

DEPARTMENT OF INSPECTIONS AND APPEALS

2/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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: 26 Number of tenants with cognitive disorder: 0  Memory Care Unit Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 5  TOTAL Census of Assisted Living Program for People with Dementia: 32  An initial certification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program resulted in the following regulatory insufficiencies:	A 000	<p>HEALTH FACILITIES</p> <p>JAN 25 2019</p>	
A 089	481-69.26(4)a Service Plans  481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance  This REQUIREMENT is not met as evidenced by:	A 089		<p>Plan of Correction is attached</p> <p>DD</p>

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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 089	<p>Continued From page 1</p> <p>Based on interview and record review the Program failed to develop service plans that reflected the identified needs of 3 of 4 tenants reviewed (Tenants #2, #3, and #4). Findings follow:</p> <ol style="list-style-type: none"> <li>1. Review on 12-5-18 of Tenant #2's file revealed an order for Nitrostat tablet 0.4 milligram one tablet sublingually every five minutes as needed for angina/chest pain. The tenant's service plan reflected staff administered medications, however it did not include the storage and administration of Nitrostat.</li> <li>2. Review on 12-5-18 of Tenant #3's file revealed she resided in the memory care unit. Progress Notes revealed the following:             <ol style="list-style-type: none"> <li>a. On 12-1-18 it was noted Tenant #3 started pounding on doors to go outside and multiple interventions were attempted without success.</li> <li>b. On 12-3-18 it was noted staff reported Tenant #3 had been wandering/exit seeking.</li> </ol> <p>The service plan reflected Tenant #3 paced and wandered and staff were to redirect if she went into other tenants' apartments. The service plan did not reflect exit seeking behaviors.</p> </li> <li>3. Review on 12-5-18 of Tenant #4's file revealed a physician's order dated 10-3-18 to crush medications as she had been chewing and/or spitting them in the water cup. The tenant's service plan reflected Tenant #4 took medications whole with a glass of water. The service plan did not reflect the crushed medications.</li> <li>4. When interviewed on 12-5-18 at 2:42 p.m. the Director of Nursing confirmed the service plan for Tenant #2 did not reflect Nitrostat and the service</li> </ol>	A 089		
-------	--	-------	--	--

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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 089	Continued From page 2  plan for Tenant #4 did not reflect crushed medications. She reported Tenant #3 had not been exit seeking since her spouse had been staying at the Program.	A 089		
A 096	481-69.27(1)c Nurse Review  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 as needed by a licensed nurse for 3 of 4 tenants reviewed (Tenant #1, #2, and #4). Findings follow:  1. Review of Tenant #1's file revealed Progress Notes indicating the following: a. On 9-21-18 an incident note indicated staff reported Tenant #1 was on the floor when they entered the apartment on 9-21-18 at 1:00 a.m.	A 096		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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	<p>Continued From page 3</p> <p>Tenant #1 complained of pain/discomfort in her back, right shoulder and right knee. Vitals were taken and an ice pack was placed on her knee. At approximately 11:00 a.m. an unlicensed staff followed up with Tenant #1 who continued to complain of pain/discomfort in her back and right knee. Tenant #1 was able to move around per usual. Family and the primary care provider (PCP) were notified. The PCP and family was to be notified if pain/discomfort worsened or if any changes were noted. The incident note was completed by an unlicensed staff.</p> <p>b. On 10-29-18 an incident note indicated Tenant #1 had fallen on 10-28-18 and sustained a large skin tear/cut to the right arm. Tenant #1 was able to complete a full range of motion (ROM) in the limbs; however, when staff sat Tenant #1 up she complained of severe back and rib pain. Staff was instructed to call 911 and not to move Tenant #1. Tenant #1 was admitted to the hospital for pain observation and received sutures to the right forearm. The incident note was completed by an unlicensed staff.</p> <p>Continued record review revealed Incident Reports dated 9-21-18 and 10-28-18 for Tenant #1's falls had follow up completed on the Incident Reports by an unlicensed staff.</p> <p>Nurse reviews were not completed for Tenant #1 by licensed nursing staff, including with a fall that resulted in a hospitalization and sutures.</p> <p>2. Review of Tenant #2's file revealed Progress Notes indicating the following:</p> <p>a. On 10-18-18 a health status note indicated Tenant #2 was transferred to the emergency room (ER) via ambulance. Staff reported Tenant</p>	A 096		
-------	---	-------	--	--

