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
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 23 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7 TOTAL Census of Assisted Living Program for People with Dementia: 32 A recertification visit was conducted to determine compliance with certification rules for a Dedicated Dementia-Specific Assisted Living Program. In addition to the recertification visit, an investigation of Complaint #73055-C was also completed. The following regulatory insufficiencies were identified:	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 including allegations of dependent adult abuse.	A 003	Per correspondence with the Administrator, the corrections specified are for all tenants of the Program. She will be in charge of ensuring compliance to the plan. DD — 3/15/18	

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 interview and record review the Program failed to follow their policies and procedures related to medication management. This affected 4 of 4 tenants reviewed (Tenants #1-#4). Findings follow:

1. Record review revealed a document indicating the Nurse became aware on 12-19-17 that staff had been counting morphine syringes prescribed for Tenant #3 that had no morphine in them. There were 11 syringes that were uncapped and in a bag for over a month. Pharmacy staff had been contacted and said the morphine probably evaporated and to ask for caps for the syringes in the future. Pharmacy staff reassured the Nurse that the morphine had evaporated as it was 75% water and the syringes were not sealed.

Review of the Narcotic Count form revealed oncoming and outgoing staff signed off at shift change that narcotic counts were accurate. No names of medications or the amounts on hand were documented on the form. Staff on all three shifts signed and dated the form for the month of December including 12-19-17 when it was discovered the 11 syringes of morphine were empty.

Review of Tenant #3's file revealed an order dated 11-7-17 for morphine 20 milligram (mg)/milliliters (ml) (dosage 0.25-0.5 mg) as needed. Further review revealed two narcotic record sheets for Tenant #3's morphine: one for a

A form has been implemented that is individualized for each persons narcotic counts and is completed at the end of each shift as per medication management procedure, as it relates to Tenants #1-#4.

Start date 2/6/18. 2/6/18

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A 003	Continued From page 2 bottle and one for syringes prefilled by the nurse from that bottle. The record sheets were utilized when the drug was administered in order to keep a count of the amount on hand. The first entry on the narcotic record sheet for the bottle indicated 30 ml of morphine on hand with 1.25 ml given and 28.5 remaining. The entry was signed by the nurse and a staff. The record revealed no date documented and no notation of when and how much morphine was received from the pharmacy before the first administration of the medication. The narcotic record sheet for the prefilled syringes revealed a total of 15 syringes prefilled by the nurse on 11-7-17. Between 11-7-17 and 11-11-17 the tenant received 4 syringes of morphine leaving a total of 11 prefilled syringes. No additional syringes of morphine were prefilled or utilized prior to the discovery of 11 empty syringes on 12/19/17. Record review of the policy and procedure for loss or spillage of medications, including controlled medications, revealed lost or spilled medications should be appropriately documented and disposed of. The loss should be investigated and appropriate authorities should be contacted if needed. When loss or spillage of any medication occurred explanatory documentation should be in the tenant's record. If loss or spillage of a controlled medication, completion of the form should be signed by the person responsible and a witness. A medication error form should be completed and the nurse be notified so the required medications could be replaced and administered on a timely basis. Review of Tenant #3's record revealed no explanatory note in the record regarding the empty syringes, no medication error report, and no indication the medication had been replaced per Program	A 003	This review, as it pertained to "loss and spillage", would also be covered under counts and verified and signed @ end of shift by the RA's (Resident assistants) on duty. These reports if discrepancies are noted would be turned into the AN for immediate follow-up, as it pertained to Tenant #3. Start date 2/6/18.	2/6/18

