatory insufficiencies cited during the course of the investigation. The following allegations were investigated in regards to Complaint #54723-C:

be made within 20 working days of the notice of [illegible]

Allegation: Activities
Findings: Unsubstantiated
Comments: Review of activity calendars for the general population and dementia unit, review of tenant files, observations, staff interviews and interviews with activity staff revealed there were no concerns identified related to activities.

Allegation: Service Plans
Findings: Unsubstantiated
Comments: Review of tenant files, staff interviews and review of Program documents revealed there were no concerns identified related to service plans.

The following allegations were investigated in regards to Complaint #55348-C:

Allegation: Tenant Rights
Findings: Unsubstantiated
Comments: Review of tenant files, staff interviews and review of Program documents revealed there were no concerns identified related to tenant rights.

Allegation: Service Plans
Findings: Unsubstantiated
Comments: Review of tenant files, staff interviews and review of Program documents revealed there were no concerns identified related to service plans.

Allegation: Life Safety
Findings: Unsubstantiated
Comments: Review of tenant files, observations, staff interviews and review of Program documents revealed there were no concerns identified related to life safety.

The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures, Staffing, Nurse Review and Structural Requirements.

Prairie Hills of Clinton ("Program") is being assessed a **$2,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

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.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$2,500 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, a tenant received a significant injury while being transported by staff in a wheelchair and the Program failed to secure courtyard exits allowing a tenant with dementia to elope.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481−67.17(5). If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **one thousand six hundred and twenty five dollars ($1,625)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

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.

IV. Conclusion

The Program is being assessed a **$2,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

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
	S0243	A. BUILDING _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

(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: 60 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 62 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 8 Total Population of Program at time of on-site: 10 TOTAL census of Assisted Living Program: 72 Incident #55341-I and Incident #55591-I were investigated and there were regulatory insufficiencies identified regarding both incidents. Complaint #54723-C and Complaint #55348-C were investigated and there were regulatory insufficiencies identified regarding both complaints. There were also regulatory insufficiencies cited during the course of the investigation.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents	A 003		

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A 003	Continued From page 1 including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to follow policies and procedures established by a Program regarding one of five tenant files reviewed (Tenant #2). The Program did not follow their policy and procedure regarding the completion of incident reports and medication administration. Tenant #2 had behaviors and incidents that required the completion of incident reports per the Program's policy and incident reports were not completed. Tenant #2 received staff assistance with medications and an order was not transcribed appropriately on the medication administration record (MAR), staff did not document medications administered and medications were documented as administered after Tenant #2 was discharged. The Program did not follow their policy and procedure regarding medication administration. (Complaint #54723-C and during the course of the investigation) 1. Tenant #2, an 84 year old, was admitted on 6-10-15 and diagnoses included: dementia, Alzheimer's disease, seizures, electrolyte imbalance, diverticulosis, urinary tract infection and hematemesis. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #2 resided in the dementia unit. Tenant #2 was discharged on 7-8-15. According to Nurse's Notes from 6-12-15 to	A 003		

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A 003	Continued From page 2 6-15-15, Tenant #2 was banging on the dementia unit doors to get out at times, became agitated when staff tried to redirect, tried moving some furniture, was wandering in and out of other tenant apartments, urinated on the floor in the living room area and urinated on a chair and coffee table. Tenant #2 became agitated with staff and combative when staff attempted to redirect. Tenant #2 hit a staff in the face and leg when staff attempted to change Tenant #2's clothes. Tenant #2 continued to exit seek and bang on the doors, removed clothing and went into a closet. Nurse's Notes from 6-26-15 to 7-6-15 indicated Tenant #2 was determined to go home, went from door to door kicking them and tried to push furniture through the doors. Tenant #2 tried to push another tenant in a wheelchair through the doors but was stopped by staff. Tenant #2 rubbed another tenant's back of the neck and shoulders. Tenant #2 set off door alarms and staff was unable to redirect. Tenant #2 was getting aggressive with staff trying to redirect. A couple of tenants said they were afraid of Tenant #2. Tenant #2 urinated in the hallway four times and became very aggressive when staff tried to help Tenant #2 in the bathroom. Tenant #2 went into another tenant's apartment naked and was very hard to redirect. It took three staff and 10 to 15 minutes to get Tenant #2 out of the apartment. Tenant #2 hit a staff in the face when attempting to redirect, tried to kiss another tenant and tried removing another tenant's sweater. Tenant #2 pulled the phone cord out of the wall, moved furniture and had a staff against the wall attempting to kiss staff. Tenant #2 hit another tenant on the tenant's forehead with Tenant #2's palm. 2. Incident reports were requested for Tenant #2. One incident report was provided regarding	A 003		

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A 003	Continued From page 3 Tenant #2's elopement on 6-10-15. Incident reports were not completed regarding Tenant #2's behaviors as documented in Nurse's Notes. 3. According to the Program's policy regarding incident reports, each associate (staff) would immediately notify the nurse/manager if a tenant became ill, had fallen, their behavior was abnormal or any unusual event occurred. An incident form would be completed by the nurse or manager for documentation purposes. A person in charge would be indicated on the schedule to fill out the report in their absence. 4. Tenant #2's file was reviewed. According to Tenant #2's service plan staff administered Tenant #2's medications. June and July 2015 MARs were reviewed. On 6-10-15 physician orders were received and noted. The orders indicated Lorazepam 0.5 milligram (mg) three times daily as needed was ordered. The June 2015 MAR reflected Lorazepam 0.5 mg three times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m. A entry on the MAR on 6-10-15 at 8:00 p.m. indicated the medication was not available. Staff documented Tenant #2 received one dose of the Lorazepam 0.5 mg on 6-11-15 at 8:00 a.m. scheduled despite the order written for Lorazepam was as needed. The order was discontinued on 6-11-15 and a new order for Lorazepam was started. Review of June 2015 MARs indicated there was an order for Lorazepam 0.5 mg give one tablet three times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m. The June 2015 MARs indicated the doses on 6-26-15 and 6-29-15 at 2:00 p.m. were not documented as administered.	A 003		

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A 003	Continued From page 4 Review of July 2015 MARs indicated on 7-9-15 staff documented 8:00 a.m. medications were given including Lasix 40 mg one tablet by mouth daily, Lorazepam 0.5 mg one tablet three times daily at 8:00 a.m., Risperdal 0.5 mg take one tablet in the morning at 8:00 a.m. and Vitamin D 400 units 1.5 tablets by mouth daily at 8:00 a.m. Nurse's Notes dated 7-8-15 at 4:00 p.m. indicated Tenant #2 was transferred to a geriatric psychiatric unit on 7-8-15. Tenant #2's discharge date provided by the Program was 7-8-15. Tenant #2 was not in the building on 7-9-15 at 8:00 a.m. when medications were documented as administered. 5. According to the Program's policy and procedure regarding medication administration, medications were administered in accordance with written orders from the physician and staff followed the six "Rights" for proper and accurate administration of medication including: the right documentation. Staff recorded with their initials afterwards in the correct date on the MAR, which verified the five rights were followed (right medication, right dose, right time, right tenant, right route/method).	A 003		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants ' identified needs. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file, a staff file, staff	A 055		

