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
	S0419	A. BUILDING: _____ B. WING _____	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE HILLS AT PRAIRIE TRAIL	1275 SW STATE STREET ANKENY, IA 50023

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 29 Number of tenants with cognitive disorder: 8 Total census of Assisted Living Program: 37 No regulatory insufficiencies were cited regarding Complaints 89447-C or 94217-C. The following regulatory insufficiencies were cited during the onsite infection control survey and the investigation of Complaint 91559-C.	A 000	See Attached 10/29/20	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to follow Standard	A 003		

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A 003	Continued From page 1 Operating Procedure for preventing respiratory outbreak. This potentially affected 37 of 37 tenants who resided in the assisted living unit. Finding follows: Based on observations on 7/20/20 from 1:40 p.m. - 2:00 p.m. staff arrived to the building which included the memory care unit and a general population assisted living unit. When staff arrived they went to the memory care unit to be screened for possible symptoms of COVID 19. Further observations revealed staff walked through the general population area of the building. One staff wore a face mask that did not cover her nose as she arrived to the memory care unit for screening. The program's Influenza and Respiratory Outbreak Record policy (revised 3/11/20) was reviewed on 8/5/20. Under the heading of Infection Control measures for Influenza and Respiratory Viruses the following directive was noted: restrict movements between AL(assisted living)/MC (memory care) neighborhoods. On 7/25/20 and 8/3/20 the Director contacted this surveyor to report a staff person had tested positive for COVID 19. Additionally on 8/3/20 the Director indicated a second staff person and tenant had tested positive for COVID 19. On 7/20/20 both staff were observed moving from memory care area of the building to the assisted living area of the building.	A 003		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to	A 055		

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A 055	Continued From page 2 fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review it could not be determed if the Program ensured sufficient staff to respond to personal emergency response pendants in a timely manner for 2 of 3 tenants reviewed (Tenant #1 and #2). Findings follow: Record review on 7/28/20 revealed the following pendant response times for Tenant #1. Tenant #1's pendant was pushed and staff cleared the pendant at the following times: 6/18/20 - 10:17 p.m. to 10:50 a.m. (753 minutes) - 8:28 p.m. to 11:17 p.m. (109 minutes) - 4:07 p.m. - 5:43 p.m. (96 minutes) 6/17/20 - 6:31 p.m. to 6:54 p.m. (23 minutes) 6/16/20 - 11:18 a.m. to 11:52 a.m. (34 minutes) 6/15/20 - 9:40 p.m. to 10:59 p.m. (79 minutes) 2. Record review on 7/28/20 revealed the following pendant response times for Tenant #2. Tenant #2's pendant was pushed and staff cleared the pendant at the following times:	A 055		

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A 055	Continued From page 3 6/15/20 - 10:17 p.m. to 10:50 a.m. (79 minutes) Pendant - 9:42 a.m. to 10:58 a.m. (76 minutes) Bath E-call (call light inside bathroom) - 8:28 p.m. to 11:17 p.m. (109 minutes) - 4:07 p.m. to 5:43 p.m. (96 minutes) 6/16/20 - 6:08 p.m. to 7:02 p.m. (54 minutes) Pendant - 6:06 p.m. to 7:03 p.m. (57 minutes) Bath E-call 6/17/20 - 7:18 p.m. to 7:52 p.m. (34 minutes) Bath E-call 6/18/20 - 11:08 a.m. to 12:47 a.m. (99 minutes) Pendant - 11:08 a.m. to 12:47 a.m. (99 minutes) Bath E-call When interviewed on 7/20/20 at 1:20 p.m. Staff A confirmed the Program scheduled two staff on each shift. When interviewed 8/3/20 the Administrator confirmed the Program scheduled two staff per shift. On 7/28/20 when asked about the length of response times as noted above, he stated he believed staff had responded to the requests for assistance in a timely manner however the system malfunctioned. When interviewed on 8/4/20 at 12:50 p.m. the Director confirmed the	A 055		

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A 055	Continued From page 4 Program had no policy to ensure the Personal Emergency Response system functioned properly.	A 055		

10/29/20

October 20, 2020

Department of Inspections and Appeals
Attn: Linda Kellen
Lucas State Office Building
321 East 12th St
Des Moines, IA 50319

Subject: Plan of Correction for Vintage Hills Assisted Living

This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the Community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding.

Please accept the following Plan of Correction as outlined below:

A. ***481-67.2 Program policies and procedures***. The Program shall follow the policies and procedures established by a program. Failed to follow Standard Operating Procedure for preventing respiratory outbreak.

1. ***Corrective Action***: The staff screening form was moved while the surveyor was still in the building from the Memory Care unit to the time clock area. The staff screening form was moved again on 10/12/20 to the two entrances/exits that staff uses. This will prevent possible contamination before being screened.

2. ***Measures to ensure the problem does not recur***: All staff were in-serviced regarding restricting movement between Assisted Living and Memory Care during an outbreak. This training was completed by 10/20/2020.

3. ***How the Program plans to monitor performance to ensure compliance:*** The Executive Director (or designee) will audit the screening logs at a minimum of weekly for each station to ensure proper screening prior to entering the Assisted Living or Memory Care unit. The results will be reported to the Quality Assurance committee for three months and determine if further monitoring is required.

4. ***Date of Compliance***: Corrective action has been taken and completed on October 20, 2020.

10/22/20

B. ***481-67.9(1) Staffing.*** A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

1. ***Corrective Action***: The Executive Director (ED) has reviewed the staffing pattern with the Regional Nurse and determined that there is a sufficient number of trained staff at all times to fully meet tenants' identified needs. A policy to ensure the Personal Emergency Response system functions properly was implemented on 10/20/2020.

2. ***Measures to ensure the problem does not recur***: The new policy will require monthly testing for all pendants to ensure they are working correctly. The maintenance department (or designee) will be responsible for the testing. All caregivers will be retrained on answering pendants timely and resetting of pendants by the Executive Director (or designee) by 10/20/2020.

3. ***How the Program plans to monitor performance to ensure compliance***: The maintenance department will submit the findings of the monthly audit to the Quality Assurance committee. The audit will review all pendants to ensure they are working correctly. This will occur for three consecutive months to determine if further monitoring will be required.

4. ***Date of Compliance***: Corrective action has been taken and completed on 10/20/2020.

If you have any questions or concerns, please feel free to contact me at jclindaniel@thevintagehills.com or (515) 639-2191.

Sincerely,

Jim Clindaniel
Executive Director