V 10/25/18

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FORM APPROVED

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
	S0228	A. BUILDING: _____ B. WING _____	C 09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 F AVENUE NW CEDAR RAPIDS, IA 52405

(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. Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 50 Total Census of Assisted Living Program for People with Dementia: 51 The investigation of Complaint #77741-C resulted in the following regulatory insufficiencies:	A 000		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide services, care, and treatment that were adequate and appropriate for 2 of 6 tenants reviewed (Tenants #5 and #6). Findings follow: 1. Review of Incident Report Forms on 9-24-18 revealed an incident between Tenant #5 and #6 on 8-2-18 at 8:30 a.m. There were two Incident	A 013	Plan of Correction is attached.	

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

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A 013	Continued From page 1 Report Forms and two Witness Statements completed (one for each tenant involved). The Incident Report Form for Tenant #5 revealed the following: On 8-2-18 at 8:30 p.m., Tenant #5 blocked his door and the nurse could not get in. The nurse asked over the walkie talkie if anyone could see Tenant #6. Two staff pushed the door open. Tenant #5 was nude standing at the foot of the bed. Tenant #6 was laying on the right side of the bed with her shirt on, pants down with her underwear off. Tenant #6 was dressed and removed from the apartment. Tenant #5 had dressed and walked away. The incident was documented as reported to the Director of Nursing (DON) on 8-3-18 at 8:30 a.m. It was reported to the Tenant #5's physician on 8-3-18 at 3:00 p.m. and Tenant #5's family on 8-3-18 at 3:00 p.m. The Witness Statement for Tenant #5 revealed the following: On 8-2-18 at 8:30 p.m. staff was looking for Tenant #6 at approximately 8:30 p.m. for her evening medications. Staff remembered a prior incident of Tenant #6 being in Tenant #5's apartment. As staff opened the door, there was a chair in front of it blocking it. Tenant #5 stood nude at the foot board of his bed. Staff saw Tenant #6 laying on the right side of Tenant #5's bed with her pants and protective undergarment off. Staff called for assistance. The Incident Report Form for Tenant #6 revealed the following: On 8-2-18 at 8:30 p.m. staff pushed on Tenant #5's apartment door and could not get in. Staff asked other staff via the walkie talkie if they had	A 013		

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A 013	Continued From page 2 seen Tenant #6. Staff pushed Tenant #5's door open as there was a chair blocking it. Tenant #5 was nude at the foot of the bed and Tenant #6 was laying on the right side of the bed with her shirt on, pants were down and her underwear off. Tenant #6 was dressed and removed from the apartment. The incident was documented as reported to the DON on 8-3-18 at 8:30 a.m. It was reported to the Tenant #6's physician on 8-3-18 at 3:00 p.m. and Tenant #6's family on 8-3-18 at 3:00 p.m. The Witness Statement for Tenant #6 revealed the following: Staff looked for Tenant #6 at approximately 8:30 p.m. to administer her evening medications. Staff remembered a previous incident of Tenant #6 being in Tenant #5's apartment. As staff opened the door, a chair was blocking the door. Tenant #5 was observed standing at the foot board with his clothes removed. Staff observed Tenant #6 laying on the right side of his bed with her pants and protective undergarment off. Staff called for assistance. 2. Review on 9-24-18 of Tenant #5's file revealed the following Nurses' Notes: a. On 8-1-18 it at 9:30 p.m. it was noted Tenant #5 was nude with Tenant #6 in his apartment. Tenant #5 wanted to get into bed with Tenant #6 and when staff walked in Tenant #5 said "we are having a party." Staff took Tenant #5 out of the apartment. Tenant #6 was fully clothed when staff first walked in. b. Late entry 8-3-18 at 2:00 p.m. noted Tenant #5 was nude with Tenant #6 in his apartment. Tenant #5 wanted to get into bed with Tenant #6 when two staff walked into the bedroom. Tenant #6 had her pants and underwear down. Staff	A 013		

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A 013	Continued From page 3 brought Tenant #6 out of the apartment after assisting with dressing. After the incident there were no new orders. Tenant #5 and Tenant #6 were kept separated. c. On 8-4-18 at 1:20 p.m. it was noted 15 minute checks continued, no behaviors were noted. 3. Review on 9-24-18 of Tenant #6's file revealed the following Nurses' Notes: a. On 8-1-18 at 10:00 p.m. it was noted Tenant #6 was found in Tenant #5's apartment. Tenant #5 was nude and Tenant #6 did not try to leave his apartment. b. Late entry on 8-3-18 at 2:30 p.m. noted Tenant #6 was in Tenant #5's apartment. Tenant #5 was nude and Tenant #6 had her pants and underwear off and was laying on the right side of Tenant #5's bed. Tenant #5 was standing at the foot of the bed. Tenant #6 was fully dressed and removed from the apartment. 4. Review on 9-24-18 of Tenant #5's file revealed diagnoses including severe Alzheimer's disease, history of dementia with behavior disturbances and delusional disorder. Tenant #5 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Review of Tenant #6's file revealed diagnoses of intermittent confusion and early dementia. Tenant #6 was staged at a five on the GDS, which indicated moderately severe cognitive decline. 5. When interviewed on 9-24-18 at 11:30 a.m. and 3:10 p.m. the Administrator confirmed the incident on 8-2-18. She was unaware of the 8-1-18 incident until after learning of the incident on 8-2-18. Fifteen minute checks were started by	A 013		

