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
	S0028	A. BUILDING: _____ B. WING _____	C 06/07/2023

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BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

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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: 28 Number of tenants with cognitive disorder: 6 TOTAL Census of Assisted Living Program for People with Dementia: 34 The investigation of Complaints #108121-C, #109054-C, #109370-C and #111147-M were completed and the following regulatory insufficiencies were identified: 235E.2 Dependent adult abuse reports in facilities and programs. 2. A staff member or employee of a facility or program who, in the course of employment, examines, attends, counsels, or treats a dependent adult in a facility or program and reasonably believes the dependent adult has suffered dependent adult abuse, shall report the suspected dependent adult abuse to the department. 3.a. If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person ' s designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours. Based on interview and record review the Program failed to report dependant adult abuse to the the Department of Inspections, Appeals and Licensing (DIAL) as required. This pertained to 1	A 000		

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of 1 tenant reviewed that reported an allegation of abuse (Tenant #1). Finding follows:

Record review of Tenant #1's Unusual Occurrence Report dated 2/13/23 at 8:30 a.m. indicated Tenant #1 had an injury to her right upper extremity and had complaints of pain. Tenant #1 said Staff A was always rough with her and today she pulled Tenant #1 out of bed and was so rough. There was a bruise approximately 2.5-3 inches by 1 inch on the top of her right wrist. The report indicated a cool cloth and Tylenol were offered to Tenant #1 and she declined. It was reported to the Executive Director after comfort was offered to Tenant #1. The report was signed by Health and Wellness Director and Family Advocate dated 2/13/23 at 10:00 a.m.

When interviewed on 3/21/23 at 1:58 p.m. the Executive Director said on 2/13/23 she was informed by the Family Advocate and Health and Wellness Director that Tenant #1 came to them with a concern from Staff A that morning. When interviewed Tenant #1 said Staff A rushed and was rough. She pulled her out of bed by her wrist. Tenant #1 pulled up her sleeve she had a 2 to 3 inch by 1 inch bruise. The bruise looked new, was purple, and was not healing. It had some red but no yellow. It was located on the inside of her right forearm. Tenant #1 said she required assistance to get out of bed, and she had concerns with cares in the past. That morning it was more than usual. Tenant #1 said she cried out in pain and Staff A did not acknowledge. Staff A's statement was collected the next day. She reached out to Corporate staff and it was determined a self-report was needed.

Continued record review revealed the Program's Abuse and Neglect policy and procedure

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A 000	Continued From page 2 indicated the directors or health care professionals who had "reasonable cause" to believe that abuse had occurred would report it immediately to the "State certification authority" and corporate. Any staff who had "reasonable cause" to believe a tenant was abuse would immediately report it to the director or nurse. The reporting procedure indicated to contact the "State certification authority" within 24 hours. The alleged victim and alleged abuser were to be kept separated until all investigations, including the Department of Inspections and Appeals investigation was completed. When interviewed on 3/21/23 at 1:58 p.m. the Executive Director confirmed the allegation occurred and was reported to her on 2/13/23. It was reported to DIAL on 2/15/23.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow it's established policies and procedures. This pertained to 3 of 5 sample clients discharged tenants reviewed (Tenant C1, Tenant C2 and Tenant #1). Findings follow: 1. Record review of Tenant #1's Unusual Occurrence Report dated 2/13/23 at 8:30 a.m. indicated Tenant #1 had an injury to her right upper extremity and had complaints of pain. Tenant #1 said Staff A was always rough with her and today she pulled Tenant #1 out of bed and	A 150		

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was so rough. There was a bruise approximately 2.5-3 inches by 1 inch on the top of her right wrist. The report indicated a cool cloth and Tylenol were offered to Tenant #1 and she declined. It was reported to the Executive Director after comfort was offered to Tenant #1. The report was signed by Health and Wellness Director and Family Advocate dated 2/13/23 at 10:00 a.m. The form lacked documentation of the notification of Tenant #1's legal representative or primary care provider.

When interviewed on 3/21/23 at 1:58 p.m. the Executive Director said on 2/13/23 she was informed by the Family Advocate and Health and Wellness Director that Tenant #1 came to them with a concern from Staff A that morning. When interviewed Tenant #1 said Staff A rushed and was rough. She pulled her out of bed by her wrist. Tenant #1 pulled up her sleeve she had a 2 to 3 inch by 1 inch bruise. The bruise looked new, was purple, and was not healing. It had some red but no yellow. It was located on the inside of her right forearm. Tenant #1 said she required assistance to get out of bed, and she had concerns with cares in the past. That morning it was more than usual. Tenant #1 said she cried out in pain and Staff A did not acknowledge. Staff A's statement was collected the next day. She reached out to Corporate staff and it was determined a self-report was needed. Staff A was made aware she was suspended and Tenant #1's family was notified.

Continued record review revealed the Program's Abuse and Neglect policy and procedure revealed the directors or health care professionals who had "reasonable cause" to believe that abuse had occurred would report it immediately to the "State certification authority" and corporate. Any staff who had "reasonable cause" to believe a tenant

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was abuse would immediately report it to the director or nurse. The reporting procedure indicated to contact the "State certification authority" within 24 hours. The alleged victim and alleged abuser were to be kept separated until all investigations, including the Department of Inspections and Appeals investigation was completed.

When interviewed on 3/27/23 at 3:15 p.m. Staff A confirmed she was not suspended until she came to work the morning on 2/17/23.

When interviewed on 3/21/23 at 1:58 p.m. the Executive Director confirmed the allegation occurred and was reported to her on 2/13/23. It was reported to the Department of Inspections and Appeals on 2/15/23.

