

OK  
10/31/17

PRINTED: 09/21/2017  
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

|                                                     |                                                                           |                                                                        |                                                        |
|-----------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>S0002</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/13/2017</b> |
|-----------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

**MARTINA PLACE**

STREET ADDRESS, CITY, STATE, ZIP CODE

**5815 WINWOOD DR  
JOHNSTON, IA 50131**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 000                    | <p>481-67 Initial Comments</p> <p>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.</p> <p>Dementia-Specific Program by Dedication</p> <p>Number of tenants without cognitive disorder: 35<br/>Number of tenants with cognitive disorder: 7<br/>Total Population of Program at time of on-site: 42</p> <p>TOTAL census of Assisted Living Program: 42</p> <p>The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program.</p>                       | A 000               | <p>A 121- Dementia Specific Education for Personnel.</p> <p>*All personnel employed to work at Martina Place Assisted Living shall receive eight hours of dementia-specific education and training within 30 days of employment.</p> <p>*Eight hours of dementia-specific education and training is being added to our New Employee Orientation Program, to ensure the problem does not reoccur.</p> <p>*Human Resources and the Department Head will monitor performance to ensure compliance.</p> <p>*The regulatory insufficiency will be corrected by October 18, 2017.</p> |                          |
| A 121                    | <p>481-69.30(1) Dementia Specific Education for Personnel</p> <p>481-69.30(231C) Dementia-specific education for program personnel.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and record review the Program failed to provide 8 hours of dementia training within 30 days of employment for 2 out of 4 staff reviewed (Staff A and Staff B). Findings</p> | A 121               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*

TITLE

*Executive Director*

(X6) DATE

*9-29-17*

STATE FORM

6899

XVET11

If continuation sheet 1 of 2

*[Signature]* 10/24/17

DEPARTMENT OF INSPECTIONS AND APPEALS

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>S0002</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/13/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MARTINA PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5815 WINWOOD DR<br/>JOHNSTON, IA 50131</b>                                   |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 121                                                    | <p>Continued From page 1</p> <p>follow:</p> <p>Review of Staff A's file revealed a hire date of 2-14-17. On 2-14-17 she completed .5 hours of dementia training. No other dementia training was completed within 30 days of employment.</p> <p>Review of Staff B's file revealed a hire date of 2-14-17. On 2-14-17 she completed .5 hours of dementia training. No other dementia training was completed within 30 days of employment.</p> <p>Interview with the Director of Marketing on 9-12-17 at 2:19 p.m. confirmed neither staff had the required 8 hours of dementia training.</p> | A 121                                                                     |                                                                                                                          |                          |                                                        |