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
	S0096	A. BUILDING: ______ B. WING ______	04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEL-LIFE ASSISTED LIVING AT ALTA	705 W 7TH ST ALTA, IA 51002

(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: 24 Number of tenants with cognitive disorder: 8 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 9 Total Census of Assisted Living Program for People with Dementia: 41 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for a Dementia Specific Assisted Living Program.	A 000		
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).	A 059	1.Staff member A, B, C & F will have nurse delegation completed by the Registered Nurse (RN) on or before May 21, 2019 The delegation list has been updated to include whirlpools, dressing assistance, bathing and supervision of self-administered insulin. This was completed on May 1st, 2019 by the RN.	5-21-19

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dan Nothwehr	Exec. Director	5-3-2019

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 059	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure 4 of 4 direct care staff reviewed received delegation training within 30 days of employment (Staff A, B, C, F). Findings include: During a medication administration pass on 4-8-19 at 5:25 p.m. Staff C was observed washing her hands and putting on gloves. The staff then assisted Tenant #6 with putting her phone in the charging station using a gloved hand. Staff C instilled drops in Tenant #6's eyes without removal of the gloves after touching a contaminated surface. Staff C then administered oral medication to Tenant #6 without removing the gloves or sanitizing her hands. Record review on 4-8-19 of Staff C's training documents revealed a hire date of 1-4-19. The nurse delegation documents were signed by the Healthcare Services Director but were not dated. Staff C did not sign or date the delegation documents. The documents did not include all tasks provided including the whirlpool, dressing assistance, bathing and supervision of self-administration of insulin. Record review on 4-8-19 of Staff A's training documents revealed a hire date of 8-29-18. The nurse delegation documents were signed and dated on 12-4-18 (more than 30 days after hire) and did not include all tasks provided including the whirlpool, dressing assistance, bathing and supervision of self-administration of insulin. Record review on 4-8-19 of Staff B's file revealed	A 059	2. The Community RN was educated on 5-1-19 by the Vice President (VP) of Operations (and RN) on the delegation requirements and use of the revised form to document and sign the delegation training. The RN will complete delegation training on all new direct care staff on or before 30 days of hire date using the newly revised delegation form. 3. The ALF Executive Director (ED) or designee will perform written audits on all newly hired direct care staff to ensure that the delegation was completed on or before 30 days of hire date. 4. Completion date: 5-21-19.	

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 059	Continued From page 2 a hire date of 9-24-18. No nurse delegated training documentation could be located. Record review on 4-8-19 of Staff F's training documents revealed a hire date of 1-4-19. The nurse delegation documents signed by the Healthcare Services Director were not dated. Staff F did not sign or date the delegation documents. The documents did not include all tasks provided including the whirlpool, dressing assistance, bathing and supervision of self-administration of insulin. An interview conducted on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and the Vice President of Operations confirmed these staff were all universal workers and did not receive delegation training as required.	A 059		
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 record review and interview the Program failed to ensure dependent Adult Abuse (DAA) training was completed as required for 1 of 2 staff reviewed employed longer than six months (Staff B). Findings follow: Chapter 235B requires employees complete two	A 149	1, Staff member B will complete Dependent adult abuse training on or before 5-21-19. 2. All newly hired staff will complete Dependent adult abuse training within 6 months of employment and then 2 hours every 5 years. 3. The ED or designee will complete written audits of the required Dependent adult abuse training for all new hires. The ED will track the initial training and the 5-year training on all staff members so training is completed	5-21-19

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 149	Continued From page 3 hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every five years. Review on 4-8-19 of Staff B's training documents revealed a hire date 9-24-18. No record of dependent adult abuse training could be located. An interview with the Executive Director, the Healthcare Services Director and the Vice President of Operations on 4-9-19 at 4:12 p.m. confirmed this finding.	A 149	timely for all staff. 4. Completion date: 5-21-19	
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.	A 037	1.Tenants #1 missed evaluation is unable to be corrected as this was back in 2018. Tenant #2 service plan was updated on 5-1-19 to reflect the accurate self-administration of medications status All residents will have an RN evaluation completed within 30 days of admit and with a significant change. 2. The community RN was educated on 5-1-19 by the VP of Operations / RN, on the evaluation process. All residents will have an RN evaluation completed within 30 days of admit and with a significant change. Functional, cognitive and	5-21-19