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A 013	Continued From page 4 the nurse on both tenants following the incident on 8-2-18. Both families were made aware of the incident. The families decided hand holding was fine; however, they did not want them in each other's apartments. There had been no further incidents since the 15 minute checks were put into place. The Administrator revealed both tenants were able to apply and remove their own clothing and protective undergarments. An incident report was not completed related to the 8-1-18 incident. When interviewed on 9-24-18 at 4:00 p.m. the DON revealed she started an investigation after the 8-2-18 incident. She stated she was unaware of anything happening on 8-1-18 until after the 8-2-18 incident. Education was provided to staff regarding reporting to the DON. She instituted 15 minute checks on the tenants. Assessments were completed on both Tenant #5 and #6 with no concerns noted. She believed the assessments were documented in Nurses' Notes (no documentation of the assessments could be located in Nurses' Notes). Their apartments were on opposite sides of the building and they did not sit together at meals. There was no prior history between Tenant #5 and #6 and no further incidents after 8-2-18. 6. Review of check forms revealed 15 minute checks were started on both tenants on 8-3-18 and continued to the present time. However, review of the forms revealed inconsistent documentation of checks. In summary, there were two documented incidents that occurred between Tenant #5 and #6, in which one or both of the tenants were in a state of undress in Tenant #5's apartment.	A 013		

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A 013	Continued From page 5 Tenant #5 and Tenant #6 had moderately severe cognitive decline. An incident report was completed related to the incident on 8-2-18; however, an incident report was not completed related to the incident on 8-1-18. The Administrator and DON were not aware of the 8-1-18 incident until they became aware of the 8-2-18 incident. The DON was not made aware of the 8-2-18 incident until 12 hours after it occurred, on 8-3-18 at 8:30 a.m. A head to toe assessment was reportedly completed for Tenant #5 and Tenant #6 after the incident; however, documentation of the assessments was not located. As an intervention checks were put into place every 15 minutes; however, the checks were not consistently documented as completed for Tenant #5 and Tenant #6.	A 013		
A 063	481-67.9(4)f 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: f. Services shall be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide services in accordance with the training provided regarding pull cord response and resetting for 2 of 5 tenants reviewed who utilized the pull cord system (Tenants #2 and #4). Findings follow:	A 063		

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A 063	Continued From page 6 Observations throughout the investigation revealed tenant apartments were equipped with pull cord call lights. The call light system was hooked into a computer. 1. Review on 9-24-18 of Tenant #2's pull cord history revealed the following: a. On 8-20-18 at 11:25 a.m. Tenant #2's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation at 11:25 a.m. until it was reset at 11:44 p.m. The pull cord clear time indicated was greater than 12 hours. b. On 8-27-18 at 7:40 a.m. Tenant #2's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation at 7:40 a.m. until it was reset at 11:46 p.m. The pull cord clear time was approximately four hours. c. On 9-4-18 at 4:35 p.m. Tenant #2's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded approximately every 15 minutes, from activation at 4:35 p.m. until it was reset at 5:36 p.m. The pull cord clear time indicated was approximately an hour. d. On 9-9-18 at 5:47 p.m. Tenant #2's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded approximately every 15 minutes, from activation at 5:47 p.m. until it was reset at 7:03 p.m. The pull cord clear time was greater than an hour. e. Pull cord history from 9-10-18 to 9-25-18 revealed there were six times the pull cord was activated when Tenant #2 was hospitalized and not in the building (9-18-18).	A 063		

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A 063	Continued From page 7 2. Review on 9-24-18 of Tenant #4's pull cord history revealed the following: a. On 8-13-18 at 3:35 p.m. Tenant #4's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation at 3:35 p.m. until it was reset at 11:00 p.m. The pull cord clear time was greater than seven hours. b. On 8-20-18 at 7:11 p.m. Tenant #4's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation at 7:11 p.m. until it was reset at 11:42 p.m. The pull cord clear time was greater than four hours. c. On 8-21-18 at 2:36 p.m. Tenant #4's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation at 2:36 p.m. until it was reset at 3:42 p.m. The pull cord clear time was one hour. d. On 8-23-18 at 11:20 a.m. Tenant #4's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation at 11:20 a.m. until it was reset at 7:48 p.m. The pull cord clear time was greater than eight hours. e. On 9-2-18 at 6:41 p.m. Tenant #4's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation at 6:41 p.m. on 9-2-18 until it was reset at 11:30 p.m. on 9-3-18. The pull cord clear time was greater than 24 hours. f. On 9-9-18 at 9:10 p.m. Tenant #4's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation	A 063		

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A 063	Continued From page 8 at 9:10 a.m. until it was reset at 11:14 p.m. The pull cord clear time was approximately two hours. g. On 9-12-18 at 7:43 a.m. Tenant #4's pull cord was activated. It repeatedly alarmed and showed the maximum alarm time was exceeded, approximately every 15 minutes, from activation at at 7:43 a.m. until it was reset 11:40 a.m. The pull cord clear time was approximately four hours. 3. When interviewed on 9-26-18 at 11:30 a.m. and 3:30 p.m. the Administrator revealed the issue was not due to inadequate staffing. Staff reported they received the pages from the pull cords; however, oftentimes forgot to reset the system after assisting the tenant. Staff were either not resetting the pull cord at the base in the tenant apartment and/or not resetting the pull cord at the computer. The Administrator stated no concerns had been brought to her regarding pull cord response times. She indicated approximately 13 staff worked on first and second shifts on the dates noted above. Staff completed orientation when hired that included training on pendants, pull cords, and pagers. The expectation was that staff would respond immediately, within 15 minutes. Staff were to reset the pull cords after assisting tenants.	A 063		
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	A 147		

