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
	S0215	A. BUILDING: _____ B. WING _____	06/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW SENIOR COMMUNITY	800 DARBY DRIVE MONONA, IA 52159

(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: 20 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 22 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 4 TOTAL census of Assisted Living Program: 26 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an assisted living program:	A 000	POC 7/22/17	
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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to consistently follow policy and procedure related to dropped medications. This affected 1 of 1 tenant observed on a medication pass (Tenant #4). Finding follows: 1. Observation of medication pass on 6-6-17 at 9:00 a.m. in the dementia unit revealed Staff E administered medications to Tenant #4 in his/her apartment. The medications were locked in a drawer in the bathroom vanity. Staff E washed her hands, donned gloves and prepared medications by emptying the medications from the cassettes and putting them into a medication cup. The medication cup tipped over on the bathroom vanity sink counter while Staff E attempted to cut one pill in half using a pill cutter. When the medication cup tipped over a pill landed on the bathroom vanity sink counter and Staff E picked up the pill with a gloved hand and put it in the medication cup. Staff E prepared the remaining medications by emptying the medications from the cassettes and putting them into a medication cup. Tenant #4 was not facing the bathroom area during the preparation of the medications and did not observe the medications being prepared, as such Tenant #4 did not witness the pill that was on the bathroom vanity sink counter. Tenant #4 consumed the medications given by Staff E. A medication prepared by Staff E fell on a contaminated surface and was placed into the medication cup for tenant consumption without notification to	A 003	A. Staff will follow the policy for Dropped/Soiled medications and use tenant discretion to whether they want to take the contaminated medication or have it disposed of. a. Facility reviewed dropped medication policy and updated it on 6/30/2017. b. Facility's registered nurse completed individual coaching on the policy for dropped medications with Staff E on 6/30/2017. c. Facility's registered nurse will complete reeducation of dropped medication policy to noncertified staff in accordance with requirements in 655-Chapter 6 governing nurse delegation, by 7/22/2017. c. Periodic medication pass audits will be completed by the facility registered nurse.	

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A 003	Continued From page 2 Tenant #4 and his/her choice regarding consumption of the contaminated medication. 2. Record review of the Program's policy regarding dropped medications indicated if a medication was dropped on the floor in a tenant's apartment, the tenant would be allowed to take the medication after it was wiped with a paper towel. It would be the tenant's discretion if they want to have it wiped off, if the medication was taken or to have the medication disposed. If the tenant did not want to take the medication that had been dropped, the medication would be placed in an envelope and given to the nurse for destruction of the medication per policy and procedure. 3. An interview with the Director of Health Services on 6-7-17 at 2:26 p.m. revealed the expectation for dropped medications if it dropped in the tenant's apartment was that if the tenant wanted to take it staff would pick it up with a gloved hand and ensured it was not soiled. Staff received training on dropped medications via nurse delegation and Staff E had been delegated.	A 003		
A 061	481-67.9(4)d Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives	A 061		

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A 061	Continued From page 3 and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse delegation training on service plan tasks, specifically wound care. This affected 4 of 4 staff who completed the task (Staff F, G, H and I). Findings follow: 1. Record review of Tenant #2's file revealed a diagnoses of diabetes mellitus (DM) type 2 with diabetic neuropathy and peripheral edema. An order was received on 4-3-17 for a dressing change that included: after shower, pour normal saline onto a couple of 4 x 4 gauze pads, squeeze out excess liquid and cover wound on the bottom of the right foot, cover with a couple of dry 4 x 4 dry gauze pads and wrap with cling gauze to hold in place. Apply ace wrap for compression from ball of the foot to just below the knee. The April 2017 and May 2017 (until time of hospitalization) medication administration records (MARs) documented staff initials for the completion of the dressing changes. Progress Notes dated 5-15-17 indicated the right foot was assessed and was warm, red, swelling was noted and there was yellow drainage from the foot ulcer. Tenant #2 reported a foul smelling odor from drainage. Progress Notes dated 5-17-17 indicated Tenant #2 was admitted to a hospital for wound care, intravenous antibiotics and pain control. Progress Notes dated 5-23-17 indicated Tenant #2 was discharged from the hospital and admitted to a nursing facility.	A 061	A. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants, including wound care. a. Tenant #2 is no longer in the facility receiving wound care. b. The program's registered nurse will document the training provided to staff F, G, H and I by 7/22/2017. c. The program's registered nurse will ensure certified and noncertified staff shall receive training regarding service plan tasks in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. d. The program will conduct periodic chart audits to ensure service plan tasks are delegated appropriately.	

