

✓ 2/3/20 OK 1/30/2020

PRINTED: 01/10/2020
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CENTERVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544
---	---

(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: 37 Number of tenants with cognitive disorder: 1 Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 6 TOTAL Census of Assisted Living Program for People with Dementia : 46 The following regulatory insufficiency was cited during the investigation into Complaint #87486-C.	A 000	See attached! POC 1/31/2020	
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 update service plans as needs changed for 3 of 4 tenants (Tenant #2, Tenant #3,	A 083		

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: S0151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CENTERVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 1 Tenant #4). Findings follow: 1. Record review from 12/23-24/2019 revealed Tenant #2 had a Negotiated Service Agreement, or service plan, dated 7/11/19. According to the Negotiated Service Plan, Tenant #2 was independent with transfers, ambulated with a two wheeled walker and had a slow and steady gait. Tenant #2 did have a history of falls. A service plan addendum dated 10/30/19 noted physical therapy services were added. A review of Clinical Notes Reports dated 10/17/19 revealed Tenant #2 fell in the men's public restroom on that date injuring his elbow. A call was placed to Tenant #2's son requesting new shoes that properly fit on that date. Tenant #2 reported pain to his left knee following the fall. The program contacted Tenant #2's primary care provider who ordered an X-ray. The X-ray determined there was no fracture. However, physical therapy was ordered for Tenant #2. The Executive Director confirmed on 12/30/19 at 3:30 PM physical therapy was started for Tenant #2 to address his fall on 10/17/19. She stated his Negotiated Service Agreement should have been updated to address the change in condition. 2. Tenant #3 had a Negotiated Service Agreement dated 11/1/19. The Negotiated Service Agreement identified Tenant #3 was independent with toileting and continent of bowel. The document noted Tenant #3 reported he was incontinent of bladder several times throughout the day but was independent with managing his dignity products and able to change them on his own. Under the cognition/behavioral health section of his Negotiated Service Agreement,	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CENTERVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 2 Tenant #3 was identified as having no identified problems or concerns. Tenant #3 was noted to be pleasant and cooperative. It was noted he missed two questions on a cognitive evaluation, the SPMSQ, but his cognitive level remained intact. The Negotiated Service Agreement noted Tenant #3 had no problems in the area of housekeeping and he would receive light housekeeping weekly and garbage removal as needed. Staff would wash, dry, fold and put away his laundry two times weekly. Tenant #3 had his medication administered by staff at the facility. No problems were identified at the time the service plan was written. A review of Clinical Notes Reports dated 11/29/19 revealed a note dated 11/29/19 in which staff reported Tenant #3 was having urinary incontinence to the point it was soaking his Depend and his pants. The Depend was wet to the point of shredding on the floor. Staff was encouraging him to change his Depend frequently when using the toilet. The RCC (Resident Care Coordinator) reported in a Clinical Note on 12/4/19 she contacted Tenant #3's primary care provider via fax and notified her of his gross urinary incontinence to the point of soaking through Depends and clothing multiple times a day. The primary care provider ordered Desitin cream applied to the buttocks and scrotum for moisture barrier due to urinary incontinence. A prescription for Tenant #3 dated 12/4/19 ordered them to apply Nystatin ointment under Tenant #3's pannus and to his perineum three times daily. The RCC asked if the primary care provider wanted Tenant #3 seen by a urologist and she said yes, he is seen at the urology clinic. The RCC said she would set up the appointment. The RCC scheduled the appointment on 12/19/19 for him to be seen on 12/31/19.	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2019
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CENTERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 3 A review of Staff Communication Reports identified one dated 11/16/19. Staff A noted Tenant #3 began screaming and cussing at her when the specific ointment he wanted applied to his scrotum was out. Staff A filled out a Staff Communication Report on 11/27/19 noting Tenant #3's pants and Depend were continuously soaked to the point of shredding all over the floor. She noted staff encouraged Tenant #3 to change his Depend frequently when using the toilet. She also noted Tenant #3 became agitated about using Desitin on his irritated skin as he said it did not work. Staff B completed a Staff Communication Report on 11/28/19 identifying Tenant #3 had an open skin tear on his left side, between his leg and genitals. She said Tenant #3 was very upset with her because she would not put Nystatin on it as it was an open sore. Staff C completed a Staff Communication report dated 12/1/19 in which she noted Tenant #3 had yelled at her for not applying Nystatin to his entire buttocks, even after she pointed out she could only apply it to his scrotum. Staff A completed a Staff Communication Report dated 12/5/19 in which she noted Tenant #3 had on pants and a Depend which were soiled with urine and feces. She observed feces all over his bottom. Tenant #3 reported to Staff A he was unable to clean himself as he could not reach his bottom. A Staff Communication Report was completed on 12/20/19 by Staff A in which she reported Tenant #3 became upset about not getting Nystatin everywhere on his bottom. Tenant #3 became aggressive and threw his walker against the heating unit and told staff to get out of his apartment. On 12/23/19 at 2:10 PM, Staff D reported Tenant #3 got very agitated and started yelling at her when she would not apply Nystatin all over his bottom. Staff A completed a Staff	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOMESTEAD OF CENTERVILLE

