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
	S0360	A. BUILDING: _____ B. WING _____	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN	1275 W FOREVERGREEN ROAD NORTH LIBERTY, IA 52317

(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: 11 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 15 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 13 Total Population of Program at time of on-site: 15 TOTAL census of Assisted Living Program: 30 The following regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	See attached POC 6/11/17	
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 including allegations of dependent adult abuse.	A 003		

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

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A 003	Continued From page 1	A 003		

This REQUIREMENT is not met as evidenced by:
Based on observation and record review the Program failed to follow their policy and procedure related to the administration of as needed (PRN) medications for 2 of 4 tenant files reviewed (Tenants #1 and #3) and 1 tenant observed on a medication pass (Tenant #5).

Findings follow:

1. Observation of a medication pass on 4-26-17 at 9:45 a.m. revealed Staff F administered scheduled medications to Tenant #5. Tenant #5 requested Tylenol (Acetaminophen) as needed and Staff F administered Acetaminophen 650 milligrams (mg) to Tenant #5. The reason for the administration of the as needed medication was not documented when the medication was administered.

2. Record review of Tenant #1's file revealed the March and April medication administration records (MARs) indicated Acetaminophen 325 mg two tablets, every six hours as needed for increased pain/fever was documented as administered on 3-23-17 at 6:59 p.m. and 4-3-17 at 12:53 p.m. At each interval the date, time, medication and effectiveness of the medication was documented; however, the dosage and reason for the administration of the medication was not documented at either interval.

3. Record review of Tenant #3's file revealed the April MAR indicated Trazodone 50 mg tablet, 1 tablet, twice daily as needed for dementia with behavioral disturbances was documented as

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A 003	Continued From page 2 administered on 4-3-17 at 12:35 p.m., 4-6-17 at 7:29 p.m., 4-7-17 at 5:10 p.m. and 4-24-17 at 4:56 p.m. At each interval the date, time, medication, dosage and effectiveness of the medication was documented; however, the reason for the administration of the medication was not documented at any of the intervals. 4. Record review revealed Tenant #5's April MAR indicated Acetaminophen 650 mg, every six hours as needed for pain/fever was documented as administered on 4-26-17 at 10:01 a.m. and 4-26-17 at 4:57 p.m. At each interval the date, time, medication and effectiveness of the medication was documented; however, the dosage and reason for the administration of the medication was not documented at either interval. 5. The Program's policy and procedure related to medication needs of tenants/medication management indicated as needed medications were recorded on the as needed MAR in the same manner that routine medications were documented. In addition to the routine medication procedure, the date, time, medication, dosage and reason for the administration of the medication was to be recorded on the as needed MAR. The effectiveness of the medication should also be recorded.	A 003		
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	A 083		

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A 083	Continued From page 3 at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update a service plan as needed and failed to ensure service plans designed to meet the specific service needs of the tenants for 3 of 4 tenant files reviewed (Tenants #1, #3 and #4). Findings follow: 1. Record review of Tenant #1's file revealed observation notes noted the following: a. On 2-3-17 Tenant #1 had some very loose stools. b. On 2-15-17 Tenant #1 had a bowel movement, within two hours he/she toileted twice and it was like a mucus. c. On 2-20-17 it was noted cloth bed pads would be beneficial for repositioning/incontinence. Incontinence chucks would be ordered. d. On 3-10-17 Tenant #1 had loose stools that morning and afternoon. The service plan updated on 4-24-17 did not reflect Tenant #1's history of loose stools and use of incontinence cloth pads. The service plan did not reflect the specific service needs of Tenant #1. An interview with the Memory Care Manager on 4-27-17 at 12:08 p.m. revealed Tenant #2's	A 083		

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A 083	Continued From page 4 service plan did not reflect the loose stools or incontinence cloth pads. 2. Record review of Tenant #3's file revealed a physician's order for Miconazorb anti-fungal powder 2%, apply topically to abdominal scar four times weekly for healing of a prior scar. Tenant #3 also had an order for Nitrostat sublingual 0.4 milligram, one tablet every five minutes as needed for chest pain (max of 3 doses/15 minutes). The service plan dated 4-19-17 failed to reflect the abdominal scar and treatment or the order for Nitrostat. The service plan also failed to include the use of Nitrostat sublingual for chest pain. When interviewed on 4-27-17 at 12:08 p.m. the Memory Care Manager stated Tenant #3 had Nitrostat and staff would administer it if requested; however, Tenant #3 had not requested it. 3. Record review of Tenant #4's file revealed a Resident Assessment, dated 2-2-17, completed due to a significant change as Tenant #4 was seen in the emergency room and returned with an order for Hospice. Further review failed to reveal a service plan related to the significant change of condition for the addition of Hospice services.	A 083		
A 086	481-69.26(3)a Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy	A 086		