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A 061	Continued From page 4 Hospital discharge documents indicated the final diagnosis was infected right diabetic foot ulcer, Methicillin sensitive Staff aureus positive, status post extensive debridement. Secondary diagnoses included: type 2 Diabetes, peripheral vascular disease, hypertension and right foot cellulitis. Hospital records indicated Tenant #2 had swelling of the right leg extending to the knee, erythema in the lower part of the leg and significant erythema and swelling of the entire foot extended up to the ankle. Tenant #2 had two open wounds, one on the lateral side of the base of his/her right to one on the plantar surface. The wounds connected through and through his/her foot. There was foul-smelling mucopurulent discharge from both wounds. An x-ray of the right foot at the outside hospital on 5-22-17 showed some gas underneath the wounds, which was concerning for gangrene. 2. Record review revealed Staff F, a universal worker (UW), did not have documented nurse delegated training on Tenant #2's wound care for a diabetic foot ulcer. 3. Record review revealed Staff G, a UW, did not have documented nurse delegated training on Tenant #2's wound care for a diabetic foot ulcer. 4. Record review revealed Staff H, a UW, did not have documented nurse delegated training on Tenant #2's wound care for a diabetic foot ulcer. 5. Record review revealed Staff I, a UW, did not have documented nurse delegated training on Tenant #2's wound care for a diabetic foot ulcer. 6. Interviews with the Director of Health Services on 6-7-17 at 2:26 and 4:11 p.m. revealed the Director of Health Services trained first shift staff	A 061		

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A 061	Continued From page 5 on Tenant #2's wound care; however, the documentation of the training was not completed. Staff F, G, H and I had provided wound care for Tenant #2.	A 061		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with a significant change of condition for 2 of 3 tenant files reviewed (Tenants #2 and #3). Findings follow: 1. Record review of Tenant #2's file revealed a diagnoses of diabetes mellitus (DM) type 2 with diabetic neuropathy and peripheral edema.	A 037	A. A program will evaluate a tenant's functional, cognitive and health status as needed with a significant change to determine the tenant's continued eligibility for the program and to determine any changes to services needed. a. Attached is a copy of the flow chart provided by the Dept of Inspections & Appeals that will be used to determine if an evaluation and/or nurse review needs to be completed. b. Periodic monitoring of tenant files will be conducted by corporate RN consultant. c. Tenant #2 has been on leave of absence from the program since 05/17/2017. Evaluation of tenant's functional, cognitive and health status will be completed upon tenant's return to the program.	

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A 037	Continued From page 6 Progress Notes dated 3-29-17 indicated Tenant #2 reported increased pain the right foot since wearing a new brace. Tenant #2 reported a callous on the bottom, lateral aspect of the ball of his/her foot that had worsened. Physical therapy (PT) was recently there and was in agreement with Tenant #2 that the brace was irritating that area. The right foot was swollen up to mid-shin area with 3-4+ pitting edema. The callous was one centimeter round with a black spot in the center about the size of a pencil lead. Tenant #2 reported pain of a 10/10 when any pressure was on it. The doctor was notified and recommendations were provided; however, Tenant #2 wanted to wait until his/her scheduled appointment on Friday. Progress Notes dated 3-30-17 indicated the calloused area on the bottom of Tenant #2's foot broke open and it drained serosanguiesous fluid. There was redness surrounding the area that extended to the top of the foot. It was warm to touch and Tenant #2 said it was uncomfortable all of the time. Tenant #2 had a temperature of 99.6 degrees. Tenant #2 was agreeable to an appointment at the clinic. Tenant #2 returned with orders for Cephalexin 500 milligrams, two capsules, four times daily for 10 days and would see his/her primary care physician (PCP) the next day. On 3-31-17 Tenant #2 returned from a appointment with his/her PCP and was ordered a daily dressing with betadine to open callous on the bottom of the right foot. Tenant #2 was scheduled to see a podiatrist on 4-3-17. An order was received on 4-3-17 for a dressing change that included: after shower, pour normal saline onto a couple of 4 x 4 gauze pads, squeeze out excess liquid and cover wound on the bottom of the right foot, cover with a couple of	A 037		