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A 003	Continued From page 3 policy. The Program's policy and procedure for controlled substances indicated when pharmacy delivered a controlled substance, staff should verify the delivery and the quantity delivered. The staff and the delivery driver should sign the manifest. The nurse or designated staff who accepted the delivery should complete the initial count of the medication with another staff. The controlled substance should be placed in a designated locked compartment separate from non-controlled medications. During shift change med counts, two staff should count controlled medications and documented the exact count. Any discrepancies should be reported immediately to the nurse. The licensed nurse should verify the count of the controlled drugs each time they set up the tenant's medications. Tenant #3's narcotic record sheet for the bottle of morphine failed to include the initial amount of the drug, or when it was delivered by the pharmacy. When interviewed on 1-31-18 at 10:10 a.m., the Nurse confirmed when staff completed the narcotic count, they failed to check if the syringes had liquid in them. The syringes for Tenant #3 were not re-filled after it was discovered they were empty. 2. Review of Tenant #1's December 2017 Medication Administration Record (MAR) revealed 13 times when staff administered as needed (PRN) medication failed to document the effectiveness or follow up of the medication. In addition, Tenant #1's MAR reflected an order	A 003	Cont... the form also indicates the initial count, verification of check in staff and a dual signature to assure accuracy of the incoming narcotic and its count as it pertains to Tenant #3. Cont. (Start date 2/14/18.) (Weekly) MAR audits for PRN follow-up have been initiated by the RN in response to Section. 2 Affecting Tenants #1-#4.	2/14/18

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A 003	Continued From page 4 for Lorazepam one tablet orally every eight hours as needed; however,the order failed to indicate the reason for the PRN medication. Tenant #2's January 2018 MAR reflected staff administered a PRN medication 11 times and failed to document the effectiveness or follow up of the medication. Tenant #2's MAR reflected an order for Tramadol one tablet two to three times per day as needed for pain. The order provided the frequency the medication could be given but failed to provide a specific timeframe for administration by unlicensed staff. Tenant #3's December 2017 MAR reflected an order for morphine concentrate 0.25 to 0.5 mg sublingually as needed for shortness of breath or pain. The physician's order dated 11-7-17 reflected morphine concentrate 20 mg/ml, (0.25-0.5) every hour as needed for shortness of breath or pain. The December MAR failed to direct the staff how often the medication could be administered. The Program's policy and procedure for the administration of PRN medications indicated the registered nurse should review PRN prescriptions to ensure the prescription clearly identified symptoms for which the medication was prescribed, the frequency allowed, the dose and the route. If delegated to unlicensed staff the prescription should not indicate a range. The policy and procedure regarding the documentation of medication management services indicated the nurse should complete a form for each PRN medication prescribed for a tenant. The staff should notify the nurse of the	A 003		

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A 003	Continued From page 5 administration of the PRN medication and any time frame for follow up to determine the medication'seffectiveness. When interviewed on 1-31-18 at 10:10 a.m., the Nurse confirmed the staff failed to follow up an hour after administration of a PRN medication. 3. When interviewed on 1-24-18 at 9:52 a.m. Staff G reported in absence of the nurse staff wrote the orders on the medication administration records (MARs). Staff G also reported she had not been trained to transcribe orders. Interview with Staff H on 1-24-18 at 1:21 p.m. revealed staff had written an order on the MAR for Tenant #4's eys drops. Staff H reported she had not been trained to transcribe orders. When interviewed on 1-31-18 at 10:10 a.m. the Nurse explained orders were normally transcribed by her or a corporate nurse. There were one to two instances when staff had sent her a picture of the order and staff transcribed it on the MAR. Record review revealed the Program's policy and procedure for requesting and receiving medications indicated the nurse should have made any changes to the MAR immediately after the receipt of a prescription for a change in medication or a new medication.	A 003	cont: transcription of orders... 3. Nursing will transcribe w/ work w/ pharmacy to obtain a printed order for MAR's. Completed on 3/9/18 (to update pharmacy contract.)	3/9/18
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	A 055		