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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	<p>Continued From page 4</p> <p>#2 was being assisted from the toilet back to her chair at 2:15 a.m. When when walking back to the chair Tenant #2 reported she was tired, took a breath, passed out and then came back to. Staff lowered her to the chair and vital signs were taken. When staff rechecked her vital signs at 3:00 a.m. she had a blood pressure of 83/58 and a pulse of 65. Staff notified the nurse on-call and were instructed to send her to the ER. An unlicensed staff followed up with the hospital and Tenant #2 was admitted for syncope and hypotension. The health status note was completed by an unlicensed staff.</p> <p>b. On 11-12-18 a health status note indicated Tenant #2 went to the ER for shortness of breath on 11-10-18. Staff helped Tenant #2 off the toilet and Tenant #2's oxygen saturation dropped to 85%. At rest it returned to 90%. Family took Tenant #2 to the ER via personal vehicle. On 11-12-18 a nurse followed up with the hospital who stated Tenant #2 was admitted for pulmonary edema and congestive heart failure. The health status note was completed by an unlicensed staff.</p> <p>Continued record review revealed an Incident Report dated 10-18-18 (regarding the incident identified above) had a follow up completed on the report by the AL Coordinator. It was indicated staff called 911 per an unlicensed staff's direction.</p> <p>Nurse reviews were not completed for Tenant #2 by licensed nursing staff, including for incidents that resulted in hospitalizations.</p> <p>3. Review of Tenant #4's file revealed Progress Notes indicating the following:</p> <p>a. On 9-14-18 an incident note indicated</p>	A 096		
-------	---	-------	--	--

**DEPARTMENT OF INSPECTIONS AND APPEALS**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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	<p>Continued From page 5</p> <p>Tenant #4 had a fall on 9-13-18. Staff witnessed the fall and reported Tenant #4 hit her head. Vital signs were taken and a neurological flow check sheet was started. An unlicensed staff. followed up on 9-14-18 and Tenant #4 was up and about per usual, denied pain or discomfort and had no injury noted. The neurological sheet was completed and discontinued on 9-14-18 as Tenant #4's vital signs were stable. The incident note was completed by an unlicensed staff.</p> <p>b. On 10-1-18 an incident note indicated Tenant #4 had a bruised eye lid and a slight headache on 9-29-18. She did not know what had happened. Tenant #4 denied pain and family was notified. An unlicensed staff followed up with Tenant #4 on 10-1-18. The tenant denied pain or discomfort and was up and about per usual. There was a reddened bruised area on the right eyelid. The PCP was notified. The incident note was completed by an unlicensed staff.</p> <p>c. On 11-29-18 an incident note indicated Tenant #4 had a fall that morning. Staff completed ROM and got her up off the floor. Tenant #4 complained of increased discomfort in her shoulder and back, which was normal for her. Tenant #4 was up and about per her usual. The PCP was notified of the fall and a request for something for additional increased discomfort was made. The incident note was completed by an unlicensed staff.</p> <p>An incident report dated 9-13-18 (regarding the incident noted above) had a follow up completed on the report by an unlicensed staff, including the initiation and discontinuation of the neurological flow sheet.</p> <p>Incident reports dated 9-29-18 and 11-29-18 (regarding the incidents noted above) had a</p>	A 096		
-------	---	-------	--	--