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A 055	Continued From page 5 interviews and Program documents, the Program failed to provide a sufficient number of trained staff available at all times to fully meet tenants' identified needs regarding an incident that occurred with Staff A and Tenant #1. Staff A assisted Tenant #1 in a wheelchair without applying the foot pedals. Tenant #1 put Tenant #1's feet down while in the wheelchair and the Tenant sustained an injury. Tenant #1 was transported to a hospital and was diagnosed with a femur fracture. Tenant #1 was discharged on 9-17-15. Staff A did not have documented training on assisting a tenant in a wheelchair and applying foot pedals, prior to or after the incident with Tenant #1 on 9-17-15. (Incident #55341-I) 1. Tenant #1, an 82 year old, was admitted on 4-10-15 and diagnoses included: dementia, atrial fibrillation, history of knee replacement and arthritis. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit. Tenant #1 was discharged on 9-17-15. According to Tenant #1's service plan dated 9-10-15, Tenant #1 ambulated independently with a cane or wheeled walker. 2. According to an incident report dated 9-17-15 at 1:20 p.m., staff pushed Tenant #1 in a wheelchair down a hallway. Tenant #1 held Tenant #1's feet and walker off the ground. Tenant #1 made a sudden stop by putting Tenant #1's feet and walker on the floor. Tenant #1's left leg was in front of the wheelchair and the right leg went under the wheelchair and bent "a little." Tenant #1 was in a lot of pain. Tenant #1 refused	A 055		

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A 055	Continued From page 6 range of motion, ice was put on the knee and the nurse was called. The nurse came to assess and Tenant #1 said Tenant #1 wanted to go to the hospital. Tenant #1 was transported to the hospital. Tenant #1 was admitted to the hospital with a fractured right femur. Wheelchair pedals were not used and staff was re-educated on the use of wheelchair pedals for safety. 3. Staff A's written statement indicated Staff A was taking Tenant #1 to an activity from the dementia unit to the general population, which was a longer distance than usual. Tenant #1 seemed to be getting tired so Staff A offered a wheelchair. Staff A got a wheelchair and Tenant #1 sat down holding Tenant #1's walker. Staff A tried to remove the walker from Tenant #1's lap and Tenant #1 insisted that it remain. Staff A was wheeling Tenant #1 in the hallway when Tenant #1 suddenly slammed Tenant #1's legs down to stop the wheelchair. Tenant #1 held Tenant #1's knee and said it hurt. Staff A brought the wheelchair backward "a little" to straighten out Tenant #1's leg to assess Tenant #1's knee. Tenant #1 refused to let Staff A lift up Tenant #1's pant leg. Staff A called the nurse to assess. 4. According to an interview with Staff A, she stated there was an activity scheduled and Tenant #1 agreed to come to the activity, which was held in the 500 hallway. Tenant #1 had problems with Tenant #1's knee so Staff A got a wheelchair to transport Tenant #1. Tenant #1 refused to put the wheeled walker down and put the walker on Tenant #1's lap with Tenant #1's legs extended. Staff A was taking Tenant #1 and other tenants from the dementia unit to the activity. Staff A turned around to check on the other tenants and Tenant #1 put both feet on the ground. Tenant #1 complained of pain and Staff A looked at Tenant	A 055		

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A 055	Continued From page 7 #1's knee and there was no redness on the leg. Tenant #1 held the right leg over the left leg and was taken back to the dementia unit. The nurse was called because Tenant #1 was in a lot of pain. Tenant #1 agreed to go to the hospital and an ambulance arrived to transport Tenant #1. Staff A said Tenant #1 used a walker but for long distances it was hard for Tenant #1 to get around. Tenant #1 had trouble walking and had knee pain. The wheelchair used to transport Tenant #1 was a Program wheelchair. Staff A had not used a wheelchair for Tenant #1 before. Staff A said the Director of Nursing (DON) had shown Staff A how to put the foot pedals on. At the time Tenant #1 was transported, the foot pedals were not used. Staff A said she did not have any follow up training regarding wheelchair foot pedals after the incident. 5. According to a Program document signed by the DON, on 9-17-15 at approximately 1:20 p.m. Staff A reported Staff A was pushing Tenant #1 in a wheelchair and Tenant #1 put Tenant #1's feet down. Tenant #1's right leg bent under the wheelchair "a little bit." Tenant #1 continued to complain of pain, ice was applied to the right knee and the DON was called to the dementia unit. Tenant #1 reported pain when the DON barely touched Tenant #1's knee so the DON did not move Tenant #1. Tenant #1's legal representative was called and an ambulance was called to transport Tenant #1 to the emergency room. Tenant #1 was admitted to the hospital for a broken femur and would be having surgery. Tenant #1 normally ambulated independently with a wheeled walker throughout the unit. Staff A used a wheelchair to transport Tenant #1 to an activity that was longer distance because it was too far for Tenant #1 to walk and Tenant #1	A 055		

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A 055	Continued From page 8 appeared to be getting tired. There were no foot pedals on the wheelchair when Staff A pushed Tenant #1 in the wheelchair. Staff A had been re-educated on the use of wheelchair pedals for tenant safety. 6. According to an interview with the DON, Tenant #1 was being pushed in a wheelchair and Tenant #1 put Tenant #1's legs down to stop. One of Tenant #1's legs was bent back underneath. The DON responded to the dementia unit and Tenant #1 was in a lot of pain. Tenant #1's leg was not moved and an ambulance was called. Tenant #1's family was notified. Tenant #1 sustained a fractured right femur. After the incident with Tenant #1, the DON provide verbal training to Staff A regarding using wheelchair foot pedals. Staff was not to transport anyone without them. The DON indicated foot pedals were available to use with the Program wheelchair. 7. Staff A's employee file was reviewed. There was no documented training regarding transporting tenants in a wheelchair and the use of wheelchair foot pedals prior to or after the incident with Tenant #1 on 9-17-15. 8. According to the Program's policy regarding staffing, the Program would employ sufficient trained associates (staff) to meet the identified tenant needs.	A 055		
A 064	481-67.9(4)g 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	A 064		