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A 055	Continued From page 6 fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record the Program failed to provide a sufficient number of trained staff at all times to fully meet tenants' identified needs. This potentially affected all tenants (Tenants #1 - #32). Findings follow: 1. Record review of the ALP(Assisted Living Program) Monitoring Entrance Form revealed 25 tenants resided in general population and 7 tenants in memory care for a total of 32. The form staff listed two staff on first and second shifts and one on third shift in the general population area of the Program. One staff worked each shift in memory care. 2. When interviewed on 1-24-18 at 9:52 a.m. Staff G reported not enough staff on first shift and tenants did not receive the cares needed. Although cares were being provided, they were not always done in a thorough manner. Staff G said Tenant #2 (who lived in the general population) had complained staff did not provide perineal care on third shift. During an interview on 1-24-18 at 1:21 p.m. Staff H reported not enough staff on third shift and the need for an additional staff from 6:00 a.m. to 10:00 a.m. on first shift. Staff H said Tenant #2 had complained he/she had not received perineal care on third shift as staff rushed too fast. When interviewed on 1-24-18 at 2:35 p.m. Staff I	A 055		

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A 055	Continued From page 7 reported Tenant #2 needed assistance to get to the bathroom overnight. The tenant had been incontinent of urine and stool and staff had not responded to Tenant #2's pendant twice in the past month. When interviewed on 1-25-18 at 9:34 a.m., Staff J reported there not enough staff on the night shift. An ambulance had to be called at least once per month to assist a tenant off the floor. Staff J believed there needed to be a second staff on third shift. 3. Review of the tenants' pendant response history from 1-18-18 to 1-25-18 revealed over 25 times the pendant response was greater than 15 minutes, including times that exceeded 30 minutes. This occurred primarily during the late night, overnight, and early morning hours. In addition, pages for assistance occurred and Program staff failed to respond at all. Review of the pendant response history for Tenant #2 from 1-1-8 to 1-25-18 revealed pendant response greater than 15 minutes on at least 30 occasions, and in some cases over 30 minute response time. Pages also occurred with no response at all. Examples included: a. On 1-11-18 at 11: 37 p.m. the pendant request announced 9 times and staff failed to respond. On 1-12-18 at 12:24 a.m. the pendant request announced 9 times and staff again failed to respond. On 1-12-18 at 1:12 a.m. the pendant sounded but staff responded 33 minutes later. b. On 1-16-18 at 4:24 a.m. the the tenant pushed the pendant 9 times and as of 5:09 a.m. staff failed to respond. On 1-16-18 at 5:10 a.m. the tenant pendant request announced 9 times and staff failed to respond as of 5:55 a.m.	A 055	Start date 2/6/18. Pendant Response audit implemented. - Audit completed daily by RN, - Response - expectation of 3-5 minutes - any overage in time must have a response form attached w/ - an explanation of why response was outside of the expected time are overage responses are followed upon - by RN, as it pertains to tenants #1-33	2/6/18

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A 055	Continued From page 8 c. On 1-22-18 at 10:45 p.m. the pendant announced 9 times and staff failed to respond as of 11:30 p.m. On 1-23-18 at 12:09 a.m. the pendant request announced 9 times and staff failed to respond as of 12:54 a.m. On 1-23-18 at 4:34 a.m. the pendant request announced 9 times and as of 5:19 a.m. staff failed to respond.	A 055		
A 059	481-67.9(4)b 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: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received nurse delegated training on tasks within 30 days of employment for 4 of 6 staff reviewed (Staff B, C, D and F). Findings follow: 1. Record review revealed Staff B's hire date as 7-11-17. The Nurse signed the Resident Assistant Basic Skills Annual Review document (nurse delegation document) dated 8-4-17. Staff B did not sign the document until 10-13-17.	A 059	Start 2/6/18. training is now tracked upon date of hire, in house, by [redacted], RN and is an essential job duty for her position. this duty was out sourced previously.	2/6/18