2. Record review on 3/22/23 of Tenant C2's file revealed an Unusual Occurrence Report dated 12/21/22 (no time provided) indicated Tenant C2 was sent out by ambulance. The only information related to the incident documented was that it took place in Tenant C2's apartment. There were no vital signs recorded on the incident report form. The form indicated Staff E notified the nurse, the PCP (Primary Care Physician) and family. It was signed by Staff E on 12/21/22.

Continued record review revealed Tenant C2's Unusual Occurrence Report dated 12/28/22 signed by Staff A (who witnessed the incident), indicated the incident occurred on 12/21/22 between 8:20 a.m. and 8:30 a.m. The report indicated Staff A went into Tenant C2's apartment between 8:20 a.m. and 8:30 a.m. and he laid on his bed with his pants and underwear down and had urine on himself. She gave him his walker to

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get up to use the bathroom and his left leg went under him. Staff A guided him to the floor and got help from Staff C. The reported indicated Tenant C2 had pain. No vital signs were recorded on the incident report form. The report failed to indicate notification of the nurse, director, family, or PCP. The incident report dated on 12/28/22 was not completed immediately following the incident (on 12/21/22) and lacked documentation related to the incident including vital signs.

When interviewed on 3/27/23 at 4:28 p.m. Staff A said at her first check on that shift Tenant C2 was asleep. When she went back at approximately 7:15 a.m. he laid on his bed on his back with his pants and underwear down. She said he was soaked in urine. She went and got his walker, put a gait belt on him (he was a one assist) pulled up his pants and he fell back on the bed. She said something was wrong, she went to get Staff C and told her she thought Tenant C2 had a stroke. They had Staff E assist and she thought he had a stroke too. They called another staff to assist and (the four staff) got Tenant C2 into a wheelchair. It was two staff on each side, for a total of four staff assisting him. Tenant C2 was a two person assist that day and a check and change for toileting. She said a corporate person said an incident report needed to filled out. She said the incident report was in the box and it disappeared. She said Staff E also completed an incident report.

When interviewed on 3/23/23 at approximately 1:45 p.m. Staff C said she opened the door said Staff A was in Tenant C2's apartment standing at the end of the bed (she could not see Tenant C2) and she was confirmed she was there to assist him. About 15 to 20 minutes later Staff A came and got Staff C and asked if she could help with

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Tenant C2. She walked in and saw Tenant C2 on the floor, in front of his side table, right next to the bed. Tenant C2 was on his knees and his headboard was out of the hinges. She tried to assist Tenant C2 to get him up and they could not get him up. Another staff responded and assisted and they put a chair under him. She said there was not a nurse there at that time. They walked him to the bathroom and he had a hard time moving his leg. Staff put Tenant C2 in a wheelchair. She said his leg got worse and he complained every time they tried to get him to go to the bathroom. Staff C said Tenant C2 was not a very verbal person but it could be seen on his face that it hurt. Staff C said he eventually was sent out to the the hospital later in the day. She said Staff A did not really say what happened just that he fell on the floor. Staff C did not ask why the bed was out of the frame.

Further record review of Tenant C2's file revealed Progress Notes indicated the following:

a. On 12/22/22 it was noted on 12/21/22 at 7:45 a.m. Staff E called the Corporate Nurse and reported Tenant C2 had trouble moving one of his legs. Staff E was directed to call Tenant C2's family and to send him out to the Emergency Room (ER). Staff E called back and said Tenant C2's family did not want him sent out to the hospital and would come to the Program and decide if they wanted him to be sent out. Staff E called the Corporate Nurse and was informed family stopped out and did not want him seen. Staff E called later at 3:40 p.m. and said Tenant #2 was pale and had diarrhea. Staff E was instructed to send Tenant C2 out to the hospital and notify his family. The note indicated after Tenant C2 transported by ambulance Staff E called the Corporate Nurse again and reported

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Staff C said that she helped Staff A pick Tenant C2 up from the floor that morning. Staff E was instructed to complete an incident report and notify family. At 8:20 p.m. the Corporate Nurse received a call from staff and it was reported that Tenant C2 sustained a hip fracture.

b. On 12/28/22 it was noted Staff A said she lowered Tenant C2 to the floor when she attempted to stand him up to get dressed for the day. Staff C said when Staff A asked her for assistance with Tenant C2 he was on the side of the bed. Later in the day Tenant C2 was sent out to the hospital for evaluation. He had a hip fracture with surgical repair of his hip, was a two person assist for transfers and would not be returning due to needing a higher level of care.

3. Record review on 3/22/23, 4/4/23 and 4/5/23 of Tenant C1's file revealed an Unusual Occurrence Report dated 12/25/22 at 11:30 a.m. indicated Tenant C1 was ill, with respiratory and gastrointestinal issues. The report indicated Tenant C1's family member noticed Tenant C1 vomited and it came out of her nose. Tenant C1's family member was concerned and was taking Tenant C1 to the emergency room. Tenant C1 was coughing every few minutes and her breathing was heavy and gargled. There were no vital signs documented on the incident report form. The report lacked notification of the nurse and primary care provider (PCP). The report was signed by Staff G. The incident report was not completed per the Program's policy and procedure, including the documentation of vital signs.