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A 037	Continued From page 7 dry 4 x 4 dry gauze pads and wrap with cling gauze to hold in place. Apply ace wrap for compression from ball of the foot to just below the knee. Apply compression stocking. The April 2017 and May 2017 (until time of hospitalization) medication administration records (MARs) documented staff initials for the completion of the dressing changes. Progress Notes dated 5-2-17 indicated Tenant #2 received a brace for the right foot and would like PT to follow up regarding it. The doctor order PT to evaluate and treat. Progress Notes dated 5-8-17 indicated orders to continue the wet to dry dressing changes daily were received and no weight bearing on the right foot as much as possible which Tenant #2 was aware of. On 5-12-17 decrease salt intake was ordered, per Progress Notes. Progress Notes dated 5-15-17 indicated the right foot was assessed and was warm, red, swelling was noted and there was yellow drainage from the foot ulcer. Tenant #2 reported an foul smelling odor from drainage. Progress Notes dated 5-17-17 indicated Tenant #2 was admitted to a hospital for wound care, intravenous antibiotics and pain control. Progress Notes dated 5-23-17 indicated Tenant #2 was discharged from the hospital and admitted to a nursing facility. Hospital discharge documents indicated the final diagnosis was infected right diabetic foot ulcer, Methicillin sensitive Staff aureus positive, status post extensive debridement. Secondary diagnoses included: type 2 Diabetes, peripheral vascular disease, hypertension and right foot cellulitis. Hospital records indicated Tenant #2 had swelling of the right leg extending to the	A 037		

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A 037	Continued From page 8 knee, erythema in the lower part of the leg and significant erythema and swelling of the entire foot extended up to the ankle. Tenant #2 had two open wounds, one on the lateral side of the base of his/her right to one on the plantar surface. The wounds connected through and through his/her foot. There was foul-smelling mucopurulent discharge from both wounds. An x-ray of the right foot at the outside hospital on 5-22-17 showed some gas underneath the wounds, which was concerning for gangrene. Health evaluations were completed on 3-30-17 and 4-4-17; however, functional and cognitive evaluations were not completed with significant change including: a diabetic foot ulcer with daily treatments, limitation of weight bearing status on the affected foot, PT services, a new brace for the affected foot and reduced salt intake. Evaluations were not completed as needed with significant change. An interview with the Director of Health Services on 6-7-17 at 2:26 p.m. revealed Tenant #2 was non-compliant with the non-weight bearing status and would take off the dressing in the morning. Tenant #2 had one wound while at the Program. 2. Record review of Tenant #3's file revealed Tenant #3 diagnoses included: congestive heart failure (CHF) and shingles. Progress Notes dated 2-13-17 revealed Tenant #3 was hospitalized since 2-4-17 for Influenza A, pancytopenia, leukopenia and CHF. Tenant #3 was diagnosed with shingles and started on Valtrex. Tenant #3 was discharged on Valtrex 1 gram every 12 hours for 7 days for shingles, which staff would administer. It was a large pill that needed to crushed for him/her to take. Tenant #3 would continue to self-administer the	A 037		

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A 037	Continued From page 9 other medications as he/she was previously. Progress Notes dated 2-17-17 indicated Tenant #3 was admitted to a hospital for dehydration and weakness. Progress Notes dated 2-23-17 indicated Tenant #3 returned on 2-22-17 and wanted to resume management and self-administration his/her own medications. Health evaluations were completed on 2-4-17, 2-13-17 and 2-23-17; however, functional and cognitive evaluations were not completed. Tenant #3 was hospitalized from 2-4-17 to 2-13-17, returned with a diagnosis of shingles and a new service of staff administration of the medication for shingles. Tenant #3 was hospitalized again from 2-17-17 to 2-22-17 and resumed self-administration of medication post discharge. Health evaluations were completed as needed with significant change; however, functional and cognitive evaluations were not completed as needed.	A 037	B. A program will evaluate a tenant's functional, cognitive and health status as needed with a significant change to determine the tenant's continued eligibility for the program and to determine any changes to services needed. a. Attached is a copy of the flow chart provided by the Dept of Inspections & Appeals that will be used to determine if an evaluation and/or nurse review needs to be completed. b. Periodic monitoring of tenant files will be conducted by corporate RN consultant. c. The program's registered nurse completed a functional, cognitive and health evaluation on Tenant #3 on 3/13/2017.	
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced	A 083		