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A 064	Continued From page 9 individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant ' s normal health, functional and cognitive status. The program ' s registered nurse or designee shall train certified and noncertified staff on reporting to the program ' s registered nurse or designee and documenting occurrences that differ from the tenant ' s normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents the Program failed to provide staff communication in writing occurrences that differed from the tenant's normal health, functional and cognitive status retained by the Program for a period of not less than three years and available to the Department upon request for two of five tenant files reviewed (Tenant #3 and #4). Two tenants had occurrences that differed from their normal health, functional and cognitive status and staff did not document the occurrences in writing (Complaint #55348-C) 1. Tenant #3, an 88 year old, was admitted on 4-28-14 and diagnoses included: type 2 diabetes mellitus, hypertension (HTN), hyperlipidemia, peptic acid disease and osteoarthritis. Tenant #3 was discharged on 9-1-15.	A 064		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0243	A. BUILDING: _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

(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 064	Continued From page 10 According to Nurse's Notes dated 8-31-15, the Registered Nurse (RN) was on call and staff called due to Tenant #3 vomiting. Tenant #3 did not want to go to the emergency room (ER). Staff attempted to call Tenant #3's family without success. Staff called a few times to tell the RN that Tenant #3 was still vomiting and did not look well. The RN instructed staff to take the phone to Tenant #3's and ask Tenant #3 questions. Tenant #3 was asked how Tenant #3 felt and Tenant #3 said a little better. Staff was concerned Tenant #3 vomited on Tenant #3 in bed and on the bed. Tenant #3 refused to let staff change Tenant #3's clothes and clean Tenant #3 up. Tenant #3 was asked if Tenant #3 wanted to go to the ER and Tenant #3 refused. Staff notified the RN and Director of Nursing (DON) that Tenant #3 started to foam at the mouth and breathing had slowed down. The RN and DON came in immediately to check on Tenant #3. According to Nurse's Notes dated 9-1-15, the RN and DON went to Tenant #3's apartment and Tenant #3 had no pulse, no respirations upon auscultation and was not breathing. Staff had called 911 due to Tenant #3's breathing and color before the RN and DON arrived. The ambulance came and left, there was a police officer who was there until the coroner arrived. The RN and DON cleaned Tenant #3 up, put clean clothes and sheets on as the RN had called Tenant #3's family and family was on the way to the Program. 2. There was no written documentation provided by the noncertified or certified staff regarding the change in Tenant #3's condition. 3. Tenant #4, a 96 year old, was admitted on 7-11-14 and diagnoses included: HTN, hyperlipidemia, atrial fibrillation, myocardial	A 064		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0243	A. BUILDING _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 064	Continued From page 11 infarction, history of pacemaker and history of hypothyroidism. Tenant #4 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. Tenant #4 was discharged on 9-6-15. According to Nurse's Notes dated 9-8-15, the RN received a call from staff on 9-6-15 regarding Tenant #4 not feeling well. Tenant #4 was weak, had a cough and was congested. Tenant #4's family was there and was concerned. The RN spoke with the family on the phone and family decided as well as the RN that Tenant #4 needed to go to the ER. Tenant #4's family took Tenant #4 to the ER. Tenant #4 was admitted to the hospital on 9-6-15 for fever, low oxygen saturation and low blood pressure. 4. According to an interview with Staff B, Tenant #4 looked terrible, had trouble breathing and Tenant #4's color was bad. Vitals were taken, Tenant #4's family was concerned and the RN was called. The family decided to take Tenant #4 to the ER. 5. According to an interview with the RN, staff called and gave Tenant #4's vitals. Tenant #4 had a low grade fever and the oxygen saturation was a little low. Tenant #4's family said Tenant #4 was not feeling well, had a cough and family was not sure if Tenant #4 should go to the ER or urgent care. There was a sickness going around the building and everyone was sick. The RN recommended family take Tenant #4 to the ER. The RN provided the RN's cellular phone number, offered wheelchair assistance from staff and asked if family wanted an ambulance called or if family would take Tenant #4. Tenant #4's family took Tenant #4 in a private car.	A 064		

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	S0243	A. BUILDING: _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 064	Continued From page 12 6. There was no written documentation provided by the noncertified or certified staff regarding the change in Tenant #4's condition.	A 064		
A 096	481-69.27(3) 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(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents, the Program failed to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there were changes in the tenant's health status if a tenant received personal or health-related care for three of five tenant files reviewed. (Tenants #3, #4 and #5). Three tenants received personal and health-related care and a nurse review was not completed every 90 days. (During the course of the investigation)	A 096		

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	S0243	A. BUILDING _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

(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 096	Continued From page 13 1. Tenant #3, an 88 year old, was admitted on 4-28-14 and diagnoses included: type 2 diabetes mellitus, hypertension (HTN), hyperlipidemia, peptic acid disease and osteoarthritis. Tenant #3 was discharged on 9-1-15. According to Tenant #3's service plan dated 6-23-15, Tenant #3 received personal and health-related care. According to a Quarterly Nursing Summary document, a 90 day nurse review was completed on 2-3-15. According to a Quarterly Nursing Summary document, a nurse review was completed dated 6-23-15. The reason for the review was indicated as an annual review. A nurse review was not completed every 90 days. 2. Tenant #4, a 96 year old, was admitted on 7-11-14 and diagnoses included: HTN, hyperlipidemia, atrial fibrillation, myocardial infarction, history of pacemaker and history of hypothyroidism. Tenant #4 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. Tenant #4 was discharged on 9-6-15. According to Tenant #4's service plan dated 7-15-15, Tenant #4 received personal and health-related care. According to a Quarterly Nursing Summary document, a 90 day nurse review was completed on 2-3-15. According to a Quarterly Nursing Summary document, a nurse review was completed dated 7-15-15. The reason for the review was indicated as an annual review. A nurse review was not completed every 90 days. 3. Tenant #5, a 93 year old was admitted on	A 096		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

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A 096	Continued From page 14 12-15-10 and diagnoses included: pacemaker, syncope, HTN, early dementia, coronary artery disease, depression and hyperlipidemia. Tenant #5 was staged a four on the GDS, which indicated moderate cognitive decline. Tenant #5 resided in the dementia unit. According to Tenant #5's service plan dated 10-7-15, Tenant #5 received personal and health-related care. According to a Quarterly Nursing Summary document, a 90 day nurse review was completed dated 8-7-15. Cognitive, health and functional evaluations and a Quarterly Nursing Summary were completed on 11-12-14. The 90 day nurse review prior to the full evaluation on 11-12-14 was dated 8-13-14. A nurse review was not completed every 90 days. 4. According to the Program's policy regarding nurse review, a nurse review would be completed every 90 days or with a change in condition. The review would be completed within 90 days of the last review or last evaluation.	A 096		
A 153	481-69.35(1)a Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. a. The structure of the program shall be designed and operated to meet the needs of the tenants. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file, staff interviews, review of Program documents and observations the Program failed to to have buildings and grounds that were well-maintained, clean, safe	A 153		