Record review revealed the Program's Incident and Accident policy and procedure indicated

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A 150	Continued From page 8 incidents and accidents included tenant injuries and falls. All incidents and accidents should be reported and documented immediately after they occurred. All accidents or incidents would be reported to the director or nurse of the building. Incidents should be immediately documented on the incident report form and included statements from any witnesses. Vital signs should be taken and documented on the incident report form. When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed all incident reports for the tenants listed above were provided.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to treat a tenant with respect, consideration, personal dignity and autonomy. This pertained to 1 of 3 tenants reviewed (Tenant #3). Finding follows: Record review revealed an Investigation Form document indicated on 12/18/22 Tenant #3 reported to staff a male staff member "groped her." Staff D was suspended pending the investigation.	A 155		

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Record review of an interview completed on 12/20/22 with Program and corporate staff and Tenant #3 indicated Tenant #3 said she walked in the hallway and Staff D "grabbed my pants from behind and said I thought you were wet." Tenant #3 said she did not say anything to him. He asked how she was and she did not respond as she thought it was inappropriate. Tenant #3 turned around and went back to her apartment. Tenant #3 said Staff D came up next to her and did it and he had not done anything like that before. Tenant #3's said she did not think she was incontinent. Tenant #3 showed staff where he grabbed her which was on her pants on her buttocks where her pad was.

Continued record review of Staff D's interview indicated he was interviewed on 12/21/22 by corporate staff and said he saw Tenant #3 and she looked soaking wet. He asked her if she needed help and she did not answer so he touched her pants to see if they were wet. Tenant #3 was not wet and he walked away. He said Tenant #3 gave him a look like she was "the type to not wet her pants." Staff D said in his interview Tenant #3 was bias and did not like men.

Further record review revealed Tenant #3's service plan dated 8/4/22, reflected Tenant #3 was independent with toileting needs. It indicated she was continent of bladder and bowel. She was independent with a.m. and p.m. cares.

When interviewed on 6/7/23 at approximately 11:15 a.m. Tenant #3's legal representative said Tenant #3 had been previously interviewed regarding the allegation and it was upsetting to her and she did not want her to be interviewed. Tenant #3's legal representative said Tenant #3 told her she was walking in the hallway by her

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apartment and a male staff came up behind her and grabbed her left buttock and said something about her wet and palpitated her buttocks. Tenant #3 was not wet and she was independent with toileting cares and did not require the assistance of staff for toileting. Tenant #3 was very appalled someone would do it. He touched her private area in a public space. She was also frightened related to her balance. Tenant #3's legal representative spoke to staff after it was reported to her and it was determined the man was a staff member. Staff then reported it very quickly to the director at that time. She said Tenant #3 was a very private person.

When interviewed on 6/7/23 at 12:57 p.m. the Family Advocate said she sat in as a witness for Tenant #3's interview with a corporate staff. Tenant #3 said she was walking down the hallway (where her apartment was located) and Staff D came up behind her and grabbed her buttocks. Tenant #3 asked what he was doing and Staff D said he was checking to see if she was wet. She said it made her feel uncomfortable. The Family Advocate said Tenant #3 was a very private person. She had not made any other reports about other staff. She was not involved with Staff D's interview and said he was no longer employed at the Program.

When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed Staff D was terminated on 1/18/23.

In summary, Tenant #3 did not require assistance with toileting at at that time of the allegation. Staff D confirmed he touched the back of her pants, and Tenant #3 felt was it inappropriate, was upset by what occurred and told her legal representative about the incident. When Staff D

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A 155	Continued From page 11 reported he checked her pants, it was in a public space as Tenant #3 walked down the hallway. On 12/18/23 Staff D failed to treat Tenant #3 with respect, dignity and consideration regarding the incident.	A 155		
A 160	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 adequate and appropriate treatment, services and cares. This pertained to 1 of 2 current tenants reviewed (Tenant #2) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 3/21/23 to 3/23/23 revealed Tenant #2's Progress Notes dated 12/5/22, documented on 12/4/22 Tenant #2 had bright red blood when using the bathroom. She was sent to the emergency room (ER) and was admitted for dehydration and a urinary tract infection (UTI). Continued record review revealed hospital records reflected the following: Tenant #2 was admitted on 12/5/22 and discharged on 12/7/22. The hospital records indicated "the patient had severe excoriations and open skin wounds all	A 160		

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over her perineal area as well as her rectal area on through her at the crack of her buttocks." She also appeared "severely dehydrated with eye sockets sunken" and appeared "severely" malnourished. The hospital records indicated the Assessment/Plan indicated skin breakdown "Due to constant sitting in the chair." Tenant #2 also was dehydrated and had a perineal rash. It was noted the rash was "Also due to pressure on the pedal areas from prolonged sitting." A wound clinic consult was ordered due to the redness in the groin and perineal area. The hospital records indicated the area was the perineal area, anterior and posterior. It was present upon admission. The skin abnormality type was a erythema, excoriation, and it was blanchable. The plan was to start Sensi-Care twice daily and as needed the perineal area. A Foley catheter was now in place. It appeared to be a rash or "even a burn from UTI." Tenant #2 also had severe calorie malnourishment. Hospital records indicated Tenant #2 was supposed to receive a nutritional supplement twice daily at the Program but Tenant #2's family indicated it was likely not happening.

Further record review revealed Tenant #2's Task Sheets for December 2022 and January 2023 were not available when requested. Tenant #2's Task Sheets for February and March 2023 reflected omissions for cares including: a.m. cares, p.m. cares, toileting, hygiene and grooming, bathing, escorts and mobility and night checks. Tenant #2's task sheet for February 2023 documented 13 entries of staff assistance for toileting during first shift and 11 documented entries on second shift. For March 2023 (until 3/22/23) there were 12 documented entries on first shift for toileting. In March 2023 (until 3/22/23) there were nine entries on second shift for toileting.