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A 083	Continued From page 10 by: Based on interview and record review the Program failed to develop service plans based on evaluations, designed to meet the specific service needs of the tenants and to update the service plans as needed for 3 of 3 tenant files reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review of Tenant #1's file revealed diagnoses included: congestive heart failure (CHF), history of pulmonary emboli, chronic and obstructive pulmonary disease. According to the ALP Monitoring Entrance Form Tenant #1 received hospice services. Review of the service plan dated 3-30-17 revealed Tenant #1 had a home health aide (HHA) for bathing. The service plan did not include other hospice services provided. The hospice care plan report indicated Tenant #1 had skilled nursing, social worker, HHA and chaplain visits. The service plan did not address those services, with the exception of the HHA for bathing. Tenant #1 had Biofreeze 4% gel twice daily for pain management ordered and a Fentanyl patch, one patch apply every 72 hours for pain after removal of old patch. The service plan reflected Tenant #1 had pain; however, did not reflect the Biofreeze or Fentanyl patch. Tenant #1 had an order for oxygen continuous at 2 liters for dyspnea. Tenant #1 also had an order for Albuterol Sulfate, one vial in nebulizer every six hours as needed for shortness of breath/wheezing. The service plan reflected Tenant #1 was unable to maintain a clean environment due to multiple comorbidities and oxygen dependence. The service plan did not reflect Tenant #1 was on continuous oxygen and who managed his/her oxygen needs and did not reflect the as needed nebulizer treatment. The	A 083	A: Tenant #1, service plan will be developed based on evaluations and designed to meet the specific needs of the tenant, including hospice services, pain management, oxygen needs and as needed medications. a. Attached is a copy of the flow chart provided by the Depart of Inspections & Appeals that will determine if an evaluation will warrant a service plan update. b. Periodic monitoring of files will be completed by corporate RN consultant. c. By 7/22/2017, an update to the service plan will be completed by the registered nurse according to Tenant #1's identified needs & services.	

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A 083	Continued From page 11 service plan did not reflect the specific service needs of Tenant #1. 2. Record review of Tenant #2's file revealed a diagnoses of diabetes mellitus (DM) type 2 with diabetic neuropathy and peripheral edema. Progress Notes dated 3-29-17 indicated Tenant #2 reported increased pain the right foot since wearing a new brace. Tenant #2 reported a callous on the bottom, lateral aspect of the ball of his/her foot that had worsened. Physical therapy (PT) was recently there and was in agreement with Tenant #2 that the brace was irritating that area. The right foot was swollen up to mid-shin area with 3-4+ pitting edema. The callous is one centimeter round with a black spot in the center about the size of a pencil lead. Tenant #2 reported pain of a 10/10 when any pressure was on it. The doctor was notified and recommendations were provided; however, Tenant #2 wanted to wait until his/her scheduled appointment on Friday. Progress Notes dated 3-30-17 indicated the calloused area on the bottom of Tenant #2's foot broke open and it drained serosanguiesous fluid. There was redness surrounding the area that extends to the top of the foot. It was warm to touch and Tenant #2 said it was uncomfortable all of the time. Tenant #2 had a temperature of 99.6 degrees. Tenant #2 was agreeable to an appointment at the clinic. Tenant #2 returned with orders for Cephalexin 500 milligrams, two capsules, four times daily for 10 days and would see his/her primary care physician (PCP) the next day. On 3-31-17 Tenant #2 returned from a appointment with his/her PCP and was ordered a daily dressing with betadine to open callous on the bottom of the right foot. Tenant #2 was scheduled to see a podiatrist on 4-3-17.	A 083		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW SENIOR COMMUNITY	800 DARBY DRIVE MONONA, IA 52159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 12 An order was received on 4-3-17 for a dressing change that included: after shower, pour normal saline onto a couple of 4 x 4 gauze pads, squeeze out excess liquid and cover wound on the bottom of the right foot, cover with a couple of dry 4 x 4 dry gauze pads and wrap with cling gauze to hold in place. Apply ace wrap for compression from ball of the foot to just below the knee. Apply compression stocking. The April 2017 and May 2017 (until time of hospitalization) medication administration records (MARs) documented staff initials for the completion of the dressing changes. Progress Notes dated 5-2-17 indicated Tenant #2 received a brace for the right foot and would like PT to follow up regarding it. The doctor order PT to evaluate and treat. Progress Notes dated 5-8-17 indicated orders to continue the wet to dry dressing changes daily were received and no weight bearing on the right foot as much as possible which Tenant #2 was aware of. On 5-12-17 decrease salt intake was ordered, per Progress Notes. Progress Notes dated 5-15-17 indicated the right foot was assessed and was warm, red, swelling was noted and there was yellow drainage from the foot ulcer. Tenant #2 reported an foul smelling odor from drainage. Progress Notes dated 5-17-17 indicated Tenant #2 was admitted to a hospital for wound care, intravenous antibiotics and pain control. Progress Notes dated 5-23-17 indicated Tenant #2 was discharged from the hospital and admitted to a nursing facility. Hospital discharge documents indicated the final diagnosis was infected right diabetic foot ulcer,	A 083		