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	S0243	A. BUILDING. _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

(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 153	Continued From page 15 and sanitary. One of five tenant files reviewed indicated one tenant eloped (Tenant #2). The building consisted of a dedicated dementia unit and a general population. The courtyard off of the dementia unit did not provide a safe environment as there were two gates that were not secured and allowed access to outside the courtyard. There was also a door that went into the general population part of the building from the courtyard that was not secured. Tenant #2, who resided in the dementia unit, eloped on 6-10-15 and one of the gates was found partially open. (Complaint #54723-C and Incident #55591-I) 1. Tenant #2, an 84 year old, was admitted on 6-10-15 and diagnoses included: dementia, Alzheimer's disease, seizures, electrolyte imbalance, diverticulosis, urinary tract infection and hematemesis. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #2 resided in the dementia unit. Tenant #2 was discharged on 7-8-15. 2. According to an incident report on 6-10-15 at 8:45 p.m., Tenant #2 was sleeping in the chair in the living room. Staff went into another tenant apartment and came back and Tenant #2 was gone. Staff went to Tenant #2's apartment and the window was open and the screen was gone. Staff searched inside and outside (the building) for Tenant #2 and called the nurse on call to come help. 3. According to a Program document dated 6-11-15, Tenant #2 was admitted on 6-10-15 at 1:30 p.m. and on 6-10-15 at 8:45 p.m. the registered nurse (RN) received a call from staff	A 153		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

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A 153	Continued From page 16	A 153		

regarding being unable to locate Tenant #2. Staff said Tenant #2 was sleeping in the recliner in the living room area in the dementia unit and staff walked into another tenant apartment for approximately five minutes. When staff came back it was noticed Tenant #2 was no longer sleeping in the recliner in the living room. Staff went to Tenant #2's apartment and noticed the screen was out of Tenant #2's window and the window was open. An outside gate to the courtyard was partially open. Staff called other staff to assist in looking for Tenant #2 inside and outside the building and notified the RN. The RN notified the Director of Nursing (DON) and both headed to the building. The RN saw Tenant #2 walking on the side of the road on the way to the building. The estimated time Tenant #2 was out of the building was approximately 15 minutes. The weather was clear and it was still light out. Tenant #2 was wearing khaki pants and a white sweatshirt. The RN was able to redirect Tenant #2 after about five minutes. Tenant #2 got into the RN's vehicle and buckled Tenant #2's own seatbelt. The RN drove Tenant #2 back to the Program and Tenant #2 walked willingly in the dementia unit. The RN assessed Tenant #2 for injuries and no injuries were noted. Extra staff was called in to provide one to one care with Tenant #2. Staff was instructed to remain with Tenant #2 at all times until further notice. The screen was placed back in the window. Staff had been instructed to provide frequent activities for Tenant #2 to keep Tenant #2 busy and to document any behaviors on each shift. A locksmith was called to put a number coded lock on both gates and all staff would be provided with the code.

4. According to observation, the Program consisted of a dedicated dementia unit and a

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	S0243	A. BUILDING: _____ B. WING _____	C 10/14/2015

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PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

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A 153	Continued From page 17	A 153		

general population. The dedicated dementia unit had two interior doors and two exterior doors and all doors were delayed egress doors. There was a courtyard off of the dementia unit. The dementia unit courtyard was contained by fencing and a retaining wall. The courtyard had two gates, which were not locked or alarmed. The gates opened and went to areas outside the courtyard. There was also a set of doors that went from the dementia unit courtyard into the general population part of the building. The doors had a key pad and could be alarmed; however, at the times the doors were observed the doors were not secured. It would allow a tenant to exit the dementia unit courtyard into the general population part of the building and possibly exit the building.

5. According to an interview with the Executive Director, a lock service was contacted after the incident with Tenant #2 regarding installing a digital lock service for the gates. The Program was awaiting direction regarding requirements before installation.

6. According to an interview with the RN, staff called and said they were looking for Tenant #2. The screen was knocked out and the window was opened. The DON was contacted and they responded immediately. The RN was on the way to the building and saw Tenant #2 walking down a street holding a newspaper. The RN said the RN pulled up behind Tenant #2 and called Tenant #2's name. Tenant #2 was difficult to redirect and said Tenant #2 was going home. Tenant #2 ended up getting in the vehicle and put on Tenant #2's seat belt. Tenant #2 was found approximately two blocks from the Program and was walking on the gravel shoulder. Tenant #2 was dressed appropriately and the weather was

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A 153	Continued From page 18 nice. As interventions extra staff was provided to sit with Tenant #2. The Executive Director called a locksmith regarding a keypad for the gate. Tenant #2 did not sustain any injuries. 7. According to an interview with Staff B, Tenant #2 was agitated the night of the elopement and was not happy about being there. Tenant #2 was seen and within 15 minutes could not be found. Staff B checked every room in the dementia unit and called staff in the general population. The window (in Tenant #2's apartment) was open and the screen was off. Staff B said she did not know how Tenant #2 got out of the courtyard. The RN found Tenant #2 approximately half a mile from the Program. Once Tenant #2 was back in the building, vitals were taken and extra staff was added. The weather was nice and Tenant #2 was dressed appropriately. Tenant #2 did not sustain any injuries. 8. According to the State Climatologist, the weather conditions at the local airport on 6-10-15 at 8:35 p.m. were as follows: temperature was 79 degrees, there were clear skies and winds were from the north at nine miles per hour (mph). 9. The incident with Tenant #2 was not witnessed; however, possible terrain Tenant #2 could have traveled would have been sidewalks, grass, a parking lot and city streets. The road Tenant #2 was found on had a posted speed limit of 35 mph. The approximately distance from the Program's parking lot to the general area Tenant #2 was located was .2 of a mile.	A 153		

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	50243	A BUILDING _____ 8. WING	C 10/14/2015

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PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

(X4J ID PREFIX TAG)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 1DENT1FY1NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
A 0001	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: 60 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 62 Dementia-Specific Program by Dedication Number of tenant? without cognitive disorder: 2 Number of tenants with cognitive disorder: 8 Total Population of Program at time of on-site: 1O TOTAL census of Assisted Living Program: 72 Incident #55341-1 and Incident #55591-1 were investigated and there were regulatory insufficiencies identified regarding both incidents. Complaint #54723-C and Complaint #55348-C were investigated and there were regulatory insufficiencies identified regarding both complaints. There were also regulatory insufficiencies cited during the course of the investigation.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. "A program ' s policies and procedures must meet the minimum standards set by appliq3ble requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents	A 003		

