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
	S0201	A. BUILDING: _____ B. WING _____	03/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CENTRE	500 1ST STREET NORTH NEWTON, IA 50208

(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: 15 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 15 TOTAL census of Assisted Living Program: 15 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that indicated tenants' identified needs for 2 of 3 tenant files reviewed (Tenants #1 and #3). Findings follow: 1. Record review of Tenant #1's file revealed	A 089		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 089	Continued From page 1 diagnoses including transient ischemic attack, lower back pain and hypertension. A Physician's Order document indicated Fentanyl 12 micrograms (mcg)/hour (hr) transdermal patch (chronic pain), one patch topically every three days was ordered. The March 2017 medication administration records reflected the following: -Daily weights, which started on 3-6-16. -Anti-embolism hose on in a.m. and off in p.m. -Triamcinolone 0.1% cream, three times daily, topically to the back of the neck for 10 days. A fax to the physician dated 3-3-17 indicated Tenant #1 had 2+ pitting edema to the left lower extremity (LE) and 1+ to the right LE. An order to start daily weights and knee high anti-embolism hose daily was received. A fax to the physician dated 3-14-17 indicated Tenant #1 had two skin issues. Tenant #1 had a red rash at the top of his/her neck and Triamcinolone 0.1% cream was ordered. An open sore was also noted to Tenant #1's left outer foot area. The size of the area was 1 centimeter and it was slightly red. An order to cleanse with hydrogen peroxide, apply triple antibiotic ointment (TAO) and cover with a band-aid daily was received. An interview with the Director of AL on 3-28-17 at 3:39 p.m. revealed Tenant #1 had a wound on the outer left foot from not wearing socks with shoes. Staff cleansed the wound with hydrogen peroxide, applied TAO and covered it with telfa or a band-aid everyday. Tenant #'1's wound had improved. Tenant #1 had pain in his/her lower back and the Fentanyl patch was effective.	A 089		

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A 089	Continued From page 2 Tenant #1 wore anti-embolism hose and had daily weights. Tenant #1 had a rash/dry scalp and the treatment was ordered for 10 days. Further record review revealed Tenant #1's service plan did not reflect the following: daily weights, edema and anti-embolism hose, the rash and Triamcinolone treatment and the wound on Tenant #1's foot and treatment. The service plan reflected lower back pain under the health status, diagnosis and health concerns section; however, did not reflect the Fentanyl patch. The service plan did not reflect the identified needs of Tenant #1. 2. Record review of Tenant #3's file revealed a diagnosis of urinary tract infection (UTI). A Physician's Orders document indicated the following was ordered: -Desitin 13%, topical cream, apply to buttocks, twice daily. -Fentanyl 25 mcg/hr transdermal patch (chronic pain), one patch topically, every three days. -Oxygen at 2-3 liters per nasal cannula as needed. Review of Nurse's Notes indicated the following: -on 1-18-17 a urinalysis (UA) was obtained. -on 1-19-17 a new order was received for Cephalexin 250 mg, one capsule, by mouth four times per day. -on 1-31-17 a new was received for a follow up UA five to seven days post antibiotic. -on 2-7-17 a new order was received for Macrobid, one tablet, by mouth twice daily for seven days. -on 2-20-17 a new order was received for a follow up UA. -on 2-23-17 a new order was received for	A 089		

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A 089	Continued From page 3 Cephalexin 500 mg, one tablet by mouth, three times daily for seven days. An interview with the Director of AL on 3-28-17 at 3:39 p.m. revealed Tenant #3 had oxygen ordered as needed; however, it had not been used since Tenant #3 returned to the Program from a long term care stay. Staff applied a barrier cream to Tenant #3's buttocks twice daily. The area was not open and was slightly pink. Tenant #3 had three UTIs and had antibiotic therapy. Further record review revealed Tenant #3's service plan did not reflect the following: the area on Tenant #3's buttocks and barrier cream treatment, the Fentanyl patch and oxygen as needed. The service plan reflected UTI under the health status, diagnosis and health concerns section; however, did not reflect the history of UTIs with antibiotic therapy. The service plan did not reflect the identified needs of Tenant #3.	A 089		

Park Centre Assisted Living
500 1st Street N
Newton, IA 50205

4/13/17

Date: April 5th, 2017

Plan of Correction (POC) Submitted For:

- Recertification visit completed on 3/28/17

POC: 481.69.26 (4)a Service Plans

a.Regulatory Insufficiency:

481.69.26(4)a. The service plan shall be individualized and shall indicate, at a minimum:
a. The tenant's identified needs and preferences for assistance.

i. **Program POC:**

1. Elements detailing how the program will correct the insufficiency as it relates to the tenant:

   With regard to Tenants #1 and #3 service plans have been updated and individualized for needs and preferences for assistance. All other tenants in the program have been audited to ensure that their service plans are individualized and indicate the tenant's identified needs and preferences for assistance.

2. Actions program is taking to protect tenants in similar situations:

   The Program Nurse will update tenant(s) service plans with physician orders as, change of condition, as requested by the tenant and as needed and appropriate to ensure service plans are individualized and meet the tenant(s) needs and request for assistance.

3. Measures taken to ensure problem does not recur:

   The Program Nurse will routinely audit tenant service plans to ensure that service plans are individualized, meet the residents needs and requests for assistance.

4. The date by which the regulatory insufficiency will be corrected:

   Plan of Correction Date April 5th, 2017

Park Centre Assisted Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.

4/10/17