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A 059	Continued From page 9 2. Record review revealed Staff C's hire date as 6-21-17. The Nurse signed the Resident Assistant Basic Skills Annual Review document on 6-29-17. Staff C did not sign the document until 1-5-18, more than 6 months after the hire date. 3. Record review revealed Staff D's hire date as 7-11-17. The Nurse and Staff D signed the Resident Assistant Basic Skills Annual Review document on 11-27-17, almost 5 months after the hire date. 4. Record review revealed Staff F's hire date as 5-17-17. The Nurse and Staff F signed the Resident Assistant Basic Skills Annual Review document on 11-20-17, more than [redacted] months past the hire date. When interviewed on 1-24-18 at approximately 3:15 p.m. the Corporate Director of Training and Support confirmed the Nurse failed to train nurse delegations within 30 days of their employment.	A 059		
A 060	481-67.9(4)c 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: c. Training for noncertified staff shall include, at a minimum, the provision of activities of daily living and instrumental activities of daily living.	A 060	Same as A059...	2/6/18

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A 060	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide training on activities of daily living (ADLs) for 5 of 6 non-certified staff reviewed (Staff A, B, C, E and F). Findings follow: 1. Record review revealed Staff A's hire date as a universal worker as 9-29-17 . The Nurse signed the Resident Assistant Basic Skills Annual Review document on 10-22-17. 2. Record review revealed Staff B's hire date as a universal worker as 7-11-17. The Nurse signed the Resident Assistant Basic Skills Annual Review document dated 8-4-17. 3. Record review revealed Staff C's hire date as a universal worker as 6-21-17. The Nurse signed the Resident Assistant Basic Skills Annual Review document on 6-29-17. 4. Record review revealed Staff E's hire date as a universal worker as 8-16-17. The Nurse signed the Resident Assistant Basic Skills Annual Review document on 8-24-17. 5. Record review revealed Staff F's hire date as a universal worker as 5-17-17. The Nurse signed the Resident Assistant Basic Skills Annual Review document on 11-20-17. In addition, the training documents for Staff A, B, C, E, and F failed to include training in all ADLs including transfers, mobility, gait belt, and perineal care. When interviewed on1-24-18 at approximately	A 060		

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A 060	Continued From page 11 3:15 p.m. the Corporate Director of Training and Support confirmed the universal workers reviewed provided assistance with all ADLs.	A 060		
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure medications and treatments were administered as ordered for 2 of 4 tenants reviewed (Tenants #1 and #3). Findings follow: 1. Record review of Tenant #1's summary of clinic visit revealed an order for Loratadine 10 milligram, one tablet, orally daily at 8:00 a.m. According to the December 2017 medication administration record (MAR), staff failed to document the medication as administered on 12-19-17. Record review revealed Tenant #3's physician order dated 12/26/17 to change the dressing on the right elbow daily and as needed when the dressing saturated. The orders included to wash, pat dry, cover with telfa and secure with Coban. According to the December MAR, the dressing	A 147	covered under PRN's + MAR audits - dressing orders...	3/9/18