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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	<p>Continued From page 6</p> <p>follow up completed on the reports by unlicensed staff.</p> <p>Nurse reviews were not completed for Tenant #4 by licensed nursing staff, including for an incidents where Tenant #4 hit her head, had an injury of unknown etiology and an incident when the PCP was contacted for additional pain management.</p> <p>4. Continued record review revealed there were 19 incident reports between 9-9-18 and 11-29-18. Of the 19 reports, 15 incident reports had follow up completed by unlicensed staff and 4 incident reports had follow up completed by the Director of Nursing (DON).</p> <p>Further record review revealed a program document indicating the Assisted Living Coordinator (an unlicensed staff) was delegated by the DON to notify her when she was on-call when a tenant had fallen, fallen and sustained an injury, was ill or when a tenant was sent to the hospital for any reason. The Assisted Living Coordinator signed the document dated 7-5-18.</p> <p>5. When interviewed on 12-5-18 at 2:42 p.m. the DON reported the Assisted Living Coordinator was on-call regarding staffing issues and would notify the DON per the document that was signed (noted above). She reported the Assisted Living Coordinator did not assess tenants.</p>	A 096		
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</p>	A 121		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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 121	<p>Continued From page 7</p> <p>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: Based on interview and record review the Program failed to ensure 7 of 7 staff reviewed received eight hours of dementia-specific education and training within 30 day of employment (Staff A, B, C, D, E, F and G). Findings follow:</p> <p>Record review on 12-4-18 revealed Staff A was hired on 9-4-18 and completed 5 hours and 57 minutes of dementia-specific videos and completed a case study. The documentation on the case study did not indicate the time spent for completion. Staff A did not have eight hours of dementia-specific education within 30 days of employment.</p> <p>Record review on 12-4-18 revealed Staff B was hired on 9-13-18 and completed 5 hours and 57 minutes of dementia-specific videos and completed a case study. The documentation on the case study did not indicate the time spent for completion. Staff B did not have eight hours of dementia-specific education within 30 days of employment.</p> <p>Record review on 12-4-18 revealed Staff C was hired on 9-4-18 and completed 5 hours and 57 minutes of dementia-specific videos and completed a case study. The documentation on the case study did not indicate the time spent for</p>	A 121		
-------	--	-------	--	--

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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 121	<p>Continued From page 8</p> <p>completion. Staff C did not have eight hours of dementia-specific education within 30 days of employment.</p> <p>Record review on 12-4-18 revealed Staff D was hired on 8-23-18 and completed 5 hours and 57 minutes of dementia-specific videos and completed a case study. The documentation on the case study did not indicated the time spent for completion. Staff D did not have eight hours of dementia-specific education within 30 days of employment.</p> <p>Record review on 12-4-18 revealed Staff E was hired on 9-26-18 and completed 5 hours and 57 minutes of dementia-specific videos and completed a case study. The documentation on the case study did not indicate the time spent for completion. Staff E did not have eight hours of dementia-specific education within 30 days of employment.</p> <p>Record review on 12-4-18 revealed Staff F was hired on 10-25-18 and completed 5 hours and 57 minutes of dementia-specific videos and completed a case study. The documentation on the case study did not indicate the time spent for completion. Staff F did not have eight hours of dementia-specific education within 30 days of employment.</p> <p>Record review on 12-4-18 revealed Staff G was hired on 9-6-18 and completed 5 hours and 57 minutes of dementia-specific videos and completed a case study. The documentation on the case study did not indicate the time spent for completion. Staff G did not have eight hours of dementia-specific education within 30 days of employment.</p>	A 121		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARK VISTA RETIREMENT LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 PARK VISTA DRIVE CAMANCHE, IA 52730</b>
---	--

(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 121	Continued From page 9  When interviewed on 12-4-18 at approximately 4:45 p.m. the Assistant Director confirmed all dementia education for the staff listed above was provided and the case studies averaged one hour for completion.	A 121		
-------	--	-------	--	--