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A 147	Continued From page 9 assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications and treatments as prescribed for 5 of 6 tenants reviewed (Tenants #1, #2, #3, #4 and #6). Findings follow: 1. Review of Tenant #'1's file on 9-20-18 revealed an admission date of 6-1-18. An admission list of orders signed by the physician on 6-1-18 reflected Ensure, one bottle daily, was ordered. A Physician's Order Sheet dated 6-14-18 indicated Ensure nutritional supplements, one bottle daily, was ordered. Medication administration records (MARs) reflected the following: a. The June MAR documented a bottle of Ensure was to be given at 7:00 a.m. daily. There were no documented entries of the Ensure being given for June 2018. From 6-27-18 to 6-30-18, staff initialed and circled on the front the MAR and recorded on the back of the MAR that Ensure was not available. b. July, August and September MARs did not reflect the order of daily Ensure. 2. Review on 9-20-18 of Tenant #2's file revealed a Physician Visit document dated 8-6-18 which included an order for a low sodium diet, 1500 milligram (mg). The Program did not provide therapeutic diets; however clarification to the physician regarding the diet and the provision of a general liberalized diet was not found. The order for the low sodium diet (1500 mg) was not discontinued and at the the time of the	A 147		

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A 147	Continued From page 10 investigation was a current order. Tenant #2's Physician's Order Sheet reflected the following orders: Lasix 40mg tablet daily at 7:00 a.m., Respi Mucus two tablets once daily and Magnesium Chloride 64mg two tablets (128 mg) every morning. A Physician's Telephone Order dated 9-6-18 reflected to increase Lasix from 40 mg to 80 mg on 9-6-18 and 9-7-18. The order was signed by the physician on 9-7-18. When interviewed on 9-24-18 at 3:10 p.m. the Administrator revealed staff assisted Tenant #2 with compression hose. No order for compression hose could be located. The assistance with the compression hose was not documented as completed. Review of Tenant #2's MARS reflected the following: a. July MARs reflected three entries indicating Respi Mucus was not available to administer. b. August MARs reflected two entries indicating Respi Mucus was not available to administer. c. September MARs reflected Lasix 40mg 1 tablet daily was discontinued on 9-10-18. Lasix 40 mg twice daily (8:00 a.m. and 12:00 p.m.) was reflected on the MAR with a start date of 9-10-18. The MARs were updated on 9-10-18 to reflect changes in the Lasix; however, an order for these changes were not found. The increased dose ordered on 9-6-18 and 9-7-18 was not transcribed on the MAR and was not documented as administered for those dates. d. Magnesium Chloride 64mg 2 tablets was discontinued on 9-11-18 on the MAR. The MAR was changed to reflect Magnesium 420mg one tablet every morning dated 9-11-18. An order to	A 147		

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A 147	Continued From page 11 change the Magnesium Chloride was not found. 3. Review on 9-20-18 of Tenant #3's file revealed a Physician's Order Sheet reflecting orders to check blood glucose three times per day at meals and to call the physician if blood glucose was less than 70 or greater than 400. It also reflected Levemir 7 units was to be injected subcutaneously (SQ) at bedtime and Novolog to be injected SQ per sliding scale. Tenant #3 also had an order for compression hose to be put on in the morning and off at bedtime. A fax from the physician reflected new orders dated 8-6-18 included one can of Boost or Ensure twice daily as a meal replacement if Tenant #3 did not eat well. An order was also received to check blood glucose if Tenant #3 exhibited anger or aggression and to send results. Review of Tenant #3's MARS reflected the following: a. June MARs reflected five times blood glucose checks were not documented (6-11-18 at 12:00 p.m., 6-13-18 at 4:00 p.m., 6-17-18 at 12:00 p.m., 6-18-18 at 8:00 a.m. and 12:00 p.m.) It also reflected Levemir was not documented as given on 6-18-18 at bedtime. There were seven entries documented that indicated the compression hose could not be found. b. August MARs reflected two entries indicating the compression hose were not on when staff went to remove them at bedtime. The August MARs did not reflect the order dated 8-6-18 regarding blood glucose check when Tenant #3 exhibited anger or agitation. One can of the nutritional supplement was documented as given in August. (Tenant #3 had a 27.4 pound	A 147		

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(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 147	Continued From page 12 weight loss from June to September). c. September MARs reflected two entries indicating compression hose were not on when staff went to remove them. 4. Review on 9-20-18 of Tenant #4's file revealed Nurse's Notes dated 6-29-18 reflecting orders were received to soak left great toe in Epsom salts and water every day. Pain relief cream and fabric band-aid were to be applied. A fax from the physician indicated the order for the Epsom Salts was discontinued on 7-23-18. A Physician's Order Sheet reflected an order dated 5-15-18 for compression stockings to be put on every morning and off at bedtime. Review of Tenant #4's MARS reflected the following: a. June MARs reflected five entries indicating compression hose were not on when staff went to remove them. b. July MARs reflected nine entries indicating compression hose were not on when staff went to remove them. There were also five entries that indicated Epsom Salts were not available to soak the tenant's toe. c. August MARs reflected seven entries of the use of compression hose not occurring as ordered for various reasons including the hose had excrement on them and staff unable to locate them. d. September MARs reflected three entries indicating compression hose were not on when staff went to remove them. 5. Review on 9-24-18 of Tenant #6's file revealed a Physician's Visit form indicating an order dated 6-13-18 for extra strength Tylenol 500mg (two tablets) to be taken up to three times daily as	A 147		