**19999 ST JOSEPH'S DRIVE
CENTERVILLE, IA 52544**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 4 Communication Report on 12/23/19 at 9:30 PM noting Tenant #3 became extremely agitated when she would not apply Nystatin to his entire bottom. An interview was conducted with Staff A on 12/23/19 at 5:00 PM. Staff A reported Tenant #3 refused to use his Desitin on his bottom, reporting it was a baby medicine. She reported he refused to use the Desitin about 95% of the time, instead requesting Nystatin. Staff A said she had noticed Tenant #3 having fecal matter on his bottom a couple of times a week due to being unable to clean himself up. She stated she had reported this to the nurse. Staff A said she had seen agitation from Tenant #3 and when he became upset, she left the situation. Staff B was interviewed on 12/24/19 at 9:35 AM. She reported the only medication Tenant #3 had refused from her was Desitin. She said Tenant #3 had not used it at all lately as he believed Nystatin was the only thing that would heal him. Staff B said Tenant #3 did not seem to understand staff had to follow doctor's order for administering medication and could not do whatever he asked of them. When they would not do what he wanted, Tenant #3 would do things like mumble, yell, curse or push his walker. She said this type of behavior occurred about one to two times a week. Staff B stated Tenant #3 had significant issues with incontinence for over a year. She stated when she knelt down in his apartment her pants would get wet from urine soaked into his carpeting. Tenant #3 often had towels on the floor of his bathroom to soak up urine. She reported she had seen him go into the dining room with his pants visibly soaked with urine.	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CENTERVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 5 Staff C was interviewed on 12/24/19 at 8:55 AM. Staff C reported Tenant #3 refused to let her apply Desitin cream to him, although he allowed her to apply all of his other treatments. She had not noticed a change in Tenant #3's level of incontinence. She had only noticed one time in which Tenant #3 was unable to clean himself following a bowel movement. Staff C said Tenant #3 had only yelled at her on one occasion. Staff D was interviewed on 12/24/19 at 10:00 AM. Staff D stated she had seen Tenant #3's soiled incontinence undergarments and pants on the floor, carpet and bathroom. She said she had found the carpet in his apartment to be wet from the saturated undergarment. She had not found Tenant #3 to have an incontinence of bowel. Staff D reported Tenant #3's incontinence level to be about the same over the past several months in her opinion. She had seen Tenant #3 walking around in soiled pants but stated he would change when asked to do so. Staff D had heard Tenant #3 yelled at others, but not at her. An interview was conducted with Tenant #3 on 12/30/19. Tenant #3 reported his incontinence had increased over the last 3-4 weeks. He stated he used to go through about 8 incontinence briefs in one day and now he uses about 20. Tenant #3 said there have been times when he was unable to make it to the bathroom before urinating on the floor which did cause his carpeting to become wet. Tenant #3 said his carpeting had been shampooed three times in the two years he had lived in the program. Tenant #3 said he did not like to use the Desitin and planned to talk with his doctor about this when he next saw her. 3. Tenant #4 had a Negotiated Service	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CENTERVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 6 Agreement dated 9/28/19. According to the Negotiated Service Agreement, Tenant #4 ambulated with a 4-wheeled walker. His gait was slow and steady. He was independent with grooming, dressing and undressing. His service plan did not address TED hose. A review of a Clinical Notes Report identified Tenant #4 was hospitalized on 11/25/19 following Tenant #4's decline in the ability to transfer, walk and dress himself. Tenant #4 was hospitalized until 11/29/19 with a diagnosis of fluid overload. A 90-day nurse review dated 12/23/19 identified Tenant #4 required staff assistance with dressing, undressing, applying and removing his TED hose. Tenant #4 at times required staff assistance with transfers. Staff B was interviewed on 12/24/19 at 9:35 AM. She reported Tenant #4 generally moved around the program in a wheelchair. He no longer walked around the program. He received assistance with dressing, but not all of the time. She said she assisted Tenant #4 with combing his hair, but not all of the time. Staff B said she provided some assistance with pericare to Tenant #4. Staff B would assist Tenant #4 on and off the toilet. Staff C was interviewed on 12/24/19 at 8:55 AM. She reported seeing Tenant #4 use a walker and wheelchair in the program. She said Tenant #4 walked in the past, but now he said he was too tired. Staff E was interviewed on 12/23/19 at 4:40 AM. She reported Tenant #4 could transfer himself. She said some days he could walk with his walker, other days he used his wheelchair. Staff E puts on Tenant #4's TED hose. He dressed	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CENTERVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 7 and groomed himself. Tenant #4 was interviewed on 12/30/19 at 11:40 AM. He was sitting in a wheelchair in his apartment. Upon entering the apartment with the Executive Director, Tenant #4 requested assistance with putting on his sock and shoe. Tenant #4 reported he used his wheelchair due to pain in his lower legs. He also said his knees hurt and his legs got tired. Tenant #4 stated some members of the staff assisted him with dressing and putting on his TED hose when he asked for help. The Executive Director and RCC were interviewed on 12/23/19 at 11:45 AM. They confirmed new service plans were not written to address the changes in condition for Tenants #3 and #4.	A 083		

OK
11/30/2020

✓
2/3/20



Linda Kellen, Bureau Chief Adult Services Bureau

Catie Campbell, Program Coordinator Adult Services Bureau

January 20, 2020

Plan of Correction for Homestead of Centerville regarding Complaint #87486-C.

1. The RCC has reviewed the service plans that were reviewed at the time of the complaint and made changes and completed a change of condition if needed. The RCC is reviewing and getting staff input on other resident service plans that may need to have a change of condition completed.
2. The RCC is including staff when reviewing a resident's care needs to determine if a change of condition is needed. The RCC understands that if any of the assessments have a change to them, that should trigger to her that a complete change of condition is required. The RCC is also using a tool to determine if a change of condition has been triggered.
3. When the RCC assess a resident and completes all required assessments she will review with staff members and consult with the Executive Director to ensure that a change of condition is completed to meet the care needs of the resident. The Regional Vice President and Resource Nurse will be monitoring resident charting to ensure proper changes of condition occur and occur in a timely manner.
4. The program will be in compliance with the Plan of Correction January 31, 2020.

Respectfully,

Carri Stone

Carri Stone, Regional Vice President