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A 160	Continued From page 13 Continued record review revealed Tenant #2's service plans dated 12/8/22 and 3/9/23 indicated staff provided routine assistance with toileting. The service plan dated 3/9/23 reflected Tenant #2 had a catheter and staff assisted with routine assistance to use the bathroom for bowel incontinence. The program failed to provided Tenant #2 adequate and appropriate care related to toileting needs in December 2022, when Tenant #2 was hospitalized and had excoriations and skin wounds in the perineal and rectal area. The hospital records indicated it was due to prolonged sitting and noted the excoriations were severe. At the time of her hospitalization she was noted to be severely dehydrated and malnourished. The task sheets during that time period were not available for review when requested. The most current task sheets available were February and March 2023 indicated cares, including toileting were not documented as completed for Tenant #2. 2. Record review on 3/22/23, 4/4/23 and 4/5/23 of Tenant C1's file revealed Tenant C1 was discharged (death) on 1/1/23. Task sheets for September, October and December 2022 indicated omissions for cares including: a.m. cares, p.m. cares, toileting, hygiene and grooming, bathing, escorts and mobility and night checks. Continued record review revealed an Unusual Occurrence Report dated 10/3/22 at 7:30 p.m. indicated Tenant C1 had a critically low blood glucose level. Tenant C1 sat in the dining room was pale, clammy and not responding to any	A 160		

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stimuli. Tenant C1 refused to eat. Tenant C1's blood glucose level was 39. Tenant C1's family and the primary care provider (PCP) were notified. The PCP recommended calling emergency medical services (EMS). They arrived and her blood glucose was 34. They administered intravenous glucose and her blood glucose rose to 146. Staff monitored her blood glucose levels every 30 minutes. The report reflected an on-call nurse, the PCP and family were notified.

Tenant C1's service plan dated 8/11/22 reflected Tenant C1 had blood glucose checks with her meals and to notify the nurse if the readings were greater than 400 or less than 60.

Further record review revealed Tenant C1's October 2022 medication administration records (MARs) indicated a blood glucose reading on 10/2/22 at 4:00 p.m. at 57 (below 60) and several blood glucose readings above 400 including on 10/8/22, 10/16/22 and 10/25/22 at 8:00 p.m. Tenant C1's November 2022 MARs reflected multiple blood glucose readings above 400 including: 508 on 11/13/22, 528 on 11/17/22 and 436 on 11/21/22 at 11:30. There were also blood glucose readings of 455 on 11/15/22, 528 on 11/18/22, 502 on 11/22/22 and 482 on 11/23/22 at 4:00 p.m. Tenant C1 had 10 blood glucose readings of greater than 400 at the 8:00 p.m. blood glucose check, including 571 on 11/26/22. The MAR pass notes reflected on 11/17/22 at 1:23 p.m. it was charted as testing showed high, on 11/22/22 at 10:02 a.m. it was charted as too high to read on the machine. On 11/13/22 in the pass notes it was charted PCP instructed to give 9 units of insulin and on 11/23/22 the PCP and family were notified. Tenant C1's December 2022 MARs reflected one reading below 60, the blood

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glucose level was 59 on 12/21/22 at 8:00 a.m. There were six blood glucose levels greater than 400 at 8:00 p.m. including a reading of 441 on 12/15/22.

When interviewed on 4/6/23 at 1:15 p.m. Staff H said Tenant C1's blood glucose levels fluctuated a lot. She said the PCP team was contacted; however, medication aides could not take verbal orders. There was not a nurse there at that time. She said the PCP team would try to give a verbal order and it could not be given as medication aides could not take verbal orders.

Tenant C1's file failed to contain documentation of the nurse's notification or PCP notification in October 2022, November 2022 and December 2022 each time Tenant C1's blood glucose levels were outside of the parameters.

Continued record review revealed Tenant C1's Progress Notes indicated the following:

a. On 11/14/22 it was noted on 11/11/22 Tenant C1 was sent to the emergency room (ER) for increased edema to the lower extremities. Orders were received to change Lasix back to 40 milligram (mg), twice daily and Keflex 500 mg, three times per day for five days.

b. On 11/20/22 it was noted Tenant C1 was seen in the ER for an elevated blood glucose reading and pneumonia in both lungs. An order was received for azithromycin 250 mg, take 500 mg the first day and 250 mg for the next four days.

Further record review revealed Tenant C1's hospital records indicated Tenant C1 was seen in the ER on 11/11/22 and she had a 12 pound weight gain that day. Tenant C1 was brought to

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the ER by her family member due to concerns of leg swelling and weight gain. The family member said her legs looked significantly more swollen and weeping. The report indicated upon arrival to the ER the wraps were "completely soaked." Staff weighed her that evening and she had a 12 pound gain from that morning. Tenant C1's Lasix dose was recently decreased. The clinical impression indicated acute cystitis without hematuria, acute chronic heart failure. Cephalexin 500 mg, take one capsule, three times daily for five days was ordered.

Continued record review revealed the October 2022 MARs reflected an order for daily weights and to call the PCP if there was a three pound weight gain in 24 hours or five pounds in one week with an order date of 10/25/22. Tenant C1's weight on 10/25/22 was 199 and was 198 on 10/26/22. Tenant C1's weight on 10/27/22 and 10/28/22 was 217, it was 215 on 10/29/22 and 10/30/22 and it was 218 on 10/31/22. Tenant C1's November 2022 MARs indicated at 8:00 a.m. on 11/11/22 her weight was 206, it was 216 on 11/12/22, 228 on 11/14/22, 222 on 11/15/22 and 223 on 11/16/22. Tenant C1's December 2022 MARs documented Tenant C1 weighed 210 from 12/17/22 to 12/20/22. She weighed 216 on 12/25/22.