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 037	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations with significant change for 2 of 5 tenants reviewed (Tenants #1 and #2). Findings follow: 1. Review on 4-9-19 of Tenant #1's file revealed a signed service plan dated 7-31-18. The service plan reflected Tenant #1 needed some assistance with toileting as staff reminded him to change his brief every morning and throughout the day. The service plan also reflected Tenant #1 performed grooming tasks independently and was able to dress without assistance most of the time. An unsigned service plan with a revision date of 11-13-18 reflected staff were to assist Tenant #1 to the bathroom per his preference, encourage him to go to the bathroom at least one time per the late night shift, and encourage and assist Tenant #1 with cleansing the perineal area after each incontinence episode. The revised service plan also reflected a diagnosis of spinal stenosis and interventions related to the diagnosis and functional activities. One intervention included to administer medications a half hour before treatments or care that were uncomfortable for Tenant #1. Tenant #1's March 2019 Documentation Survey Report reflected staff assisted Tenant #1 with dressing in the morning and bedtime, shaving and grooming on a daily basis. Staff also reminded the tenant to use the bathroom every 2 hours and performed safety checks on an hourly basis.	A 037	health status will be evaluated. 3. The ED or designee will complete written audits monthly x 3 months and then as needed based on results on all admits and significant changes to ensure that the evaluation was completed by the RN. 4 Completion date: 5-21-19	

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 037	Continued From page 5 Evaluations could not be located regarding the significant changes of the increase in cares including toileting, grooming and dressing as well as interventions related to the diagnosis of spinal stenosis. 2. Review of Tenant #2's file on 4-9-19 revealed the current service plan reflected self-administration of medications with assistance from her spouse. A review of the tenant's April medication administration records (MARs) reflected staff administered her oral medications and eye drops, and applied a transdermal patch once daily. An interview completed on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and the Vice President of Operations revealed staff started administering the tenant's medications in February 2019. No evaluations for this significant change could be located.	A 037		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception	A 071	1.Tenant #5 documentation and assessment is unable to be corrected as tenant #5 is discharged from the community. 2. All physician orders will be documented by the RN in the tenant's medical record at the time the orders are received. Medications and treatments will be documented in the tenant's EMAR (electronic medication administration record.)	5-21-19

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 071	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document physician ordered wound care for 1 of 1 tenants reviewed receiving wound treatment (Tenant #5). Findings follow: According to an interview with the Healthcare Services Director conducted on 4-9-19 at 4:12 p.m., Tenant #5 had two wounds, one of which was on the thoracic curve of the spine requiring treatment three times per week. The second wound was a skin tear on the calf requiring treatment twice per week. As of 4-2-19 the universal workers had stopped assisting with Duoderm dressing changes on the thoracic spine as the Healthcare Services Director began doing the treatment. The Healthcare Services Director completed the treatment on the tenant's calf twice per week. Tenant #5 was seen at the wound clinic weekly for both wounds. Review on 4-9-19 of Tenant #5's file revealed diagnoses including hypoxemia and type 2 diabetes mellitus without complications. Wound care orders indicated the following: - A Physician Changes and Progress Note document dated 3-22-19 reflected an order to replace skin barrier Duoderm if it was leaking out of the edge. The document was dated 3-22-19 but not noted until 4-4-19. - A physician's Progress Note document (encounter date 4-1-19) indicated the pressure sores on Tenant #5's back did not appear to be healing with the application of Duoderm twice per week. Tenant #5 had an extremely kyphotic thoracic back where it touched the chair. She had two decubitus ulcers on the thoracic spine at	A 071	3. The VP of Operations (RN) or designee will complete written audits of tenant medical records, including physician orders and EMAR documentation on at least 3 tenant records per month x 3 months. 4. Completion date: 5-21-19	

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 071	Continued From page 7	A 071		

approximately the T6 level. One ulcer measured 1.5 centimeter (cm) and the other ulcer measured 0.8 millimeter (mm). Both were covered by Duoderm which had "liquefied and is dripping down her clothing." It was ordered to be replaced if any signs of drainage from the patch and was to be replaced twice per week. Tenant #5 had a 5 mm ulcer on the dorsal lateral left calf covered with Telfa which had some drainage. The dressing was replaced with Telfa and Bactroban and held in place with Coban. - A Change Dressing document dated 4-2-19 indicated the dressing change to the skin tear to the left posterior lower leg was twice per week and as needed. It indicated to remove the old dressing, cleanse with normal saline, pat dry, apply Prisma and Hydrofera blue ready foam and secure with sensitive skin tape.
- A Physician Changes and Progress Note document dated 4-9-19 indicated the thoracic ulcers measured 1.6 x 0.7 cm and 1.9 x 1.45 cm. The left calf ulcer measured 1.6 x 0.7 cm. The thoracic ulcers were smaller. The document indicated to continue on the current treatment plan. It was noted on 4-9-19.