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	S0228	A. BUILDING: _____ B. WING _____	C 09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 147	Continued From page 13 needed for pain. The order was transcribed on the June 2018 MAR; however, was not reflected on the July, August or September 2018 MARs. An order to discontinue the extra strength Tylenol was not found. 6. When interviewed on 9-26-18 at 11:30 a.m. the Administrator confirmed all of the MARs and orders for the tenants noted above had been provided.	A 147		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change for 6 of 6 tenants	A 037		

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A 037	Continued From page 14 reviewed (Tenants #1, #2, #3, #4, #5 and #6). Findings follow: 1. Review on 9-20-18 of Tenant #1's file revealed a service plan was not developed within 30 days of taking occupancy. In addition, Nurses' Notes revealed the following: a. On 6-5-18 it was noted a fax was sent to the physician for suggestions regarding Tenant #1's sexually inappropriate behaviors towards female tenants and staff. b. On 6-7-18 it was noted a fax was received regarding behaviors and Prozac 10 milligrams (mg) daily was ordered. Depakote Sprinkles were increased to 500 mg, orally, three times per day. c. On 6-13-18 it was noted Tenant #1 was observed on the floor on his knees in his apartment. d. On 6-14-18 it was noted Tenant #1 drank only half of the drink that his afternoon medications were in and spit out all of his night medications. e. On 6-18-18 it was noted Tenant #1 fell in his apartment while getting out of a lift chair. He complained his head hurt and a laceration was noted above the left eyebrow. Tenant #1 was sent to the hospital via ambulance and returned with five sutures. f. On 8-22-18 it was noted Tenant #1 was found lying on the tile area with a small puddle of blood on the floor. A wound on the top of his head was two centimeters in length. g. On 8-30-18 it was noted Tenant #1 made threatening statements to various people throughout the evening, tried to take another tenant's walker and attempted to hit another tenant. Tenant #1's file revealed an admission date of	A 037		

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A 037	Continued From page 15 6-1-18. The initial Health and Functional Assessment reflected a weight of 200 to 210 with a question mark. A weight recorded in Sept was 163.6. No other weights could be located. An admission list of orders signed by the physician on 6-1-18 reflected Ensure, one bottle daily, was ordered. A Physician's Order Sheet dated 6-14-18 indicated Ensure nutritional supplements, one bottle daily, was ordered. June, July and August 2018 medication administration records (MARs) reflected times when Tenant #1 refused medications. Physician's Order Sheets reflected the tenant was to wear a surgical shoe during ambulation. In addition, he was to have Povidone-Iodine Solution 10% applied to his left foot wound and covered with a band-aid daily. Continued record review revealed evaluations were last completed on 6-29-18 but were not completed with significant change including behaviors, falls, refusals of medications, possible weight loss and nutritional supplement, the surgical shoe when ambulatory and the treatment to the left foot. 2. Record review on 9-20-18 of Tenant #2's file revealed a service plan was not developed within 30 days of taking occupancy. In addition, Nurse Reviews indicated the following: a. A Nurse Review dated 5-29-18 reflected Tenant #2 fell on 5-28-18. No injuries were noted. b. A Nurse Review dated 7-19-18 reflected Tenant #2 fell on 7-18-18. A skin tear was noted on the left forearm and two skin tears to the left elbow.	A 037		

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A 037	Continued From page 16 c. A Nurse Review dated 8-8-18 reflected Tenant #2 fell on 8-4-18. No injuries were noted. d. A Nurse Review dated 8-14-18 reflected Tenant #2 fell on 8-13-18. Nurse's Notes indicated the following: a. On 7-12-18 and 7-13-18 it was noted a new order was received for antibiotic for a urinary tract infection (UTI). b. On 7-19-18 it was documented the tenant had a seven pound weight gain between 7-1-18 and 7-19-18 and an increase in edema in bilateral lower extremities (BLE) was noted. The physician was made aware. Review of a Physician's Order Sheet dated 9-13-18 reflected an order for a can of a nutritional supplement daily. The physician's orders on admission (5-25-18) reflected a general diet. A Physician Visit document dated 8-6-18 reflected an order for a low sodium diet (1500 mg) and daily weights. The physician was to be notified if the tenant had a three pound increase in one day or a five pound increase in a week. Copies of electronic mail (e-mail) provided by the Program reflect a discussion with Tenant #2's family regarding the low sodium diet. The discussions included no added salt to food and no salt shaker on the table. His family was to bring in substitutions and review the menu for high sodium items. In addition an alternate menu would be displayed on his table for him to use. When interviewed on 9-24-18 at 3:10 p.m. the Administrator revealed staff assisted Tenant #2 with compression hose.	A 037		