Tenant C1's file failed to contain documentation of the nurse's notification and PCP notification of weight gains that exceeded the parameters ordered in October 2022, November 2022 and December 2022.

Further record review revealed Tenant C1's orders reflected an order to crush medications, put in applesauce or pudding and a mechanical soft diet was ordered. The orders also reflected

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an order for benzonatate, take one capsule, three times per day as needed for cough. Tenant C1 also had an order for a liquid cough syrup as needed for cough The December 2022 MAR did not reflect any administered doses of liquid or capsule cough medication on 12/24/22 or 12/25/22.

Tenant C1's service plan dated 8/11/22, indicated Tenant C1 had a mechanical soft diet that was ordered by her physician and she had a narrowed esophagus. The Physician's Order document reflected the order for the mechanical soft diet and crushed medications in applesauce or pudding.

Continued record review revealed of Tenant C1's file revealed Progress Notes indicated the following:

-On 12/29/22 it was noted on 12/25/22 Tenant C1 was taken by car to the ER due to respiratory illness. Staff reported Tenant C1 was coughing/vomiting phlegm from her mouth and nose. Tenant C1's family reported staff did not crush medications as ordered. The staff reported she did crush medications as ordered. The note indicated the nurse at the hospital indicated Tenant C1 was diagnosed with respiratory failure, had pneumonia and hospice was being consulted.

Further record review revealed an Unusual Occurrence Report dated 12/25/22 at 11:30 a.m. indicated Tenant C1 was ill, respiratory and gastrointestinal. The reported indicated Tenant C1's family member noticed Tenant C1 vomited and it came out of her nose. The family member was concerned and said he/she was taking Tenant C1 to the ER. Copies were made of her

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MARs. Tenant C1 was coughing every few minutes and her breathing was heavy and gargled. There were no vital signs documented on the incident report. The report lacked notification of the nurse and PCP. The report was signed by Staff G.

When interviewed on 6/7/23 at 8:32 a.m. Staff I said she was working second and third shifts at that time. Staff I said a prior shift noticed Tenant C1 had a cough. Staff I said Tenant C1 had a chronic cough, although it was worse at that time. She slept most of the night (on the couch in the living room). Staff I said typically three of seven days she worked Tenant C1 was up at night. Tenant C1 started coughing at 5:45 a.m. and a co-worker put a pillow behind her. She said Tenant C1 had been sick for one to two weeks. Tenant C1 had an order for as needed Tessalon Perles. She mentioned to oncoming first shift staff, Staff G, that if she started coughing to give her the as needed medication. Tenant C1 had not vomited on her shift. Staff I said to give the Tessalon Perles with a crushed medication order, she would cut the medication in half and put the liquid in pudding.

When interviewed on 4/5/23 at 11:54 a.m. Staff G said she worked that day (when Tenant C1 was sent out). She said Tenant C1 coughed a lot normally. She said in the morning Tenant C1 was sitting on the couch and she wrapped her legs. Staff G said she just started coughing. Staff G gave her Tessalon Perles, she kept spitting it out and eventually took it whole in pudding. She took one capsule. She said the day before the liquid cough syrup drained all over the day before. Staff G did not know she had a new bottle. She said over lunch her cough was a different cough and it was harder for her to cough up. It came out of

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her nose and mouth. Tenant C1's family member was there and said Tenant C1 was coughing and it was coming out of her nose. She said third shift had told her that Tenant C1 had cold symptoms. She said her scheduled medications were crushed but her Tessalon capsules could not be crushed. The PCP was notified after Tenant C1 was out of the building. Tenant C1's family member in the building (regarding notification).

When interviewed on 4/4/23 at 4:13 p.m. Tenant C1's family member arrived on 12/25/22 at about 10:00 a.m. or 10:30 a.m. Tenant C1 was sitting in the dining room and was coughing. She was coughing and vomiting out of her nose and mouth. The family member called the PCP and was told to take to her to the ER. When getting Tenant C1 in the car staff told her that Tenant C1 had vomited and was sick the day/evening prior and it had been reported to Staff I. Tenant C1 had pneumonia in both lungs.

Record review revealed Tenant C1's hospital records indicated Tenant C1 was admitted on 12/25/22. The principal diagnosis was pneumonic due to inhalation of food and vomit. Diagnosis also included acute respiratory failure with hypoxia. Hospital problems listed included: Acute hypoxemic respiratory failure (present on admission) and aspiration pneumonia (present on admission). Tenant C1 presented with altered mental status, vomiting and cough. Tenant C1 arrived and was unresponsive. She had vomit all over her and was not responding. Her oxygen saturation was 79% on room air. The hospital records indicated Tenant C1 had several episodes of nausea vomiting and was brought to the ER. She audibly wheezing and required supplemental oxygen. "Sepsis secondary to aspiration pneumonia."