Review of the tenant's March 2019 medication administration records (MARs) revealed an order for Duoderm 4x4 dressing to the upper back spinal area wound to be changed twice weekly. Direct care staff documented the completion of the task in March except on 3-9-19 which was left blank. The order dated 3-22-19 to replace the Duoderm as needed if leaking out of the edges was not reflected on the MAR.

The April 2019 MARs reflected an order for the Duoderm 4x4 dressing to the upper back spinal area wound to be changed twice weekly. The

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 071	Continued From page 8 MARs did not reflect the order dated 3-22-19 to replace the Duoderm as needed if leaking out of the edges. The April MARs did not reflect documentation of the treatment on the spinal area wound as completed by the Healthcare Services Director since 4-2-19. The March and April MARs did not reveal an order for left calf ulcer treatment or the completion of the wound treatment twice weekly by the Healthcare Services Director. An interview completed on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and the Vice President of Operations confirmed these findings.	A 071		
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 by: Based on interview and record review the Program failed to ensure service plans were developed based on evaluations, designed to meet tenant needs and updated as necessary for 5 of 5 tenants reviewed (Tenants #1, #2, #3, #4	A 083	1.Tenant #1, 2, 3 & 4 service plans will be developed and reviewed based on evaluations on or before 5-21-19. Tenant #5s service plan is unable to be corrected, as tenant #5 is discharged from the community. 2. The community RN was educated on 5-1-19 by the VP of Operations (RN) on service plan requirements based on tenant evaluations. All tenant service plans will be coordinated with the evaluation and signed and dated by the RN & tenant or representative (or per phone if unable to be at the community in person)	5-21-19

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A 083	Continued From page 9 and #5). Findings follow: 1. Review of Tenant #1's file on 4-9-19 revealed a signed service plan dated 7-31-18. The service plan was not based on evaluations as no evaluations were completed on or near 7-31-18. The service plan reflected Tenant #1 needed some assistance with toileting as staff reminded him to change his brief every morning and throughout the day. The service plan also reflected Tenant #1 performed grooming tasks independently and was able to dress without assistance most of the time. Tenant #1's March 2019 Documentation Survey Report reflected staff assisted Tenant #1 with dressing in the morning and bedtime, shaving and grooming on a daily basis. Staff also reminded the tenant to use the bathroom every 2 hours and performed safety checks on an hourly basis. An unsigned service plan with a revision date of 11-13-18 reflected staff was to assist Tenant #1 to the bathroom per his preference, encourage him to go to the bathroom at least one time per the late night shift, and encourage and assist Tenant #1 with cleansing the perineal area after each incontinence episode. The revised service plan also reflected a diagnosis of spinal stenosis and interventions related to the diagnosis and functional activities. One intervention included to administer medications a half hour before treatments or cares that were uncomfortable for Tenant #1. The revised service plan reflected an increase in cares from the signed service plan of 7-31-18, including with toileting and care interventions for	A 083	3. The ED or VP of Operations (RN) will complete a minimum of 3 written audits per month x 3 months and then as needed based on findings for service plans and evaluations. 4. Completion date: 5-21-19	

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 083	Continued From page 10 a diagnosis of spinal stenosis. No evaluations for the service plan revised on 11-13-18 could be located. The current service plan did not reflect the assistance reflected by the Documentation Survey Report including dressing, shaving, toileting reminders every two hours and hourly safety checks. 2. Review of Tenant #2's file on 4-9-19 revealed the current service plan reflected self-administration of medications with assistance from her spouse. A review of the tenant's April medication administration records (MARs) reflected staff administered her oral medications and eye drops, and applied a transdermal patch once daily. An interview completed on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and the Vice President of Operations revealed staff started administering the tenant's medications in February 2019. The tenant's service plan was not updated as needed with significant change and did not reflect staff administration of medications including oral medications, eye drops and a transdermal patch. 3. Review of Tenant #3's file on 4-9-19 revealed the April 2019 MAR reflected staff recorded blood glucose readings and documented supervision of self-administered insulin. Tenant #3's service plan signed on 6-12-18 included a goal to have no complications due to diabetes. Interventions included to complete blood sugar levels as ordered by the physician and for staff to observe the tenant draw up and insulin and administer correct dosage daily.	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 083	Continued From page 11	A 083		

An interview completed on 4-9-19 at 4:12 p.m. with the Healthcare Services Director revealed Tenant #3 completed his blood glucose check and reported the reading to staff who recorded the number on the MAR.