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A 083	Continued From page 13 Methicillin sensitive staph aureus positive, status post extensive debridement. Secondary diagnoses included: type 2 DM, peripheral vascular disease, hypertension and right foot cellulitis. Hospital records indicated Tenant #2 had swelling of the right leg extending to the knee, erythema in the lower part of the leg and significant erythema and swelling of the entire foot extended up to the ankle. Tenant #2 had two open wounds, one on the lateral side of the base of his/her right to one on the plantar surface. The wounds connected through and through his/her foot. There was foul-smelling mucopurulent discharge from both wounds. An x-ray of the right foot at the outside hospital on 5-22-17 showed some gas underneath the wounds, which was concerning for gangrene. Health evaluations were completed on 3-30-17 and 4-4-17; however, functional and cognitive evaluations were not completed with significant change. The service plan was updated to reflect the daily dressing changes; however, was not based on evaluations. The service plan did not reflect the limitation of weight bearing status on the affect foot, PT services, the foot brace on the affected foot and reduced salt intake. The service plan was not updated as needed, based on evaluations and did not reflect the specific service needs of Tenant #2. An interview with the Director of Health Services on 6-7-17 at 2:26 p.m. revealed Tenant #2 was non-compliant with the non-weight bearing status and would take off the dressing in the morning. Tenant #2 had one wound at the time at the Program. 3. Record review of Tenant #3's file revealed Tenant #3 diagnoses included: CHF and	A 083	A: Tenant #2, service plan will be developed based on evaluations and designed to meet the specific needs of the tenant, including PT services, weight bearing status, use of foot brace & reduced salt intake. a. Attached is a copy of the flow chart provided by the Depart of Inspections & Appeals that will determine if an evaluation will warrant a service plan update. b. Periodic monitoring of files will be completed by corporate RN consultant. c. Tenant #2 has been on leave of absence from the facility since 5/16/2017. Facility nurse will develop service based on evaluations and identified needs upon Tenant #2 return to the facility.	

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A 083	Continued From page 14 shingles. Progress Notes dated 2-13-17 revealed Tenant #3 was hospitalized since 2-4-17 for Influenza A, pancytopenia, leukopenia and CHF. Tenant #3 was diagnosed with shingles and started on Valtrex. Tenant #3 was discharged on Valtrex 1 gram every 12 hours for 7 days for shingles, which staff would administer. It was a large pill that needed to crushed for him/her to take. Tenant #3 would continue to self-administer the other medications as he/she previously did. Progress Notes dated 2-17-17 indicated Tenant #3 was admitted to a hospital for dehydration and weakness. Progress Notes dated 2-23-17 indicated Tenant #3 returned on 2-22-17 and wanted to resume management and self-administration his/her own medications. Health evaluations were completed on 2-4-17, 2-13-17 and 2-23-17; however, functional and cognitive evaluations were not completed. Tenant #3 was hospitalized from 2-4-17 to 2-13-17, returned with a diagnosis of shingles and a new service of staff administration of the medication for shingles. Tenant #3 was hospitalized again from 2-17-17 to 2-22-17 and resumed self-administration of medication post discharge. The service plan was not updated post hospitalization to reflect changes in medication administration from self-administering, to staff assistance with Valtrex to resumption of self-administration of medications. The service plan did not reflect shingles or precautions post hospitalization with a diagnosis of shingles and Valtrex administration. According to the ALP Monitoring Entrance Form, Tenant #3 was identified as a tenant who consistently refused cares. The service plan	A 083		