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A 160	Continued From page 20 When interviewed on 6/7/23 at 12:05 p.m. the Divisional Director of Health and Wellness said staff probably did not document the notifications (for blood glucose levels and weights) but just did it, regarding notifications to the PCP. She said regarding Tessalon Perles prescribed with a crush medications order, she would have the called the doctor back and asked for a liquid. She said sometimes capsules were broken into applesauce. She said she was not on-call the nurse but had come to the building as Tenant C1's family member had made a complaint about the licensed practical nurse (LPN). She said she talked to the LPN who said she crushed her medications, got her out for breakfast and then she started vomiting. She said 911 was not called as Tenant C1's family member took her in a private vehicle. In summary, Tenant C1 did not receive services that were adequate and appropriate related to her high and low blood glucose levels and lack of notification to the nurse and PCP for readings outside of the parameters. Tenant C1 also did not receive services that were adequate and appropriate related to her daily weights and lack of notification to the nurse and PCP for weights outside of the parameters. Tenant C1 also did not receive services that were adequate and appropriate related to health status change with an illness and the administration of as needed medication. Prior shifts/staff reported Tenant C1 was ill and she was not taken to the hospital until her family arrived and noticed she had vomited out of her nose and mouth and was coughing. No vitals were recorded prior to leaving for the hospital. When she arrived at the hospital her oxygen saturation was 79% on room air.	A 160		

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A 160	Continued From page 21 3. Record review on 3/22/23 of Tenant C2's file revealed an Unusual Occurrence Report dated 12/21/22 (no time provided) indicated Tenant C2 was sent out by ambulance. The only information related to the incident documented was it took place in Tenant C2's apartment. There were no vital signs recorded on the incident report form. The form indicated Staff E notified the nurse, the PCP and family. It was signed by Staff E on 12/21/22. Continued record review revealed an Unusual Occurrence Report dated 12/28/22 signed by Staff A (who witnessed the incident), indicated the incident occurred on 12/21/22 between 8:20 a.m. and 8:30 a.m. The report indicated Staff A went into Tenant C2's apartment between 8:20 a.m. and 8:30 a.m. and he was lying on his bed with his pants and underwear down and had urine on himself. She gave him his walker to get up to use the bathroom and his left leg went under him. Staff A guided him to the floor and got help from Staff C. The reported indicated Tenant C2 had pain. No vital signs were recorded on the incident report form. The report did not indicated any notification of the nurse, director, family, or PCP. The incident reported dated on 12/28/22 was not completed immediately following the incident (on 12/21/22) and lacked documentation related to the incident including vital signs. When interviewed on 3/27/23 at 4:28 p.m. Staff A said at her first check (on that shift) Tenant C2 was asleep. When she went back at 7:15 a.m./7:30 a.m. he was lying on his bed on his back with his pants and underwear down. She said he was soaked in urine. She went and got his walker, put a gait belt on him (he was a one assist) pulled up his pants and he fell back on the	A 160		

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bed. She said something was wrong, she went to get Staff C and told her she thought Tenant C2 had a stroke. They had Staff E assist and she thought he had a stroke too. They called another staff to assist and (the four staff) got Tenant C2 into a wheelchair. It was two staff on each side, for a total of four staff assisting him. Tenant C2 was a two person assist that day and a check and change for toileting. She said a corporate person said an incident report needed to filled out. She said the incident report was in the box and it disappeared. She said Staff E also completed an incident report.

When interviewed on 3/23/23 at approximately 1:45 p.m. Staff C said she opened up the door said Staff A was in Tenant C2's apartment standing at the end of the bed (she could not see Tenant C2) and she was confirmed she was there to assist him. About 15 to 20 minutes later Staff A came and got Staff C and asked if she could help with Tenant C2. She walked in and saw Tenant C2 on the floor, in front of his side table, right next to the bed. Tenant C2 was on his knees and his headboard was out of the hinges. She tried to assist Tenant C2 to get him up and they could not get him up. Another staff responded and assisted and they put a chair under him. She said there was not a nurse here at that time. They walked him to the bathroom and he had a hard time moving his leg. Staff put Tenant C2 in a wheelchair. She said his leg got worse and he complained every time they tried to get him to go to the bathroom. Staff C said Tenant C2 was not a very verbal person but it could be seen on his face that it hurt. Staff C said he eventually was sent out to the the hospital later in the day. She said Staff A did not really say what happened just that he fell on the floor. Staff C did not ask why the bed was out of the frame.

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A 160	Continued From page 23 Further record review of Tenant C2's file revealed Progress Notes indicated the following: -On 12/22/22 it was noted that on 12/21/22 at 7:45 a.m. that Staff E called the Corporate Nurse and reported Tenant C2 had trouble moving one of his legs. Staff E was directed to call Tenant C2's family and to send him out to the ER. Staff E called back and said Tenant C2's family did not want him sent out to the hospital and would come to the Program and decide if they wanted him to be sent out. Staff E called the Corporate Nurse was informed that family had stopped out and did not want him seen. Staff E called later at 3:40 p.m. and said that Tenant #2 was pale and had diarrhea. Staff E was instructed to send Tenant C2 out to the hospital and notify his family. The note indicated after Tenant C2 transported by ambulance Staff E called the Corporate Nurse again and reported Staff C said that she helped Staff A pick Tenant C2 up from the floor that morning. Staff E was instructed to complete an incident report and notify family. At 8:20 p.m. the Corporate Nurse received a call from staff and it was reported that Tenant C2 had sustained a hip fracture. -On 12/28/22 it was noted Staff A said she lowered Tenant C2 to the floor when she attempted to stand him up to get dressed for the day. Staff C said when Staff A asked her for assistance with Tenant C2 he was on the side of the bed. Later in the day Tenant C2 was sent out to the hospital for evaluation. He had a hip fracture with surgical repair of his hip, was a two person assist for transfers and would not be returning due to needing a higher level of care. Continued record review of Tenant C2's file	A 160		

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revealed Tenant C2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant C2's service plan dated 12/5/22 reflected Tenant C2 got into bed himself and usually slept in his underwear. For morning cares, Tenant C2 was able to get himself up and ready. Staff set out new clean clothes for the day. Tenant C2 was independent with toileting and wore regular underwear. Tenant C2 was independent with mobility with cane/walker.