132 6<sup>th</sup> Avenue South | Canton, Iowa 52732 | Main: (563) 503 - 6001

Linda Kellen  
Bureau Chief  
Adult Services Bureau  
Health Facilities Division  
Lucas State Office Building  
321 East 12<sup>th</sup> Street  
Des Moines, IA 50319-4115

HEALTH FACILITIES

JAN 25 2019

✓ 2/1/19

January 18, 2019

**RE: SOD #ROQS11 – Plan of Correction**

Dear Linda,

The following letter contains the Plan of Correction for the violation dated January 8, 2019 for Park Vista Retirement Living, 1810 Park Vista Drive, Camanche, Iowa 52730. Enclosed, please find the Statement of Deficiencies (Enclosure 1) and Plan of Correction. The Plan of Correction as stated below is in effect as of January 18, 2019 to correct the regulatory insufficiencies. All specific findings have been corrected as of January 10, 2019.

**Plan of Correction: A 089 481-69.26(4)a**

On January 16, 2019, a New Order Checklist (Enclosure 2) was created to ensure that all new orders were addressed by the Registered Nurse, the Tenant’s Service Plan is updated to reflect new orders received and to identify needs and preferences for assistance.

On January 16, 2019, a Tenant Change of Condition Report Form (Enclosure 3) was created to ensure that any deviation to the service plan is reported to the Registered Nurse for appropriate review and to ensure that service plans are individualized and appropriately identifying the needs and preferences for assistance.

On January 9, 2019, a Service Plan Audit (Enclosure 4) was created to audit Service Plans quarterly by the Registered Nurse to ensure service plans are individualized and appropriately identifying the needs and preferences for assistance.

**Plan of Correction: A096 481-69.27(1)c**

On January 16, 2019, a Fall/Incident Check List (Enclosure 5) was created to ensure that a nurse review is conducted with any significant change in condition

✓ 1/28/19

or health status for tenants receiving personal or health-related care or not receiving personal or health -related care as incidents occur.

On January 16, 2019, the AL Coordinator Job Description (Enclosure 6) was reviewed, updated, and discussed with the AL Coordinator and Director of Nursing to ensure proper knowledge of responsibilities and duties as it pertains to the Healthcare Department and Nurse Delegation. An additional signed list of duties (Enclosure 7) was also updated and reviewed with the AL Coordinator and Director of Nursing to ensure proper delegation for unlicensed staff.

A qualified representative of Park Vista Senior Housing Management, LLC will complete a monthly audit of processes to ensure compliance.

**Plan of Correction: A 121 481-69.30(1)**

On January 16, 2019, A Dementia Training Time Tracker (Enclosure 8) was created to reflect the start and end times of the Dementia videos, quizzes and Dementia Case Study. All Park Vista staff will complete dementia specific education and training in the amount of eight (8) hours/480 minutes within thirty (30) days of either employment or contract date. The designated time for the viewing the videos is 357 minutes, each quiz is approximately 10 min (12 video quizzes=approximately 120 minutes) to complete, the case study observation period is 60 min and the case study questions take approximately 60 minutes to complete.

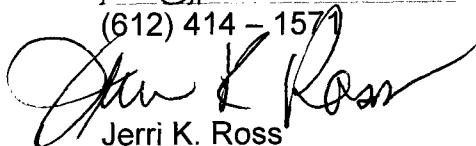
The Executive Director of Park Vista Retirement Living – Camanche, Jerri K. Ross, will audit each new hire record each month to ensure compliance.

Please let us know if you have any questions.

Sincerely,



Julie Lonergan  
President  
Park Vista Senior Housing Management, LLC.  
[julie@jplinvestments.com](mailto:julie@jplinvestments.com)  
(612) 414 – 1571



Jerri K. Ross  
Executive Director  
Park Vista Retirement Living – Camanche  
[jerri.k.ross@parkvistaliving.org](mailto:jerri.k.ross@parkvistaliving.org)  
(563) 447 – 7447

[Enclosures]