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A 037	Continued From page 17 Continued record review revealed evaluations were last completed on 6-25-18 but not completed as needed with significant change including falls, a UTI, diet needs and changes, increased edema, weight gain, compression hose, a daily supplement and daily weights with parameters. 3. Record review on 9-20-18 of Tenant #3's file revealed a service plan was not developed within 30 days of taking occupancy. In addition, Nurse Reviews revealed the following: a. A Nurse Review dated 6-16-18 revealed an antibiotic was ordered for a UTI. b. A Nurse Review dated 7-12-18 revealed a fall occurred on 7-11-18. Tenant #3 complained of lower back pain. c. A Nurse Review dated 7-20-18 revealed an antibiotic was ordered for a UTI. d. A Nurse Review dated 8-6-18 revealed Tenant #3 had an altercation with another tenant. On 8-2-18 Tenant #3 had a verbal altercation with another tenant who became angry and struck Tenant #3 on the right cheek. Both tenants were separated and no injuries were noted. On 8-3-18 Tenant #3 struck/punched the other tenant on the shoulder as he sat eating dinner. e. A Nurse Review dated 8-14-18 revealed Tenant #3 had a fall on 8-12-18. No injuries were noted. July, August and September 2018 MARs reflected several instances of Tenant #3 refusing medications and treatments. A fax from the physician reflected new orders dated 8-6-18 including one can of Boost or Ensure twice daily as a meal replacement if	A 037		

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A 037	Continued From page 18 Tenant #3 did not eat well. An order was also received to check blood glucose if Tenant #3 exhibited anger or aggression and to send results. Monthly Vitals and Weights document reflected a 27.4 pound weight loss from June 2018 to September 2018. A Physician's Order Sheet dated 9-13-18 reflected an order for compression hose to be worn daily. Continued record review revealed evaluations were last completed on 7-6-18 but were not completed as needed with significant change including falls, behaviors, UTIs, medication refusals, compression hose, weight loss and a nutritional supplement. 4. Record review on 9-20-18 of Tenant #4's file revealed a service plan was not developed within 30 days of taking occupancy. In addition, Nurse Reviews revealed the following: a. A Nurse Review dated 5-7-18 revealed Tenant #4 was found sitting on the floor yelling for help. It was the first time Tenant #4 had been found on the floor and he had experienced anxiety since coming to the Program on 5-1-18. b. A Nurse Review dated 5-16-18 revealed Tenant #4 was diagnosed with a deep vein thrombosis (DVT) to the left lower extremity (LLE) and was started on Xarelto. When compression stockings were placed on 5-15-18, the LLE was noted to be slightly more swollen than the right lower extremity. A quarter sized firm purple area to the LLE and 1-2 pitting edema were noted. Tenant #4 was transported to the emergency room and returned with the above	A 037		

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A 037	Continued From page 19 diagnosis and order. c. A Nurse Review dated 6-5-1-8 revealed Tenant #4 sustained a fall. He suffered a skin tear to the left forearm. d. A Nurse Review dated 7-20-18 indicated Tenant #4 touched a female tenant on her arms and legs. Tenant #5 witnessed it and saw the female tenant upset. Tenant #5 slapped Tenant #4 on the abdomen and told him to leave her alone. Tenant #4 and Tenant #5 swatted at each other and then Tenant #5 pushed Tenant #4 and he fell to the ground. The altercation was broken up by staff. There were no injuries sustained. Both tenants were separated and redirected. e. A Nurse Review dated 8-6-18 indicated on 8-3-18 Tenant #4 walked over to a female tenant and kissed her hands and then kissed her on the lips. The tenants were separated and no injuries occurred. Continued record review revealed Nurse's Notes dated 6-29-18 reflected orders were received to soak the left great toe in Epsom salts and water every day. Pain relief cream and a fabric band-aid was to be applied. Cephalexin 500mg three times a day was also ordered. A fax to the physician indicated the order for the Epsom Salts was discontinued on 7-23-18. A Physician's Order Sheet reflected an order dated 5-15-18 for compression stockings to be worn daily. Further record review revealed evaluations were last completed on 5-31-18 but were not completed as needed with significant change including for diagnosis of a DVT and a new order for Xarelto, falls, behaviors, treatment to the left great toe and compression stockings.	A 037		

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A 037	Continued From page 20 5. Review on 9-24-18 of Tenant #5's file revealed diagnoses including severe Alzheimer's disease, history of dementia with behavior disturbances and delusional disorder. Tenant #5 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. A Nurse Review dated 7-20-18 indicated Tenant #5 had an altercation with another tenant. Tenant #4 tenant touched a female tenant on her arms and legs. Tenant #5 witnessed it and saw the female tenant upset. Tenant #5 slapped Tenant #4 on the abdomen and told him to leave her alone. Tenant #4 and Tenant #5 swatted at each other and then Tenant #5 pushed Tenant #4 and he fell to the ground. There were no injuries sustained. Both tenants were separated and redirected. Review of Incident Report Forms revealed an incident occurred between Tenant #5 and #6 on 8-2-18 at 8:30 a.m. The two were found in Tenant #5's apartment with the door blocked shut. When staff were able to access the apartment, they noted Tenant #5 standing nude at the foot of the bed. Tenant #6 was laying on the right side of the bed with her shirt on, pants down with her underwear off. The tenant's Nurses' Notes revealed the following: a. On 8-1-18 it at 9:30 p.m. it was noted Tenant #5 was nude with Tenant #6 in his apartment. Tenant #5 wanted to get into bed with Tenant #6 and when staff walked in Tenant #5 said "we are having a party." Staff took Tenant #5 out of the apartment. Tenant #6 was fully clothed when	A 037		

