PRINTED: 09/18/202
FORM APPROVEI

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
	S0009	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY PLACE	2807 CEDAR ST MUSCATINE, IA 52761

(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 impairment: 15 Number of tenants with cognitive impairment: 13 Total census: 28 No regulatory insufficiencies were cited during the investigation of Complaint #121396-C. The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	A 000		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall 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, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	A 145		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0009	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY PLACE	2807 CEDAR ST MUSCATINE, IA 52761

(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 145	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete assessments in a timely manner following a significant change for 1 of 4 tenants reviewed (Tenant #4). Finding follows: On 8/01/24 record review revealed nursing progress notes which indicated Tenant #4 had a psychiatric hospitalization from 6/27/24 to 7/02/24 due to suicidal ideation. The Executive Director developed a new service plan with Tenant #4 upon return to the program on 7/02/24. The service plan included a new restriction regarding being outside of the building alone and intervention information for suicidal ideation. The service plan was signed by the Executive Director on 7/02/24 and by the Registered Nurse (RN) on 7/09/24. Additional record review revealed the RN completed Tenant #4's functional, health and cognitive assessments on 7/09/24. On 8/01/24 the RN said she was on vacation when Tenant #4 returned to the program on 7/02/24. The Executive Director, a Licensed Practical Nurse (LPN), developed the new service plan, but did not complete the assessments, as she did not meet the criteria for a health care professional. The RN completed the assessments for Tenant #4 when she returned to the program from vacation. The RN verified the assessments were not completed prior to the development of the new service plan.	A 145	POC- RN/HWD will perform complete health assessments and complete service plan documentation on admission, 30 days after admission, then quarterly thereafter, and upon readmission from the hospital or at change of condition. A regional nurse officer or an RN from a sister branch will perform required assessments in the event Pearl City Place RN/HWD is out of the office and unable perform required assessment.	Implemen d 8/1/2024 Complete Ongoing