The service plan signed on 6-12-18 did not identify Tenant #3 completed his own blood glucose checks and staff recorded the reading.

4. Review of Tenant #4's file on 4-9-49 revealed a diagnosis of vascular dementia with behavioral disturbance. Tenant #4 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Progress Notes indicated the following:
- On 3-23-19 it was noted Tenant #4 yelled at staff because she missed breakfast after an attempt by staff to inform her of the meal previously. Tenant #4 told staff they were "lazy" and "good for nothing" and were "treating her like an animal."
- On 4-6-19 it was noted staff had opened the windows in the unit to get some fresh air. Tenant #4 and her spouse came down for the breakfast meal and Tenant #4 started yelling about the cool air coming through the windows. Tenant #4 threw her silverware across the table and "stormed" out of the dining area yelling at staff. - On 4-7-19 it was noted Tenant #4 yelled at staff because she was not made aware of the supper meal. Staff reported everyone had been out for supper.

The ALP Monitoring Entrance Form indicated Tenant #4 was a tenant who consistently refused cares.

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 083	Continued From page 12 The service plan signed on 7-31-18 was not based on evaluations as no evaluations were completed on or near 7-31-18. The service plan did not reflect Tenant #4's behaviors as noted above or the consistent care refusals or interventions related to the behavior. 5. Review of Tenant #5's file on 4-9-19 revealed diagnoses including hypoxemia and type 2 diabetes mellitus without complications. According to an interview with the Healthcare Services Director conducted on 4-9-19 at 4:12 p.m. Tenant #5 had two wounds, one of which was on the thoracic curve of the spine requiring treatment three times per week. The second wound was a skin tear on the calf requiring treatment twice per week. As of 4-2-19 the universal workers had stopped assisting with Duoderm dressing changes on the thoracic spine as the Healthcare Services Director began completing the treatment. The Healthcare Services Director completed the treatment on the tenant's calf twice per week. Tenant #5 was seen at the wound clinic weekly for both wounds. Wound care orders included dressing changes to the skin tear on the left posterior leg twice a week and as needed, and a Duoderm 4x4 dressing to the upper back to be changed twice weekly. The current unsigned service plan with a revision date of 4-4-19 reflected Tenant #5 had a pressure ulcer on the top of the kyphotic spine related to extreme curving of the spine. The service plan reflected to administer medication and treatments as ordered. The plan did not include the calf ulcer, treatment or who completed the wound care. The service plan did	A 083		

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
	S0096	A. BUILDING: ___ B. WING ___	04/09/2019

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A 083	Continued From page 13 not reflect Tenant #5 was seen at the wound clinic weekly. 6. An interview completed on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and Vice President of Operations confirmed these findings.	A 083		
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 ensure nurse reviews were completed every 90 days for 5 of 5 tenants reviewed who received personal or health-related care (Tenants #1, #2, #3, #4 and #5). Findings follow: Record review on 4-9-19 revealed Tenant #1	A 096	1.Tenant #1, 2, 3 & 4 will have a quarterly (or change in condition) evaluation completed on or before 5-21-19. Tenant #5 is unable to be completed as tenant no longer lives at the community. 2. The community RN will complete tenant evaluations on each tenant every 90 days. All tenants will have an updated evaluation completed on or before 5-21-19. 3.The ED or VP of Operations (RN) will complete monthly audits x 3 months and then as needed based on findings on all tenants quarterly evaluations. 4.Completion date: 5-21-19	5-21-19

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 096	Continued From page 14 received personal and health-related care. Nurse reviews were completed on 1-5-18, 6-29-18, 10-6-18 and 1-21-19. Nurse reviews were not completed every 90 days. Record review on 4-9-19 revealed Tenant #2 received personal and health-related care. A 30 day evaluation was completed on 12-31-18. A 90 day nurse review was due in March 2019 but was not completed. Record review on 4-9-19 revealed Tenant #3 received personal and health-related care. Nurse reviews were completed on 1-30-18, 6-12-18 and 11-9-18. Nurse reviews were not completed every 90 days. Record review on 4-9-19 revealed Tenant #4 received personal and health-related care. Nurse reviews were completed on 2-20-18 and 10-9-18. Nurse reviews were not completed every 90 days. Record review on 4-9-19 revealed Tenant #5 received personal and health-related care. Nurse reviews were completed on 2-27-18, 7-9-18, 11-2-18, 12-11-18 and 4-3-19 (in process). Nurse reviews were not completed every 90 days. An interview on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and Vice President of Operations confirmed nurse reviews were not completed as required.	A 096		
A 106	481-69.28(5)a(2) Food Service 481-69.28(231C) Food service.	A 106	1.Staff members B, D, E & F will have training completed on sanitation and safe food handling on or before 5-21-19.	5-21-19