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A 083	Continued From page 15 reflected Tenant #3 refused bathing; however, did not provide interventions related to the bathing refusals. According to an incident report dated 2-14-17 staff reported staff went into Tenant #3's apartment to administer medication and found he/she had attempted to heat up water in the pan on the stove and had three burners on high that were not being used and the burner with the water was not on. The stove was turned off and the nurse was called. All but one burner on the stove were unhooked and staff was informed. The service plan did not reflect the safety intervention related to the stove. The service plan was not updated as needed post hospitalization with addition and discontinuation of services and did not reflect the identified service needs of Tenant #3 including history of shingles and precautions, interventions related to bathing refusals and the stove safety intervention. The service plan was not updated as needed and did not reflect the specific service needs of Tenant #3.	A 083	A: Tenant #3, service plan will be developed based on evaluations and designed to meet the specific needs of the tenant, including history of shingles and precautions, interventions related to bathing refusals, and stove safety intervientions. a. Attached is a copy of the flow chart provided by the Depart of Inspections & Appeals that will determine if an evaluation will warrant a service plan update. b. Periodic monitoring of files will be completed by corporate RN consultant. c. By 7/22/2017, an update to the service plan will be completed by the registered nurse according to Tenant #3's identified needs & services.	
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.	A 121		

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A 121	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have staff complete a minimum of eight hours of dementia-specific education and training within 30 days of employment for 4 of 5 staff files reviewed (Staff A, B, C and D). Findings follow: 1. Record review revealed Staff A, a universal worker (UW), was hired on 4-19-17. Staff A did not have eight hours of dementia-specific education and training completed within 30 days of employment. 2. Record review revealed Staff B, a UW, was hired on 4-19-17. Staff B did not have eight hours of dementia-specific education and training completed within 30 days of employment. 3. Record review revealed Staff C, a UW, was hired on 3-20-17. Staff C did not have eight hours of dementia-specific education and training completed within 30 days of employment. 4. Record review revealed Staff D, a UW, was hired on 12-1-16. Staff D did not have eight hours of dementia-specific education and training completed within 30 days of employment. 5. An interview with the Executive Director on 6-7-17 at 3:55 p.m. revealed Staff A, B, C and D worked in the general population and dementia unit.	A 121	A. Staff A, hired on 4/19/2017, will have a minimum of 8 hours of dementia-specific education and training within 30 days of hire and annually there after. a. By 7/22/2017, Staff A will have completed 8 hours of dementia-specific education. b. Facility Executive Director will conduct periodic employee training file audits to ensure staff training is current. B. Staff B, hired on 4/19/2017, will have a minimum of 8 hours of dementia-specific education and training within 30 days of hire and annually there after. a. By 7/22/2017, Staff B will have completed 8 hours of dementia-specific education. b. Facility Executive Director will conduct periodic employee training file audits to ensure staff training is current. C. Staff C, hired on 3/20/2017, will have a minimum of 8 hours of dementia-specific education and training within 30 days of hire and annually there after. a. By 7/22/2017, Staff C will have completed 8 hours of dementia-specific education. b. Facility Executive Director will conduct periodic employee training file audits to ensure staff training is current. D. Staff D, hired on 12/1/2016, will have a minimum of 8 hours of dementia-specific education and training within 30 days of hire and annually there after. a. By 7/22/2017, Staff D will have completed 8 hours of dementia-specific education. b. Facility Executive Director will conduct periodic employee training file audits to ensure staff training is current.	

Randee Koenig 7/3/17
Randee Koenig, Executive Director