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A 003	Continued From page 1 including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to follow policies and procedures established by a Program regarding one of five tenant files reviewed (Tenant #2). The Program did not follow their policy and procedure regarding the completion of incident reports and medication administration. Tenant #2 had behaviors and incidents that required the completion of incident reports per the Program's policy and incident reports were not completed. Tenant #2 received staff assistance with medications and an order was not transcribed appropriately on the medication administration record (MAR), staff did not document medications administered and medications were documented as administered after Tenant #2 was discharged. The Program did not follow their policy and procedure regarding medication administration. (Complaint #54723-C and dur[ng the course of the investigation) 1. Tenant #2, an 84 year old, was admitted on 6-10-15 and diagnoses included: dementia, Alzheimer's disease, seizures, electrolyte imbalance, divertculosis, urinary tract infeclton and hematemesis. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #2 resided in the dementia unit. Tenant#2 was discharged on 7-8"15. According to Nurse's Notes from 6-12-15 to	A003	54723-C Resident #2 discharged 7-8-15 Retraining with staff on guidelines for filling out Incident reports including all incidents of resident becoming ill, falling, behavior episodes or unusual events. As well as, who is to complete incident reports; RN/ED or person in charge as indicated by the schedule. Training will be completed by 11-14-15. Medication Aides will be re-delegated on transcribing orders to MARS by 11-14-15. Retraining entire direct care staff on the six rights of administering medication. Training to be completed by 11-14-15. Nurse Clinician/RN will review incident reports on a quarterly basis for proper completion and documentation. RN will review MARS weekly for one month then at her discretion on a monthly basis for proper transcribing and administering of medication.	

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	50243	A BUILDING _____ B.WING	C 10/14/2015

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PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA52732

(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 (EA CH CORRECTIVE ACTJON SHOULD *BE* CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
A 003	Continued From page 2 6-15-15, Tenant #2 was banging on the dementia unit doors to get out at times, became agitated when staff tried to redirect, tried moving some furniture, was wandering in and out of other tenant apartments, urinated on the floor in the living room area and urinated on a chair and coffee table. Tenant #2 became agitated with staff and combative when staff attempted to redirect. Tenant #2 hit a staff in the face and leg when staff attempted to change Tenant #2's clothes. Tenant #2 continued to exit seek and bang on the doors, removed clothing and went into a closet. Nurse's Notes from 6-26-15 to 7-6-15 indicated Tenant #2 was determined to go home, went from door to door kicking them and tried to push furniture through the doors. Tenant #2 tried to push another tenant in a wheelchair through the doors but was stopped by staff. Tenant #2 rubbed another tenant's back of the neck and shoulders. Tenant #2 set off door alarms and staff was unable to redirect. Tenant #2 was getting aggressive with staff trying to redirect. A.couple of tenants said they were afraid of Tenant #2. Tenant #2 urinated ,n the hallway four times and became very aggressive when staff tried to help Tenant #2 in the bathroom. Tenant.#2 went into another tenant's apartment naked and was very hard to redirect. It took three staff and 10 to 15 minutes to get Tenant #2 out of the apartment. Tenant #2 hit a staff in the face when attempting to redirect,_ tried to kiss another tenant and tried removing another tenant's sweater. Tenant #2 pulled the phone cord out of the wall, moved furniture and had a staff against the wall attempting to kiss staff Tenant #2 hit another tenant on the tenant's forehead with Tenant #2's palm. 2. Incident reports were requested for Tenant #2. Orie incident report was provided regarding	A003		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50243	A BUILDING: _____ B. WING	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

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A 003	Continued From page 3 Tenant #2's elopement on 6-10-15. Incident reports were not completed regarding Tenant #2's behaviors as documented in Nurse's Notes. 3. According to the Program's policy regarding incident reports, each associate (staff) would immediately notify the nurse/manager if a tenant became ill, had fallen, their behavior was abnormal or any unusual event occurred. An incident form would be completed by the nurse or manager for documentation purposes. A person in charge would be indicated on the schedule to fill out the report in their absence. 4. Tenant #2's file was reviewed. According to Tenant #2's service plan staff administered Tenant #2's medications. June and July 2015 MARs were reviewed. On 6-10-15 physician orders were received and noted. The orders indicated Lorazepam 0.5 milligram (mg) three times daily as needed was ordered. The June 2015 MAR reflected Lorazepam 0.5 mg three times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m. A entry on the MAR on 6-10-15 at 8:00 p.m. indicated the medication was not available. Staff documented Tenant #2 received one dose of the Lorazepam 0.5 mg on 6-11-15 at 8:00 a.m. scheduled despite the order written for Lorazepam was as needed. The order was discontinued on 6-11-15 and a new order for Lorazepam was started Review of June 2015 MARs indicated there was an order for Lorazepam 0.5 mg give one tablet three times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m. The June 2015. MARs indicated the doses on 6-26-15 and 6-29-15 at 2:00 p.m. were not documented as administered	A 003		

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A 003	Continued From page 4 Review of July 2015 MARs indicated on 7-9-15 staff documented 8:00 a.m. medications were given including Lasix 40 mg one tablet by mouth daily, Lorazepam 0.5 mg one tablet three times daily at 8:00 a.m., Risperdal 0.5 mg take one tablet in the morning at 8:00 a.m. and Vitamin D 400 units 1.5 tablets by mouth daily at 8:00 a.m. Nurse's Notes dated 7-8-15 at 4:00 p.m. indicated Tenant #2 was transferred to a geriatric psychiatric unit on 7-8-15. Tenant #2's discharge date provided by the Program was 7-8-15 Tenant #2 was not in the building on 7-9-15 at 8:00 a.m. when medications were documented as administered. 5. According to the Program's policy and procedure regarding medication administration, medications were administered in accordance with written orders from the physician and staff followed the six "Rights" for proper and accurate administration of medication including: the right documentation. Staff recorded with their initials afterwards in the correct date on the MAR, which verified the *five* rights were followed (right medication, right dose, right time, right tenant, right route/method).	A 003		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of *staff.* A sufficient number of trained staff shall be available at all times to fully meet tenants ' identified needs. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file, a staff file, staff	A 055		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	(X2) MUITIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50243	A. BUILDING.———— B. WING	C 10/14/2015