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A 147	Continued From page 12 change should have occurred daily at 7:00 a.m. Further review of the MAR revealed staff failed to document the dressing change from 12-27-17 through 12-31-17. 2. When interviewed on 1-31-18 at 10:10 a.m. the nurse reported she thought Tenant #3's dressing changes had been completed but not charted on the MAR.	A 147	started 2/6/18. Same as A104 insert: Dependent adult Abuse training,* was completed w/in five year requirement but was not completed w/in hiring requirements. * Now tracked on site by acting campus director, [redacted], RN	2/6/18
A 149	481-67.9(6) Staffing 481-67.9(231B,231C,231D) Staffing. (6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed dependent adult abuse training within six months of hire for 2 of 6 staff reviewed (Staff C and F). Findings follow: Record review revealed Staff C's hire date as 6-21-17. Staff C completed dependent adult abuse training on 1-5-18. Record review revealed Staff F's hire date as 5-17-17 and he completed the training on 12-18-17. When interviewed on 1-31-18 at 10:10 a.m. the Nurse confirmed no evidence of dependent adult abuse training for Staff C and Staff F.	A 149		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 037	Continued From page 13	A 037		
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 with significant change of condition on 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file revealed diagnoses of anxiety and depression. Tenant #1 staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1 resided in the memory care unit and had a service plan dated 7-17-17. No evaluations were found related to the development of the service plan. [redacted]	A 037	Start date 3/1/18 Care plan/SP conference & health assessment will be completed w/in 30 days of admissions by the agency RN, [redacted] presently, and every 90 days after that. As change of status updates are identified, the RN will determine if necessary updates or reassessment is needed and initiate meetings, care planning conferences and follow up as needed.	3/1/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	930265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 037	Continued From page 14 According to an MD (medical doctor) Contact form dated 12-12-17, Tenant #1 had bilateral edema, cellulitis in bilateral extremities and had a 12 pound weight gain. New orders included Furosemide, Keflex, sodium restriction and physical therapy (PT) wrap. Hospital records indicated on 12-15-17 Tenant #1 was directly admitted to the inpatient unit for intravenous antibiotics and diuresis due to cellulitis of the left leg. According to an MD Contact form dated 12-29-17, the wraps to the bilateral lower extremities were to continue upon discharge. According to notes written by a Physical Therapist, dated 1-10-18, staff should have assisted with putting on compression socks first thing in the morning and removed the socks at night. Lotion should have been applied every night and the socks needed to be washed out every night with mild soap and hung to dry. The Nurse noted the orders on 1-10-18. Record review revealed 90 day nurse review dated 10-16-17 indicated Tenant #1 had been having outbursts in the previous two months. Tenant # 1's outbursts worsened after a room mate moved in. Medication changes occurred and the roommate moved out due to the outbursts. A 90 day nurse review dated 1-16-18 indicated Tenant #1 an increase in outbursts and wanted to go home in the afternoons and early evenings. Further record review revealed the Nurse failed to complete evaluations when Tenant #1's	A 037	Furthermore. Consistency in nursing notes must be documented in the care plans and will be the responsibility of the agency RN to assure the entering is done as all changes occur. in status, as it pertains to all Residents #1-33.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 037	Continued From page 15 condition changed. 2. Review of Tenant #2's file revealed diagnoses including severe recurrent major depression with psychotic features, anxiety, and service plan dated 7-14-17. The file did not contain evaluations related to the development of the service plan. According to an MD Visit form dated 9-29-17, Tenant #2 gained eight pounds in the previous two weeks. Tenant #2 had trouble swallowing and his/her medications were given in applesauce. According to an MD Visit form dated 10-26-17, Tenant #2 continued to gain weight and had been sent to the emergency room (ER) twice for the weight gain. According to an MD Visit form dated 11-2-17, Tenant #2 continued to gain weight, had shortness of breath (SOB), and had been to the doctor and ER at last three times. Tenant #2 had an overnight hospital stay the weekend of 10-26-17 to help diuresis. He/she diuresed three liters and still gained weight. According to an MD Contact form dated 12-12-17, Tenant #2's weight increased 12 pounds, required a low sodium diet and increase in Lasix. According to an MD Contact form dated 12-29-17, Tenant #2 had osteoarthritis to bilateral hands and wore wrist splints at bedtime each day. New orders were received for Hydrocodone at bedtime as needed for pain.	A 037		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 037	Continued From page 16 Further record review revealed no evaluations completed when changes in condition occurred. 