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A 037	Continued From page 21 staff first walked in. b. Late entry 8-3-18 at 2:00 p.m. noted Tenant #5 was nude with Tenant #6 in his apartment. Tenant #5 wanted to get into bed with Tenant #6 when two staff walked into the bedroom. Tenant #6 had her pants and underwear down. Staff brought Tenant #6 out of the apartment after assisting with dressing. After the incident there were no new orders. Tenant #5 and Tenant #6 were kept separated today. Further record review revealed evaluations were not completed as needed with significant change after altercation the altercation with Tenant #4 and the incidents with Tenant #6. 6. Review on 9-24-18 of Tenant #6's file revealed diagnoses of intermittent confusion and early dementia. Tenant #6 was staged at a five on the GDS, which indicated moderately severe cognitive decline. An Incident Report Form for Tenant #6 revealed on 8-2-18 at 8:30 p.m. she was found on the bed in a state of undress in Tenant #5's apartment as he stood naked nearby. Staff helped her dress and escorted her from the apartment. Further record review revealed evaluations were not completed as needed after the incidents with Tenant #5. 7. When interviewed on 9-26-18 at 11:30 a.m. the Administrator confirmed all evaluation documents were provided for the tenants noted above.	A 037		
A 085	481-69.26(3) Service Plans 481-69.26(231C) Service plans.	A 085		

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A 085	Continued From page 22 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days and as needed with significant change for 6 of 6 tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6). Findings follow: 1. Review on 9-20-18 of Tenant #1's file revealed a service plan was not developed within 30 days of taking occupancy. In addition, Nurses' Notes revealed the following: a. On 6-5-18 it was noted a fax was sent to the physician for suggestions regarding Tenant #1's sexually inappropriate behaviors towards female tenants and staff. b. On 6-7-18 it was noted a fax was received regarding behaviors and Prozac 10 milligrams (mg) daily was ordered. Depakote Sprinkles were increased to 500 mg, orally, three times per day. c. On 6-13-18 it was noted Tenant #1 was observed on the floor on his knees in his apartment. d. On 6-14-18 it was noted Tenant #1 drank only half of the drink that his afternoon medications were in and spit out all of his night medications. e. On 6-18-18 it was noted Tenant #1 fell in his apartment while getting out of a lift chair. He complained his head hurt and a laceration was	A 085		

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A 085	Continued From page 23	A 085		

noted above the left eyebrow. Tenant #1 was sent to the hospital via ambulance and returned with five sutures.

f. On 8-22-18 it was noted Tenant #1 was found lying on the tile area with a small puddle of blood on the floor. A wound on the top of his head was two centimeters in length.

g. On 8-30-18 it was noted Tenant #1 made threatening statements to various people throughout the evening, tried to take another tenant's walker and attempted to hit another tenant.

Tenant #1's file revealed an admission date of 6-1-18. The initial Health and Functional Assessment reflected a weight of 200 to 210 with a question mark. A weight recorded in Sept was 163.6. No other weights could be located. An admission list of orders signed by the physician on 6-1-18 reflected Ensure, one bottle daily, was ordered. A Physician's Order Sheet dated 6-14-18 indicated Ensure nutritional supplements, one bottle daily, was ordered.

June, July and August 2018 medication administration records (MARs) reflected times when Tenant #1 refused medications.

Physician's Order Sheets reflected the tenant was to wear a surgical shoe during ambulation. In addition, he was to have Povidone-Iodine Solution 10% applied to his left foot wound and covered with a band-aid daily.

The service plan dated 5-29-18 was not updated as needed with significant change including behaviors and interventions, falls and interventions, refusals of medications and interventions, possible weight loss and nutritional

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A 085	Continued From page 24 supplements, the surgical shoe when ambulatory and the treatment to the left foot. 2. Record review on 9-20-18 of Tenant #2's file revealed a service plan was not developed within 30 days of taking occupancy. In addition, Nurse Reviews indicated the following: a. A Nurse Review dated 5-29-18 reflected Tenant #2 fell on 5-28-18. No injuries were noted. b. A Nurse Review dated 7-19-18 reflected Tenant #2 fell on 7-18-18. A skin tear was noted on the left forearm and two skin tears to the left elbow. c. A Nurse Review dated 8-8-18 reflected Tenant #2 fell on 8-4-18. No injuries were noted. d. A Nurse Review dated 8-14-18 reflected Tenant #2 fell on 8-13-18. Nurse's Notes indicated the following: a. On 7-12-18 and 7-13-18 it was noted a new order was received for antibiotic for a urinary tract infection (UTI). b. On 7-19-18 it was documented the tenant had a seven pound weight gain between 7-1-18 and 7-19-18 and an increase in edema in bilateral lower extremities (BLE) was noted. The physician was made aware. Review of a Physician's Order Sheet dated 9-13-18 reflected an order for a can of a nutritional supplement daily. The physician's orders on admission (5-25-18) reflected a general diet. A Physician Visit document dated 8-6-18 reflected an order for a low sodium diet (1500 mg) and daily weights. The physician was to be notified if the tenant had a three pound increase in one day or a five	A 085		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 085	Continued From page 25 pound increase in a week. Copies of electronic mail (e-mail) provided by the Program reflect a discussion with Tenant #2's family regarding the low sodium diet. The discussions included no added salt to food and no salt shaker on the table. His family was to bring in substitutions and review the menu for high sodium items. In addition an alternate menu would be displayed on his table for him to use. When interviewed on 9-24-18 at 3:10 p.m. the Administrator revealed staff assisted Tenant #2 with compression hose. The service plan dated 5-25-18 was not updated as needed with significant change including falls and interventions, a UTI and treatment, increased edema, weight gain, daily weights, the nutritional supplement or compression hose. The service plan did reflect Tenant #2 was on a low sodium diet (1500 mg) and not to leave salt on the table. The additional accommodations and agreement with Tenant #2 and his family regarding the low sodium diet were not reflected in the service plan. 3. Record review on 9-20-18 of Tenant #3's file revealed a service plan was not developed within 30 days of taking occupancy. In addition, Nurse Reviews revealed the following: a. A Nurse Review dated 6-16-18 revealed an antibiotic was ordered for a UTI. b. A Nurse Review dated 7-12-18 revealed a fall occurred on 7-11-18. Tenant #3 complained of lower back pain. c. A Nurse Review dated 7-20-18 revealed an antibiotic was ordered for a UTI. d. A Nurse Review dated 8-6-18 revealed	A 085		