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A 106	Continued From page 15 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. a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by: (2) Obtaining certification as a food protection professional This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff who served or prepared food completed an orientation on sanitation and safe food handling. Additionally, the Program failed to have the Dietary Services Director complete a state-approved food protection program. This pertained to 6 of 6 staff reviewed (Staff A, B, C, D, E and F). Findings follow: Review of Staff A's file on 4-8-19 revealed a hire date of 8-29-18. An orientation on sanitation and safe food handling was not completed until 11-4-18, more than two months after hire. Review of Staff B's file on 4-8-19 revealed a hire date 9-24-18. No record of an orientation on sanitization and safe food handling could be located. Review of Staff C's file on 4-8-19 revealed a hire date of 1-4-19. An orientation on sanitization and	A 106	Staff members A & C completed required training as noted in 2567, but were late per requirements. 2. All new hired staff who are responsible for food prep or service will have sanitation and food handling prior to handling food and annual in-service on food protection. All staff will have annual in-service on food protection on or before 5-21-19. The Dietary Services Manager (DSM) will be enrolled in a state approved food protection program on or before 5-21-19. 3.The ED or designee will complete written audits on new hires to ensure that sanitation and food handling training was completed prior to food handling. 4.Completion date: 5-21-19.	

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 106	Continued From page 16 safe food handling was not completed until 2-2-19, nearly one month after hire. Review of Staff D's file on 4-8-19 revealed she was the Dietary Services Director and was hired on 3-9-19. Staff D did not have an orientation on sanitation and safe food handling and did not have a current certificate as a food professional. Review of Staff E's file on 4-8-19 a hire date of 2-18-19. No record of an orientation on sanitization and safe food handling could be located. Review of Staff F's file on 4-8-19 revealed a hire date of 1-4-19. No record of an orientation on sanitization and safe food handling could be located. An interview completed on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and Vice President of Operations confirmed Staff A, B, C and F served food and Staff D and E prepared food. Food safety training was completed for Staff A and C. Staff D was not currently enrolled in a food protection course.	A 106		
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	1.Staff members A, B, E & F will complete the required 8 hours dementia education on or before 5-21-19. 2. All newly hired staff members will complete the required 8 hours of dementia education within 30 days of employment.	5-21-19

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 121	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete eight hours of dementia-specific education and training as required for 4 of 5 staff reviewed employed longer than 30 days (Staff A, B, E and F). Findings follow: Review of employee files on 4-8-19 revealed the following: - Staff A was hired on 4-8-19. - Staff B was hired on 9-24-18. - Staff E was hired on 2-18-19. - Staff F was hired on 1-4-19. None of these staff had eight hours of dementia specific training located in their file An interview on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and Vice President of Operations confirmed this finding.	A 121	3.The ED or designee will audit all newly hired associates at or before 30 days of hire date to ensure that the 8 hours of dementia education was completed and documented. 4.Completion date: 5-21-19.	
A 138	481-69.32(2) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation and interview the Program	A 138	1.All residents are potentially at risk. No resident elopements have occurred as a results of these doors not being alarmed. 2. All 6 courtyard exits will be alarmed on or before 5-21-19. Work was evaluated by an outside contractor on 4-30-19 and will be completed on or before 5-21-19 by that contractor.	5-21-19

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 138	Continued From page 18 failed to have an operating alarm system connected to each exit door in a dementia-specific program. This potentially affected all tenants of the Program (census of 41 tenants). Findings follow: Observations on 4-8-19 at approximately 2:45 p.m. and on 4-9-19 at approximately 3:45 p.m. revealed the building had two courtyards. Each courtyard had three doors to the interior of the building. The exit doors to the courtyards were not alarmed (six doors total). The courtyards were surrounded by the structure and did not have a gate or a way to leave the area. When interviewed on 4-9-19 at 9:33 a.m. the Maintenance Director confirmed there were three doors in each courtyard and the doors were not alarmed. An interview on 4-9-19 at 4:12 p.m. with the Executive Director, the Healthcare Services Director and Vice President of Operations confirmed the exit doors to the courtyards were not alarmed.	A 138	3.ED will monitor work progress to ensure work is completed timely and according to the estimate. 4.Completion date: 5-21-19.	