3. Review of Tenant #3's file revealed diagnoses including history of colon cancer, seizures post cerebral vascular accident, and a service plan dated 7-10-17. Evaluations were not found related to the development of the service plan. According to a 90 day review dated 10-23-17, Tenant #3 had a history of colon cancer, was taken to the ER with blood in his/her stool, and returned to the Program on Hospice services. Hospice provided oxygen as Tenant #3's oxygen saturation was below 90 %. Record review revealed physician's orders, dated 11-15-17 to apply Nystatin Powder to left third and fourth toes twice daily for 10 days for yeast. The orders indicated to cleanse the left third and fourth toes with wound wash, pat dry, apply Nystatin and wrap with gauze for 10 days. Further review of the file revealed physician's orders, dated 12-26-17 to change the dressing to the right elbow daily and as needed when the dressing was saturated. The orders included to wash, pat dry, cover with telfa and secure with Coban. According to a 90 day review dated 1-19-18, Tenant #3 was placed on Hospice in October and his/her condition improved. Tenant #3 began ambulating, going to exercises daily, and had no need for oxygen so it was removed from the apartment.	A 037		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 037	Continued From page 17 Evaluations were not completed as needed with the initiation of hospice services, initiation and discontinuation of oxygen, wound care and treatments and changes in ambulation. 4. Review of Tenant #4's file revealed diagnoses of hypertension, insulin dependent diabetes mellitus, and a service plan dated 7-7-17. Evaluations related to the development of the service plan were not found in the file. Further review revealed notes from a physician visit, dated 9-11-17 indicated Tenant #4 had a toe infection and started on Augmentin 500 mg twice daily for 10 days. Epsom salt soaks were also to be completed daily. Tenant #4's 90 day nurse review dated 10-16-17, noted he/she went to urgent care on 10-15-17 for a reddened and painful shoulder area. Tenant #4 left urgent care with a diagnosis of cellulitis and started Cefadroxil every 12 hours for 10 days. Evaluations were not completed when the tenant's condition changed. 5. When interviewed on 1-24-18 at approximately 3:15 p.m., the Corporate Director of Training and Support confirmed evaluations for changes in condition could not be located.	A 037		
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	A 083		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 18 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 by: Based on interview and record review Program staff failed to develop service plans based on evaluations, failed to develop service plans designed to meet the specific service needs, and failed to update service plans as needed for 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file revealed diagnoses including anxiety and depression. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1 resided in the dementia unit and had a service plan dated 7-17-17. According to an MD Contact form dated 12-12-17, Tenant #1 had bilateral edema, cellulitis in bilateral extremities and had a 12 pound weight gain. New orders included Furosemide, Keflex, sodium restriction, and physical therapy (PT) wrap. Hospital records indicated on 12-15-17 Tenant #1 was directly admitted to the inpatient unit for intravenous antibiotics and diuresis due to cellulitis of the left leg.	A 083	Start date 3/1/18. 3/1/18 Service Plan review/ development has been completed for tenants #1-#4. All have been designed to meet the specific service needs of the tenants.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 19 According to an MD Contact form dated 12-29-17, the physical therapy wraps to bilateral lower extremities were to continue. According to notes written by the PT, dated 1-10-18,staff should have assisted with putting on compression socks first thing in the morning and removed the socks at night. Lotion was to be applied every night and the socks needed to be washed out every night with mild soap and hung to dry. The nurse noted the orders on 1-10-18. A 90 day nurse review dated 10-16-17 indicated Tenant #1 had been having outbursts in the previous couple of months. Tenant #1's outbursts worsened when a roommate moved in. Medication changes occurred and the roommate moved out due to the outbursts. A 90 day nurse review dated 1-16-18 indicated Tenant #1's outbursts increased and he/she wanted to go home in the afternoons and early evenings. The service plan did not reflect the history of cellulitis, edema, weight gain, compression hose, outbursts and interventions related to the behavior. The staff failed to base the service plan on evaluations, failed to update as needed and failed to reflect the service needs of Tenant #1. 2. Review of Tenant #2's file revealed diagnoses including severe recurrent major depression with psychotic features and anxiety. A service plan was dated 7-14-17; however, no evaluations were found related to the development of the service plan.	A 083		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 20 According to an MD Visit form dated 9-29-17, TEnant #2 was referred for an eight pound weight gain in two weeks and trouble swallowing, requiring medication be given in applesauce. According to an MD Visit form dated 10-26-17, Tenant #2 continued to gain weight and had been sent to the emergency room (ER) twice for the weight gain. According to an MD Visit form dated 11-2-17, Tenant #2 continued to gain weight and had shortness of breath (SOB). Tenant #2 had been to the doctor and ER at last three times, and stayed overnight in the hospital the weekend of 10/26/18. He/she diuresed three liters and still gained weight. According to an MD Contact form dated 12-12-17, Tenant #2's weight increased 12 pounds, requiring low sodium diet and increase in Lasix. According to an MD Contact form dated 12-29-17, Tenant #2 had osteoarthritis to the bilateral hands. Wrist splints were to be placed on his/her hands at bedtime every day. New orders were received for Hydrocodone at bedtime as needed and wrist splints. The service plan was not updated as needed and did not reflect weight gain, SOB, swallowing difficulty, wrist splints and pain medication. The service plan was not based on evaluations, was not updated as needed and did not reflect the service needs of Tenant #2. 3. Review of Tenant #3's file revealed diagnoses including history of colon cancer, seizures post	A 083		