In summary, Tenant C2 had an incident in the morning on 12/21/22, where he was reportedly lowered to the ground by Staff A. Tenant C2 required the assistance of four staff to get him into a wheelchair after the incident. Tenant C2 had facial expressions of pain when staff assisted him to the restroom during the shift. Per his current service plan he was independent with mobility and was independent with toileting. The Corporate Nurse (nurse on-call) and Tenant C2's family were not made aware of the incident and change of condition with Tenant C2 when it occurred. Staff E contacted the Corporate Nurse regarding Tenant C2 not moving his leg and was directed to send him out to the ER and to notify family. Tenant C2's family elected initially not to have him sent out but was also not made aware of the incident from the morning on 12/21/22 at that time. Tenant C2 turned pale and had diarrhea and staff again contacted the Corporate Nurse. The Corporate Nurse directed staff to send Tenant C2 out to the hospital and notify family. It was not until after Tenant C2 had left the building via ambulance that the Corporate Nurse and Tenant C2's family were made aware of the incident from the morning on 12/21/22. Tenant C2 was transferred to the hospital and was diagnosed with a hip fracture. Tenant C2 did

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A 160	Continued From page 25 not receive services, cares and treatment that was adequate and appropriate related to the incident on 12/21/22. Tenant C2 died in January of 2023.	A 160		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications and complete treatments as ordered. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 3/22/23, 4/4/23 and 4/5/23 of Tenant C1's file revealed Progress Notes indicated the following: a. On 10/5/22 it was noted a new order was received to discontinue current humalog orders and start sliding scale insulin per orders. b. On 11/14/22 it was noted on 11/11/22 Tenant C1 was sent to the emergency room (ER) for increased edema to the lower extremities. Orders were received to change Lasix back to 40	A 285		

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milligram (mg), twice daily and Keflex 500 mg, three times per day for five days.

c. On 11/20/22 it was noted Tenant C1 was seen in the ER (emergency room) for an elevated blood glucose reading and pneumonia in both lungs. An order was received for azithromycin 250 mg, take 500 mg the first day and 250 mg for the next four days.

d. On 11/22/22 it was noted a new order was received to discontinue azithromycin and start Levaquin 750 mg, every other day, for seven doses.

Continued record revealed Tenant C1's October 2022 medication administration records (MARs) reflected the order for sliding scale insulin with a start date of 10/4/22. Staff documented sliding scale insulin was administered by recording their initials; however the MAR did not reflect the number of sliding scale units given each time the sliding scale insulin was administered.

Further record reviewed revealed the November 2022 MARs reflected the following omissions:

a. The MAR reflected an order for blood glucose checks four times per day. There were three omissions, when the blood glucose checks was not completed as ordered.

b. The MAR reflected an order for straight catheter, twice daily and to record the output. There were five omissions when the treatment was not completed as ordered.

c. The MAR reflected an order for elastic tubular bandages on the lower extremities in the morning and off a bedtime. There were two omissions

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when the treatment was not completed as ordered.

Continued record review revealed the November MARs also reflected the order for sliding scale insulin and staff documented as times the insulin was administered by recording their initials; however, the MAR did not reflect he number of sliding scale units each time the sliding scale insulin was administered.

Further record review revealed the November 2022 MARs reflected an order for cephalexin (antibiotic) capsule 500 mg, take one capsule by mouth daily for 5 days (see order above in notes). The order was started on 11/14/22 and was stopped on 11/19/22. The MAR reflected the medication was not available to administer for all doses on 11/18/22 and 11/19/22 (three times per day, each day, for a total of six doses). The medication was not administered due to not having a supply of the medication. The medication was documented as administered on the 11/15/22, 11/16/22 and 11/17/22 despite not having a supply of the medication for the remaining two dates the medication was ordered.

The November 2022 MARs reflected the order for azithromycin (antibiotic) was on the MAR with a start date of 11/20/22 and stop date of 11/25/22 (see order above in notes). The MAR reflected on 11/22/22, 11/24/22 and 11/25/22 the medication was charted as not administered due to not having a supply of the medication.

The November 2022 MAR reflected the order for levofloxacin (antibiotic) tablet, 750 mg, take one tablet every other day for seven days. The order was started on 11/22/22 and stopped on 12/4/22. The doses scheduled for 11/24/22 and 11/26/22

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were not administered as ordered due to not having a supply of the medication. A dose on 11/22/22 was charted as administered despite not having a supply of the medication on two following scheduled doses. Doses were documented as administered on 11/28/22 and 11/30/22 despite not having a supply of medication prior to and after (December 2022 see below).

Continued record review revealed December 2022 MARs reflected the order for sliding scale insulin and staff documented as times the insulin was administered by record their initials; however, the MAR did not reflect he number of sliding scale units each time the sliding scale insulin was administered.

The December 2022 MARs reflected the order for levofloxacin (antibiotic) tablet, 750 mg, take one tablet every other day for seven days. The order was started on 11/22/22 and stopped on 12/4/22. The doses scheduled to be administered in December were on 12/2/22 and 12/4/22. The medication was not administered as ordered due to not having a supply of the medication. The December 2022 MAR also reflected an order for Trulicity 0.75 mg/0.5 ml solution. Inject 0.75 mg subcantaneously once per week (Friday). It had a start date of 12/21/22. It was documented as administered on 12/23/22 and 12/24/22; despite only being ordered once weekly.