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
	S0228	A. BUILDING: _____ B. WING _____	C 09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 085	Continued From page 26 Tenant #3 had an altercation with another tenant. On 8-2-18 Tenant #3 had a verbal altercation with another tenant who became angry and struck Tenant #3 on the right cheek. Both tenants were separated and no injuries were noted. On 8-3-18 Tenant #3 struck/punched the other tenant on the shoulder as he sat eating dinner. e. A Nurse Review dated 8-14-18 revealed Tenant #3 had a fall on 8-12-18. No injuries were noted. July, August and September 2018 MARs reflected several instances of Tenant #3 refusing medications and treatments. A fax from the physician reflected new orders dated 8-6-18 including one can of Boost or Ensure twice daily as a meal replacement if Tenant #3 did not eat well. An order was also received to check blood glucose if Tenant #3 exhibited anger or aggression and to send results. Monthly Vitals and Weights document reflected a 27.4 pound weight loss from June 2018 to September 2018. A Physician's Order Sheet dated 9-13-18 reflected an order for compression hose to be worn daily. The service plan dated 8-6-18 was not updated as needed with significant change including falls and interventions, medication refusals and interventions, behaviors and interventions, UTIs and treatment, compression hose, weight loss and a nutritional supplement. The service plan also did not reflect the order to check Tenant #3's blood glucose if anger or aggression was	A 085		

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A 085	Continued From page 27 exhibited and to send results to the physician. 4. Record review on 9-20-18 of Tenant #4's file revealed a service plan was not developed within 30 days of taking occupancy. In addition, Nurse Reviews revealed the following: a. A Nurse Review dated 5-7-18 revealed Tenant #4 was found sitting on the floor yelling for help. It was the first time Tenant #4 had been found on the floor and he had experienced anxiety since coming to the Program on 5-1-18. b. A Nurse Review dated 5-16-18 revealed Tenant #4 was diagnosed with a deep vein thrombosis (DVT) to the left lower extremity (LLE) and was started on Xarelto. When compression stockings were placed on 5-15-18, the LLE was noted to be slightly more swollen than the right lower extremity. A quarter sized firm purple area to the LLE and 1-2 pitting edema were noted. Tenant #4 was transported to the emergency room and returned with the above diagnosis and order. c. A Nurse Review dated 6-5-1-8 revealed Tenant #4 sustained a fall. He suffered a skin tear to the left forearm. d. A Nurse Review dated 7-20-18 indicated Tenant #4 touched a female tenant on her arms and legs. Tenant #5 witnessed it and saw the female tenant upset. Tenant #5 slapped Tenant #4 on the abdomen and told him to leave her alone. Tenant #4 and Tenant #5 swatted at each other and then Tenant #5 pushed Tenant #4 and he fell to the ground. The altercation was broken up by staff. There were no injuries sustained. Both tenants were separated and redirected. e. A Nurse Review dated 8-6-18 indicated on 8-3-18 Tenant #4 walked over to a female tenant and kissed her hands and then kissed her on the lips. The tenants were separated and no injuries	A 085		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 085	Continued From page 28 occurred. Continued record review revealed Nurse's Notes dated 6-29-18 reflected orders were received to soak the left great toe in Epsom salts and water every day. Pain relief cream and a fabric band-aid was to be applied. Cephalexin 500mg three times a day was also ordered. A fax to the physician indicated the order for the Epsom Salts was discontinued on 7-23-18. A Physician's Order Sheet reflected an order dated 5-15-18 for compression stockings to be worn daily. Further record review revealed the service plan dated 4-30-18 was not updated as needed with significant change including diagnosis of a DVT and a new order for Xarelto, falls, behaviors, treatment to the left great toe and compression stockings. 5. Review on 9-24-18 of Tenant #5's file revealed diagnoses including severe Alzheimer's disease, history of dementia with behavior disturbances and delusional disorder. Tenant #5 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. A Nurse Review dated 7-20-18 indicated Tenant #5 had an altercation with another tenant. Tenant #4 tenant touched a female tenant on her arms and legs. Tenant #5 witnessed it and saw the female tenant upset. Tenant #5 slapped Tenant #4 on the abdomen and told him to leave her alone. Tenant #4 and Tenant #5 swatted at each other and then Tenant #5 pushed Tenant #4 and he fell to the ground. There were no injuries	A 085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 085	Continued From page 29 sustained. Both tenants were separated and redirected. Review of Incident Report Forms revealed an incident occurred between Tenant #5 and #6 on 8-2-18 at 8:30 a.m. The two were found in Tenant #5's apartment with the door blocked shut. When staff were able to access the apartment, they noted Tenant #5 standing nude at the foot of the bed. Tenant #6 was laying on the right side of the bed with her shirt on, pants down with her underwear off. The tenant's Nurses' Notes revealed the following: a. On 8-1-18 it at 9:30 p.m. it was noted Tenant #5 was nude with Tenant #6 in his apartment. Tenant #5 wanted to get into bed with Tenant #6 and when staff walked in Tenant #5 said "we are having a party." Staff took Tenant #5 out of the apartment. Tenant #6 was fully clothed when staff first walked in. b. Late entry 8-3-18 at 2:00 p.m. noted Tenant #5 was nude with Tenant #6 in his apartment. Tenant #5 wanted to get into bed with Tenant #6 when two staff walked into the bedroom. Tenant #6 had her pants and underwear down. Staff brought Tenant #6 out of the apartment after assisting with dressing. After the incident there were no new orders. Tenant #5 and Tenant #6 were kept separated today. Further record review revealed the service plan dated 5-22-18 was not updated as needed with significant change after the altercation with Tenant #4 and the incidents with Tenant #6, including 15 minute checks put in place by the DON.	A 085		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 085	Continued From page 30 6. Review on 9-24-18 of Tenant #6's file revealed diagnoses of intermittent confusion and early dementia. Tenant #6 was staged at a five on the GDS, which indicated moderately severe cognitive decline. An Incident Report Form for Tenant #6 revealed on 8-2-18 at 8:30 p.m. she was found on the bed in a state of undress in Tenant #5's apartment as he stood naked nearby. Staff helped her dress and escorted her from the apartment. Further record review revealed the service plan dated 6-6-18 was not updated as needed after the incidents with Tenant #5, including 15 minute checks put in place by the DON. 7. When interviewed on 9-26-18 at 11:30 a.m. the Administrator confirmed all service plan documents were provided for the tenants noted above.	A 085		
A 092	481-69.26(4)d Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by:	A 092		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 092	Continued From page 31 Based on interview and record review the Program failed to ensure service plans included planned and spontaneous activities for 3 of 6 tenants reviewed unable to plan their own activities (Tenants #1, #2, and #3). Findings follow: 1. Review on 9-20-18 of Tenant #1's file revealed diagnoses including dementia and depression. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. The service plan dated 5-29-18 did not reflect planned and spontaneous activities. 2. Review on 9-20-18 of Tenant #2's file revealed he was staged at a four on the GDS, which indicated moderate cognitive decline. The service plan dated 5-25-18 did not reflect planned and spontaneous activities. 3. Review on 9-20-18 of Tenant #3's file revealed a diagnosis of depression. Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan dated 8-6-18 did not reflect planned and spontaneous activities. 4. When interviewed on 9-26-18 at 11:30 a.m. the Administrator confirmed all service plan documents were provided for the tenants noted above.	A 092		