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	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 21 cerebral vascular accident, and service plan dated 7-10-17. No evaluations were found related to the development of the service plan. According to 90 day review dated 10-23-17, Tenant #3 had a history of colon cancer and was taken to ER with blood in his/her stool. Tenant #3 was placed on Hospice services and returned to the Program. Hospice provided oxygen as Tenant #3's oxygen saturation was below 90 %. Physician's Orders dated 11-15-17 indicated to apply Nystatin Powder to left third and fourth toes twice daily for 10 days for yeast. The orders indicated to cleanse the left third and fourth toes with wound wash, pat dry, apply Nystatin and wrap with gauze for 10 days. Physician's Orders dated 12-26-17 indicated to change the dressing to the right elbow daily and as needed when the dressing was saturated. The orders included to wash, pat dry, cover with telfa and secure with Coban. According to 90 day review dated 1-19-18, Tenant #3 had swelling of feet and legs, used a wheelchair, and placed on Hospice in October, and then improved. Tenant #3 resumed ambulation and attended exercises daily. The oxygen was removed from the apartment. The service plan did not reflect hospice services, initiation and discontinuation of oxygen, wound care and treatments and changes in ambulation. The service plan was not based on evaluations, was not updated as needed and did not reflect the service needs of Tenant #3. 4. Review of Tenant #4's file revealed diagnoses	A 083		