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A 086	Continued From page 5 and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans signed by the tenant or the tenant's legal representative (as applicable) when a significant change triggered the review and update of the service plan for 2 of 4 tenant files (Tenants #2 and #3). Findings follow: 1. Record review of Tenant #2's file revealed the update of the service plan, dated 2-28-17, due to a significant change of condition. The service plan was signed by a health care professional; however, was not signed by Tenant #2 or Tenant #2's legal representative. 2. Record review of Tenant #3's file revealed the update of the service plan, dated 2-7-17, updated due to a significant change of condition. The service plan was signed by a health care professional; however, was not signed by Tenant #3 or Tenant #3's legal representative. An interview with the Memory Care Manager on 4-27-17 at 12:08 p.m. revealed there was no	A 086		

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A 086	Continued From page 6 additional service plan information related to tenant signatures for Tenant #2 or Tenant #3.	A 086		
A 125	481-69.30(5) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide dementia-specific training that included hands-on training for 5 of 7 staff files reviewed (Staff A, B, C, D and E). Findings follow: Record review revealed the following: 1. Staff A was hired on 2-8-17. Further record review revealed no documentation for hands-on dementia training. 2. Staff B was hired on 10-28-16. Additional record review revealed no documentation for hands-on dementia training. Staff B had documented training on the Program's elopement/missing person policy dated 11-10-16. 3. Staff C was hired on 3-6-17. Further record review revealed no documentation for hands-on	A 125		

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A 125	Continued From page 7 dementia training. 4. Staff D was hired on 1-31-17. Continued record review revealed no documentation for hands-on dementia training. Staff D had documented training on the Program's elopement/missing person policy dated 2-27-17. 5. Staff E was hired on 3-16-17. Additional record review revealed no documentation for hands-on dementia training. 6. An interview with the Director of Health and Wellness on 4-27-17 at 12:08 p.m. revealed Staff A, B, C, D and E worked in the general population and the dementia unit.	A 125		

√ RL 6/8/17 CAC 6/8/17

Keystone Place
At Forevergreen
A Life Fulfilling Retirement Community

May 22, 2017

Department of Inspections and Appeals
Attn: Catie Campbell
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Campbell:

On behalf of Keystone Place at Forevergreen in North Liberty, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report for the onsite visit on April 25 through April 27, 2017. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Policies and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenants #1, #3, and #5 will have PRN medications administered per policy.
    - Staff F will be redelegated on administration of PRN medications including documentation requirements related to PRN medication administration.

2. What measures will be taken to ensure the problem does not recur.
    - All staff responsible for medication administration will be redelegated on PRN administration including documentation requirements.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and or Designee will observe staff with medication administration at least annually to ensure staff follows appropriate protocol.

- The RN and or Designee will review the medication record at least every 90 days to ensure staff is documenting PRN medications as required per policy.

4. The date by which the regulatory insufficiency will be corrected.
   - This regulatory insufficiency will be corrected by June 11, 2017.

Service Plan
NOTE: There appears to be a typo on the DIA regulatory report. Refer to page 4, bottom sentence on the page. I believe this should be Tenant #1, not Tenant #2.

1. Elements detailing how the Program will correct each regulatory insufficiency.
   - The RN will update service plans for Tenant #1 and Tenant #3. (Tenant # 4 no longer resides at Keystone Place at Forevergreen.)
   - Tenant #2, #3 will have service plan signed as required by regulation.

2. What measures will be taken to ensure the problem does not recur.
   - The RN will be educated on regulatory requirements for completion of a service plan.
   - The RN will be educated on regulatory requirements for signatures on the service plan.
   - All tenant charts will be audited to determine if signatures are missing. Necessary signatures will be obtained.

3. How the Program plans to monitor performance to ensure compliance.
   - The RN and or Designee will review service plans at least annually to ensure the service plan identifies tenant needs and desired services.
   - The RN and or Designee will review a sample of tenant charts at least annually to ensure signatures are obtained as required by regulation.

4. The date by which the regulatory insufficiency will be corrected.
   - This regulatory insufficiency will be corrected by June 11, 2017.

Dementia Specific Education for Personnel
1. Elements detailing how the Program will correct each regulatory insufficiency.
   - Staff A, B, C, D, and E will receive hands on dementia training.

2. What measures will be taken to ensure the problem does not recur.
   - All staff will receive hands on dementia training as part of the required 8 hours of dementia specific training within 30 days of hire and annually.
   - An inservice will be scheduled to provide hands on dementia training to current staff.

3. How the Program plans to monitor performance to ensure compliance.

RN and/or designee will audit staff training records at least annually to ensure compliance.

Per MaryJo Pipkin CAC 6/6/17

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by June 11, 2017.

If you have any questions regarding this plan of correction, please feel free to contact me at 319-459-1964. Thank you.

Sincerely,

Mary Jo Pipkin
Executive Director