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A 055	Continued From page 5 interviews and Program documents, the Program failed to provide a sufficient number of trained staff available at all times to fully meet tenants' identified needs regarding an incident that occurred with Staff A and Tenant #1. Staff A assisted Tenant #1 in a wheelchair without applying the foot pedals. Tenant #1 put Tenant #1's feet down while in the wheelchair and the Tenant sustained an injury. Tenant #1 was transported to a hdsp1tal and was diagnosed with a femur fracture. Tenant #1 was discharged on 9-17-15. Staff A did not have documented training on assisting a tenant in a wheelchair and applying foot pedals, prior to or after the incident with Tenant #1 on 9-17-15. (Incident #55341-1) 1. Tenant #1, an 82 year old, was admitted on 4-10-15 and diagnpses included: dementia, atrial fibrillation, history (bf knee replacement and arthritis. Tenant #) was staged at a four on the Global Deterioratiqn Scale, which indicated moderate cognitive deciine. Tenant #1 resided in the dementia unit. Tenant #1 was discharged on 9-17-15. According to Tenant #1's service plan dated 9-10-15, Tenant #1 ambulated independently with a cane or wheeled walker. 2. According to aii incident report dated 9-17-15 at 1:20 p.m., staff 'pushed Tenant #1 in a wheelchair down a hallway. Tenant #1 held Tenant #1's feet and walker off the ground. Tenant #1 made a sudden stop by putting Tenant #1's feet and walker on the floor. Tenant #1's left leg was in front of the wheelchair and the right leg went under the wheelchair and bent "a little" Tenant #1 was in a lot of pain. Tenant #1 refused	A 055	55341-1 Direct care staff will be delegated by the RN on the proper use of wheelchair and foot pedals. Training will be completed by 11-14-15. RN will do discretionary checks with direct care staff that there is proper use of wheelchairs and foot pedals then document those checks.	

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A 055	Continued From page 6 range of motion, ice was put on the knee and the nurse was called. The nurse came to assess and Tenant #1 said Tenant #1 wanted to go to the hospital. Tenant #1 was transported to the hospital. Tenant #1 was admitted to the hospital with a fractured right femur. Wheelchair pedals were not used and staff was re-educated on the use of wheelchair pedals for safety. 3. Staff A's written statement indicated Staff A was taking Tenant #1 to an activity from the dementia unit to the general population, which was a longer distance than usual. Tenant #1 seemed to be getting tired so Staff A offered a wheelchair. *Staff* A got a wheelchair and Tenant #1 sat down holding Tenant #1's walker. Staff A tried to remove the walker from Tenant #1's lap and Tenant #1 insisted that it remain. Staff A was wheeling Tenant #1 in the hallway when Tenant #1 suddenly slammed Tenant #1's legs down to stop the wheelchair. Tenant #1 held Tenant #1's knee and said it hurt. Staff A brought the wheelchair backward "a little" to straighten out Tenant #1's leg to assess Tenant #1's knee. Tenant #1 refused to let Staff A lift up Tenant #1's pant leg. Staff A called the nurse to assess. 4. According to an interview with Staff A, she stated there was an activity scheduled and Tenant #1 agreed to come to the activity, which was held in the 500 hallway. Tenant #.1 had problems with Tenant #1's knee so Staff A got a wheelchair to transport Tenant #1. Tenant #1 refused to put the wheeled walker down and put the walker on Tenant #1's lap with Tenant #1's legs extended. Staff A was taking Tenant #1 and other tenants from the dementia unit to the activity. Staff A turned around to check on the other tenants and Tenant #1 put both feet on the ground. Tenant #1 complained of pain and Staff A looked at Tenant	A 055		

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A 055	Continued From page 7	A 055		

#1's knee and there was no redness on the leg. Tenant #1 held the right leg over the left leg and was taken back to the dementia unit. The nurse was called because Tenant #1 as in a lot of pain. Tenant #1 agreed to go to the hospital and an ambulance arrived to transport Tenant #1.

Staff A said Tenant #1 used a walker but for long distances it was hard for Tenant #1 to get around. Tenant #1 had trouble walking and had knee pain. The wheelchair used to transport Tenant #1 was a Program wheelchair. Staff A had not used a wheelchair for Tenant #1 before. Staff A said the Director of Nursing (DON) had shown Staff A how to put the foot pedals on. At the time Tenant #1 was transported, the foot pedals were not used. Staff A said she did not have any follow up training regarding wheelchair foot pedals after the incident.

5. According to a Program document signed by the DON, on 9-17-15 at approximately 1:20 p.m. Staff A reported Staff A was pushing Tenant #1 in a wheelchair and Tenant #1 put Tenant #1's feet down. Tenant #1's right leg bent under the wheelchair "a little bit" Tenant #1 continued to complain of pain, ice was applied to the right knee and the DON was called to the dementia unit. Tenant #1 reported pain when the DON barely touched Tenant #1's knee so the DON did not move Tenant #1. Tenant #1's legal representative was called and an ambulance was called to transport Tenant #1 to the emergency room. Tenant #1 was admitted to the hospital for a broken femur and would be having surgery. Tenant #1 normally ambulated independently with a wheeled walker throughout the unit. Staff A . . used a wheelchair to transport Tenant #1 to an activity that was longer distance because it was too far for Tenant #1 to walk and Tenant #1

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	50243	A. BUILDING:_____ B WING	C 10/14/2015

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(X4) 1D 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)	(XS) COMPLETE DATE
A055	Continued From page 8 appeared to be getting tired. There were no foot pedals on the wheelchair when Staff A pushed Tenant #1 in the wheelchair. Staff A had been re-educated on the use.of wheelchair pedals for tenant safety. 6. According to an interview with the DON, Tenant #1 was being pushed in awheelchair and Tenant #1 put Tenant #1's legs down to stop. One of Tenant #1's legs was bent back underneath. The DON responded to the dementia unit and Tenant #1 was in a lot of pain. Tenant #1's leg was not moved and an ambulance was called. Tenant #1's family was notified. Tenant #1 sustained a fractured right femur. After the incident with Tenant #1, the DON provide verbal training to Staff A regarding using wheelchair foot pedals. Staff was not to transport anyone without them. The DON indicated foot pedals were available to use with the Program wheelchair. 7. Staff A's employee file was reviewed. There was no documented training regarding transporting tenants in a wheelchair and the use of wheelchair foot pedals prior to or after the incident with Tenant #1 on 9-17-15. 8. According to the Program's policy regarding staffing, the Program would employ sufficient trained associates (staff) to meet the identified tenant needs.	A055		
A064	481-67.9(4)g Staffing 481-67.9(2318,231C,231D) Staffing. 67.9(4) Nurse d,:,legation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the	A064		

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A064	Continued From page 9 individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant ' s normal health, functional and cognitive status. The program ' s registered nurse or designee shall train certified and noncertified staff on reporting to the program ' s registered nurse or designee and documenting occurrences that differ from the tenant ' s normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews and *review* of Program docbments the Program failed to provide staff communication in writing occurrences that differed from the tenant's normal health, functional and cognitive status retained by *the* Program for a period of not less than three years and available to the Department upon request for two of five tenant files reviewed (Tenant #3 and #4). Two tenants had occurrences that differed from their normal health, functional and cognitive status and staff did not document the_occurrences in writing (Complaint#55348-C) 1. Tenant #3, an 88 year old, was admitted on 4-28-14 and diagnoses included: type 2 diabetes mellitus, hypertension (HTN), hyperlipidem1a, peptic acid disease and osteoarthritis. Tenant #3 was discharged on 9-1-15.	A064	55348 – C Tenant #3 discharged 9-1-15 Tenant #4 discharged 9-6-15 Tenant #5 discharged 10-12-15 Direct care staff will be trained on completing a stop and watch form alerting RN/ED of change in residents cognitive, functional, and physical health that differs from their norm. Training will be completed by 11-14-15. Nurse clinician/RN will review stop and watch forms quarterly for proper completion and reporting.	