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	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

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TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

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A 083	Continued From page 22 including hypertension, insulin dependent diabetes mellitus, and service plan dated 7-7-17. No evaluations were found related to the development of the service plan. According to a document in Tenant #4's file dated 9-11-17, Tenant #4 had a toe infection. Augmentin was ordered twice daily for 10 days. Epsom salt soaks daily were to be completed. According to 90 day nurse review dated 10-16-17, Tenant #4 went to urgent care on 10-15-17 for reddened and painful shoulder area and diagnosed with cellulitis. Tenant #4 started Cefadroxil every 12 hours for 10 days. The service plan did not reflect the cellulitis of the shoulder and treatment or the toe infection and treatment. The service plan was not based on evaluations, was not updated as needed and did not reflect the service needs of Tenant #4. 5. When interviewed on 1-24-18 at approximately 3:15 p.m., the Corporate Director of Training and Support confirmed service plans did not address tenants' needs.	A 083	start date 3/1/18.	3/1/18
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 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.	A 086	Service Plans will be reviewed and any tenants with change of status will have planning meetings scheduled. →	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	809 HWY 150 N WEST UNION, IA 52175

(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 086	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain signatures by all parties on service plans for 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file revealed the service plan dated 7-17-17 was not signed by Tenant #1 or Tenant #1's legal representative or a health-care or human-service professional. 2. Review of Tenant #2's file revealed the service plan dated 7-14-17 was not signed by Tenant #2 or Tenant #2's legal representative or a health-care or human-service professional. 3. Review of Tenant #3's file revealed the service plan dated 7-10-17 was not signed by Tenant #3 or Tenant #3's legal representative or a health-care or human-service professional. 4. Review of Tenant #4's file revealed the service plan dated 7-7-17 was not signed by Tenant #4 or Tenant #4's legal representative or a health-care or human-service professional. 5. Interview with the Corporate Director of Training and Support on 1-24-18 at approximately 3:15 p.m. confirmed signed service plans could not be located.	A 086	at these meetings) all changed/updated plans will be signed by the tenant and the their legal representative or health care or human-service professional as applicable. This pertains to tenants #1-#4.	

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A 096	Continued From page 24	A 096	start date 3/1/18. Same as A086 only health care/health assessment specific and updated at a minimum of every 90 days, this is pertaining to tenants #1-#4.	3/1/18
A 096	481-69.27(1)c Nurse Review	A 096		

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(1)c 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 interview and record review the Program failed to complete nurse reviews every 90 days for 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow:

1 Review of Tenant #1's file revealed an admission date of 1-16-15. The service plan indicated Tenant #1 received personal and health-related care. Nurse reviews were completed on 1-16-18 and 10-16-17 (90 day reviews). The previous nurse review located in Tenant #1's file was dated 7-25-16.

2. Review of Tenant #2's file revealed an admission date of 11-25-09. The service plan indicated Tenant #2 received personal and

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TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 25 health-related care. Nurse reviews were completed on 11-16-17 (post hospitalization), 10-24-17 (hospitalization) and 10-16-17 (90 day). The previous nurse review located in Tenant #2's file was dated 9-12-16. 3. Review of Tenant #3's file revealed an admission date of 6-24-11. The service plan indicated Tenant #3 received personal and health-related care. Nurse reviews were completed on 1-19-18 and 10-23-17 (90 day). The previous nurse review located in Tenant #3's file was dated 11-17-16. 4. Review of Tenant #4's file revealed an admission date of 12-18-09. The service plan indicated Tenant #4 received personal and health-related care. Nurse reviews were completed on 1-16-18 and 10-16-17. The previous nurse review located in Tenant #4's file was dated 11-17-16. 5. Interview with the Corporate Director of Training and Support on 1-24-18 at approximately 3:15 p.m. confirmed no other nurse reviews could be located.	A 096		
A 102	481-69.28(3)c Food Service 481-69.28(231C) Food service. 69.28(3) Menus shall be planned to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program: c. One hundred percent if the program provides three meals per day.	A 102		

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
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT WEST UNION	609 HWY 150 N WEST UNION, IA 52175

(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 102	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure planned menus provided 100% of the recommended dietary allowances (RDA) which potentially affected all of the tenants (Tenants #1- #32). Findings follow: 1. When interviewed on 1-24-18 the Dietary Manager reported she developed menus for meals on her own. She didn not know if the menus met the RDA requirements. She said the Program always provided meat at lunch and dinner, and used scoops to ensure serving guidelines. She also reported none of the tenants required special diets. 2. Record review of menus revealed the Program offered three meals per day, however menus had not been signed by a dietician ensuring they met the RDA.	A 102	Start date 3/1/18. Menus have been provided for the dietary Manager to utilize and have been incorporated for use at Traditions. All need to be LRD reviewed and approved, we have been in contact with Sundermon Health on 3/9/18 to arrange contracted LRD (Licensed Registered Dietician) services. Contract pending.	* Contract pending - anticipated completion date of: 3/30/18
A 104	481-69.28(5) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by:	A 104	All staff (RA's + Admin, also food service staff) will have completed orientation training on safe food handling practices and be current in the training requirements for food service by March 16th, 2018. and prior to working any scheduled shift.	

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
	S0265	A. BUILDING: _____ B. WING _____	C 01/31/2018

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A 121	Continued From page 29 approximately 3:15 p.m. revealed eight hours of dementia-specific training was not completed for the staff reviewed.	A 121		