The Views

V 10/25/18

October 25, 2018

Department of Inspections and Appeals
Attn: Deb Dixon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of MeadowView Memory Care Village in Cedar Rapids, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report dated October 12, 2018. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Tenant Rights

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - A health, functional, and cognitive assessment will be completed for Tenants #5 and #6.
    - Intervention checks will be documented as directed by the RN and/or designee for Tenants #5 and #6.

2. What measures will be taken to ensure the problem does not recur.
    - The RN will be re-educated on regulatory requirements for completion of documentation in the clinical record, nurse reviews, and assessments.
    - Staff will be re-educated on documentation requirements.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will audit tenant charts and documentation at least two times per year to ensure regulatory compliance.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by November 12, 2018.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Staff will respond to and reset pull cords for Tenants #2, #4

2. What measures will be taken to ensure the problem does not recur.
    - Staff will be retrained on responding to and resetting the pull cord system.

DD 10/25/18

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will audit pull cord response log at least quarterly to ensure regulatory compliance.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by November 12, 2018.

Medications

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #1, #2, #3, #4, and #6 will have medications administered as directed by the physician.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and/or Designee will be re-educated on processes related to medication administration. This will include review of processes related to receiving orders, noting orders, adding new orders to the MAR, and review of MARs received from the pharmacy.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will audit MARs at least every 90 days when completing a 90-day nurse review to ensure regulatory compliance. This process will include reviewing medications to ensure orders are current.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by November 12, 2018.

Evaluation of Tenant

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - A health, functional, and cognitive evaluation will be completed for Tenants #1, #2, #3, #4, #5, and #6.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and/or Designee will be re-educated regulatory requirements for completing a health, functional, and cognitive evaluation. This will include review of regulation and MeadowView policies and forms.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will audit tenant charts at least two times per year to ensure compliance.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by November 12, 2018.

Service Plan

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Service plans will be updated after completion of a health, functional, and cognitive evaluation for Tenants #1, #2, #3, #4, #5, and #6.
    - Service plans will be updated to reflect planned and spontaneous activities for Tenant #1, #2, and #3.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and/or Designee will be re-educated regulatory requirements for completing a service plan. This will include review of regulation and MeadowView policies and forms.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will audit tenant charts at least two times per year to ensure compliance.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by November 12, 2018.

If you have any questions regarding this plan of correction, please feel free to contact me at 319-294-9669. Thank you.

Sincerely,

Tiffany Bunting

Tiffany Bunting
Community Director