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A 064	Continued From page 10 According to Nurse's Notes dated 8-31-15, the Registered Nurse (RN) was on call and staff called due to Tenant #3 vomiting. Tenant #3 did not want to go to the emergency room (ER). Staff attempted to call Tenant #3's family without success. Staff called a few times to tell the RN that Tenant #3 was still vomiting and did not look well. The RN instructed staff to take the phone to Tenant #3's and ask Tenant #3 questions. Tenant #3 was asked how Tenant #3 felt and Tenant #3 said a little better. Staff was concerned Tenant #3 vomited on Tenant #3 in bed and on the bed. Tenant #3 refused to let staff change Tenant #3's clothes and clean Tenant #3 up. Tenant #3 was asked if Tenant #3 wanted to go to the ER and Tenant #3 refused. Staff notified the RN and Director of Nursing (DON) that Tenant #3 started to foam at the mouth and breathing had slowed down. The RN and DON came in immediately to check on Tenant #3. According to Nurse's Notes dated 9-1-15, the RN and DON went to Tenant #3's apartment and Tenant #3 had no pulse, no respirations upon auscultation and was not breathing. Staff had called 911 due to Tenant #3's breathing and color before the RN and DON arrived. The ambulance came and left, there was a police officer who was there until the coroner arrived. The RN and DON cleaned Tenant #3 up, put clean clothes and sheets on as the RN had called Tenant #3's family and family was on the way to the Program. 2. There was no written documentation provided by the noncertified or certified staff regarding the change in Tenant #3's condition. 3. Tenant #4, a 96 year old, was admitted on 7-11-14 and diagnoses included. HTN, hyperlipidemia, atrial fibrillation, myocardial	A 064		

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A 064	Continued From page 11	A 064		

infarction, history of pacemaker and history of hypothyroidism. Tenant #4 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. Tenant #4 was discharged on 9-6-15.

According to Nurse's Notes dated 9-8-15, the RN received a call from staff on 9-6-15 regarding Tenant #4 not feeling well. Tenant #4 was weak, had a cough and was congested. Tenant #4's family was there and was concerned. The RN spoke with the family on the phone and family decided as well as the RN that Tenant #4 needed to go to the ER Tenant #4's family took Tenant #4 to the ER. Tenant #4 was admitted to the hospital on 9-6-15 for fever, low oxygen saturation and low blood pressure.

4. According to an interview with Staff B, Tenant #4 looked terrible, had trouble breathing and Tenant #4's color was bad. Vitals were taken, Tenant #4's family was concerned and the RN was called. The family decided to take Tenant #4 to the ER

5. According to an interview with the RN, staff called and gave Tenant #4's vitals. Tenant #4 had a low grade fever and the oxygen saturati9n was a little low. Tenant #4's family said Tenant #4 was not feeling well, had a cough and family was not sure if Tenant #4 should go to the ER or urgent care. There was a sickness going around the building and everyone was sick. The RN recommended family take Tenant #4 to the ER The RN provided the RN's cellular phone number, offered wheelchair assistance from staff and asked if family wanted an ambulance called or if family would take Tenant #4. Tenant #4's family took Tenant #4 in a private car.

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A 064	Continued From page 12 6. There was no written documentation provided by the noncertified or certified staff regarding the change in Tenant #4's condition.	A 064		
A 096	481-69.27(3) 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(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents, the Program failed to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there were changes in the tenant's health status if a tenant received personal or health-related care for three of five tenant files reviewed. (Tenants #3, #4 and #5). Three tenants received personal and health-related care and a nurse review was not completed every 90 days. (During the course of the investigation)	A 096	55348-C RN will be retrained by Provision Living Nurse Clinician on 481-69.27(3) Nurse Review requirements of evaluation every 90 days or with change in tenants health status. Training will be completed by 11-14-15. RN/Nurse Clinician will review assessment tracker every 6 months at minimum and will choose a random selection of charts for compliance monitoring.	

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A096	Continued From page 13 1. Tenant #3, an 88 year old, was admitted on 4-28-14 and diagnoses included: type 2 diabetes memtus, hypertension (HTN), hyperlipidemia, peptic acid disease and osteoarthritis. Tenant #3 was discharged on 9-1-15. According to Tenant #3's service plan dated 6-23-15, Tenant #3 received personal and health-related care. According to a Quarterly Nursing Summary document, a 90 day nurse review was completed on 2-3-15. According to a Quarterly Nursing Summary document, a nurse review was completed dated 6-23-15. The reason for the review was indicated as an annual review. A nurse review was not completed every 90 days. 2. Tenant #4, a 96 year old, was admitted on 7-11-14 and diagnoses included: HTN, hyperlipidemia, atrial fibrillation, myocardial infarction, history of pacemaker and history of hypothyroidism. Tenant #4 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. Tenant #4 was discharged on 9-6-15. According to Tenant #4's service plan dated 7-15-15, Tenant #4 received personal and health-related care. According to a Quarterly Nursing Summary document, a 90 day nurse review was completed on 2-3-15; According to a Quarterly Nursing Summary document, a nurse review was completed dated 7-15-15. The reason for the review was indicated as an annual review. A nurse review was not completed every 90 days. 3. Tenant #5, a 93 year old was admitted on	A096		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	$0243	A. BUILDING, ———————— B. WING	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

(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 CROSSREFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A096	Continued From page 14 12-15-10 and diagnoses included: pacemaker, syncope, HTN, early dementia, coronary artery disease, depression and hyperlipidemia. Tenant #5 was staged a four on the GOS, which indicated moderate cognitive decline. Tenant #5 resided in the dementia unit. According to Tenant #5's service plan dated 10-7-15, Tenant #5 received personal and health-related care. According to a Quarterly Nursing Summary 9ocument, a 90 day nurse review was compleied dated 8-7-15. Cognitive, health and functional evaluations and a Quarterly Nursing Summary were completed on 11-12-14. The 90 day nurse review prior to the full evaluation on 11-12-14 was dated 8-13-14. A nurse review was not completed every 90 days. 4. According to the Program's policy regarding nurse review, a nurse review would be completed every 90 days or with a change in condition. The review would be completed within 90 days of the last review or last evaluation.	A096		
A 153	481-69.35(1)a Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. a. The structure of the program shall be designed and operated to meet the needs of the tenants. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file, staff interviews, review of Program document:; and observations the Program failed to to have buildings and grounds that were well-maintained, clean, safe	A 153		

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	50243	A. BUILDING. ———— B. WING	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

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A 153	Continued From page 15 and sanitary. One of five tenant files reviewed indicated one tenant eloped (Tenant #2). The building consisted of a dedicated dementia unit and a general population. The courtyard off of the dementia unit did not provide a safe environment as there were two gates that were not secured and allowed access to outside the courtyard. There was also a door that went into the general population part of the building from the courtyard that was not secured. Tenant #2, who resided in the dementia unit, eloped on 6-10-15 and one of the gates was found partially open. (Complaint #54723-C and Incident #55591-1) 1. Tenant #2, an 84 year old, was admitted on 6-10-15 and diagnoses included: dementia, Alzheimer's disease, seizures, electrolyte imbalance, diverticulosis, urinary tract infection and hematemesis. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #2 resided 1n the dementia unit. Tenant #2 was discharged *on* 7-8-15. 2. According to an incident report *on* 6-10-15 at 8:45 p.m., Tenant #2 was sleeping in the chair in the living room. Staff went into another tenant apartment and came back and Tenant #2 was gone. Staff went to Tenant #2's apartment and the window was open and the screen was gone. Staff searched inside and outside (the building) for Tenant #2 and called the nurse on call to come help. 3. According to a Program document dated 6-11-15, Tenant #2 was admitted on 6-10-15 a!. 1:30 p.m. and on 6-10-15 at 8:45 p.m. the registered nurse (RN) received a call from staff	A 153	54723-C/ 55591-1 Locking company was contracted to install a locking system on exterior memory care gates that all staff will have key/code to allow them access. This will be completed by 11-10-15. All staff will be trained in using the locking system on date of installation, to be completed by 11-14-15. Gates and locking system will be checked monthly by maintenance and documented. Keypad general population door has been repaired. The door will be checked monthly by maintenance and documented.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL/ER/CL/A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	\$0243	A. BUILDING. _____ B. WING	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

(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 CROSSREFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 153	Continued From page 16 regarding being unable to locate Tenant #2. Staff said Tenant #2 was sleeping in the recliner in the living room area in the dementia unit and staff walked into another tenant apartment for approximately five minutes. When staff came back it was noticed Tenant #2 was no longer sleeping in the recliner in the living room. Staff went to Tenant #2's apartment and noticed the screen was out of Tenant #2's window and the window was open. An outside gate to the courtyard was partially open. Staff called other staff to assist in looking for Tenant #2 inside and outside the building and notified the RN. The RN notified the Director of Nursing (DON) and both headed to the building. The RN saw Tenant #2 walking on the side of the road on the way to the building. The estimated time Tenant #2 was out of the building was approximately 15 minutes. The weather was clear and it was still light out. Tenant #2 was wearing khaki pants and a white sweatshirt. The RN was able to redirect Tenant #2 after about five minutes. Tenant #2 got into the RN's vehicle and buckled Tenant #2's own seatbelt. The RN drove Tenant #2 back to the Program and Tenant #2 walked willingly in the dementia unit: The RN assessed Tenant #2 for injuries and no injuries were noted. Extra staff was called in to provide one to one care with Tenant #2. Staff was instructed to remain with Tenant #2 at all times until further notice. The screen was placed back in the window. Staff had been instructed to provide frequent activities for Tenant #2 to keep Tenant #2 busy and to document any behaviors on each shift. A locksmith was called to put a number coded lock on both gates and all staff would be provided with the code. 4. According to observation, the Program consisted of a dedicated dementia unit and a	A 153		

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	$0243	A. BUILDING: _____ B. WING	C 10/14/2015

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A 153	Continued From page 17	A 153		

general population. The dedicated dementia unit had two interior doors and two exterior doors and all doors were delayed egress doors. There was a courtyard off of the dementia unit. The dementia unit courtyard was contained by fencing and a retaining wall. The courtyard had two gates, which were not locked or alarmed. The gates opened and went to areas outside the courtyard. There was also a set of doors that went from the dementia unit courtyard into the general population part of the building. The doors had a key pad and could be alarmed; however, at the times the doors were observed the doors were not secured. It would allow a tenant to exit the dementia unit courtyard into the general population part of the building and possibly exit the building.

5. According to an interview with the Executive Director, a lock service was contacted after the incident with Tenant #2 regarding installing a digital lock service for the gates. The Program was awaiting direction regarding requirements before installation.

6. According to an interview with the RN, staff called and said they were looking for Tenant #2. The screen was knocked out and the window was opened. The DON was contacted and they responded immediately. The RN was on the way to the building and saw Tenant #2 walking down a street holding a newspaper. The RN said the RN pulled up behind Tenant #2 and called Tenant #2's name. Tenant #2 was difficult to redirect and said Tenant #2 was going home. Tenant #2 ended up getting in the vehicle and put on Tenant #2's seat belt. Tenant #2 was found approximately two blocks from the Program and was walking on the gravel shoulder. Tenant #2 was dressed appropriately and the weather was

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	$0243	A. BUILDING: _____ B WING	C 10/14/2015

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A 153	Continued From page 18 nice. As interventions extra staff was provided to sit with Tenant #2. The Executive Director called a locksmith regarding a keypad for the gate. Tenant #2 did not sustain any injuries. 7. According to an interview with Staff B, Tenant #2 was agitated the night of the elopement and was not happy about being there. Tenant #2 was seen and within 15 minutes could not be found. Staff B checked every room in the dementia unit and called staff in the general population. The window (in Tenant #2's apartment) was open and the screen was *off. Staff* B said she did not know how Tenant #2 got out of the courtyard. The RN found Tenant #2 approximately half a mile from the Program. Once Tenant #2 was back in the building, vitals were taken and extra staff was added. The weather was nice and Tenant #2 was dressed appropriately. Tenant #2 did not sustain - any injuries. 8. According to the State Cl1matolog1st, the weather conditions at the local airport on 6-10-15 at 8:35 p.m. were as follows· temperature was 79 degrees, there were clear skies and winds were from the north at nine miles per hour (mph). 9. The incident with Tenant #2 was not witnessed; however, possible terrain Tenant #2 could have traveled would have been sidewalks, grass, a parking lot and city streets. The road Tenant #2 was found on had a posted speed limit of 35 mph. The approximately distance from the Program's parking lotto the general area Tenant #2 was located was .2 of a mile.	A 153		