In summary, Tenant C1 was prescribed three different antibiotics with start dates from 11/14/22 to 11/22/22. Tenant C1 did not receive the medications as ordered in November and December 2022. All three antibiotics were not administered as ordered due to not having a supply of the medications. Additionally, the

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A 285	Continued From page 29 documentation of actual sliding scale insulin units was not completed for October, November and December 2022 for each dose of sliding scale insulin administered. There were also omissions related to Tenant C1's treatments not being completed as ordered. Tenant C1 did not receive medications and treatments as ordered. When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed all MARs and orders for the tenant listed above were provided. When interviewed on 6/7/23 at 12:05 p.m. and 1:12 p.m. the Divisional Director of Health and Wellness confirmed there was nothing additional regarding documentation for sliding scale insulin on the MARs. She said regarding the supply of medications, at times Tenant C1's family picked up medications from the back up pharmacy.	A 285		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide a sufficient number of trained staff available to fully meet to the needs of the tenants. This potentially affected all tenants (census of 34). Findings follow: 1. When interviewed on 3/23/23 at 1:11 p.m. Staff B said sometimes tenants were put on the toilet and staff wait too long to come back, especially before and after meals. She said	A 325		

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A 325	Continued From page 30 Tenant #1 voiced a concern that yesterday she was left on the toilet for a while. Regarding if there was enough staff to meet tenant needs, she said it was dependent on the day. She said it did happen on occasion where laundry was behind, showers were pushed back to the next day and it usually happened on second shift. When asked about the average response time to pendants, she said it dependent on the worker said 5 to 7 minutes and times could be upwards of 30 minutes to 1 hour. She said the pagers were not working today and staff went to the computer screen (located in the office to view pages). She said staff were supposed to carry a pager with them and it beeped every three minutes. She said there were three other staff working on first shift and none of them had a pager. She said she checked the computer when she walked by and was constantly checking the computer. She said about once every two weeks none of the pagers worked. She said they were usually missing one pager. Two new pagers were ordered. 2. When interviewed on 3/23/23 at approximately 1:45 p.m. Staff C said she did not have a pager with her. She said one of the staff who was working on first shift today had a pager. She was told there was one pager in the medication room. She said every time she walked by she checked the screen (for pages). She said she checked every 15 to 20 minutes. She said the pagers were broken right now and some were ordered. 3. When observed on 3/23/23 at approximately 2:45 p.m. the three staff who were working on second shift were asked by the Executive Director to see their pagers and only one staff had a pager.	A 325		

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A 325	Continued From page 31 4. Record review of pendant records for 3/23/23 (date staff reported not carrying pagers) was requested and indicated the following: a. There were 10 pendant calls over 15 minutes b. There were two pendant calls that were not responded to for about 1 hour. Continued record review revealed pendant records from 3/17/23 to 3/21/23 indicated the following: a. There was 1 pendant call that was not responded to for about 2 hours b. There were 8 pendant calls that were not responded to for about 1 hour c. There were 11 pendant calls that were not responded to for about 30 minutes or greater d. There were over 50 pendants calls that were not responded to for about 15 minutes or greater 5. When interviewed on 3/23/23 at about 3:45 p.m. and 6/7/23 at 11:48 a.m. the Executive Director said four pagers were working and two more pagers were ordered. The Executive Director said five minutes was the goal to response to pages.	A 325		
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	A 145		

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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.

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. This pertained to 1 of 2 discharged record reviewed (Tenant C1). Findings follow:

1. Record review on 3/22/23, 4/4/23 and 4/5/23 of Tenant C1's file revealed Progress Notes indicated the following:

a. On 10/5/22 it was noted on 10/3/22 Tenant C1's blood glucose reading was 39. Staff was advised to call emergency medical services and they administered glucose. Tenant C1's blood glucose rose and she was given food. Her blood glucose reading was 146.

b. On 10/5/22 it was noted a new order was received to discontinue current humalog orders and start sliding scale insulin per orders.

c. On 10/10/22 it was noted on 10/8/22 new orders were received including for a chest x-ray and Tessalon capsules, 100 milligram (mg) three times per day as needed for a cough.

d. On 10/25/22 it was noted new orders were received to decrease Lasix to 40 mg, once daily, discontinue metolazone, daily weights, call if weight gain was greater than 3 pounds in 24

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hours or 5 pounds in one week.

e. On 11/14/22 it was noted on 11/11/22 Tenant C1 was sent to the emergency room (ER) for increased edema to the lower extremities. Orders were received to change Lasix back to 40 mg, twice daily and Keflex 500 mg, three times per day for five days. On 11/12/22 an order was received for Robitussin DM 10 milliliters (ml), every six hours for a cough.

f. On 11/20/22 it was noted Tenant C1 was seen in the ER for an elevated blood glucose reading and pneumonia in both lungs. An order was received for azithromycin 250 mg, take 500 mg the first day and 250 mg for the next four days.

g. On 11/21/22 it was noted a new order was received to change the sliding scale insulin to four times daily with scheduled blood glucose checks and add three units of scheduled Novolog, three times daily with meals. The orders indicated to hold if her intake was less than 50%, not to give insulin until the meal is complete and to ensure she ate.

h. On 11/22/22 it was noted a new order was received to discontinue azithromycin and start Levaquin 750 mg, every other day, for seven doses.

i. On 11/28/22 it was noted new orders were received on 11/23/22 to discontinue amlodipine and a referral to physical therapy (PT) for lymphedema.

j. On 12/21/22 it was noted on 12/15/22 Tenant C1 fell and hit her head and was sent to the ER. A new order was received doxycycline 100 mg, twice daily for 7 days.

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A 145	Continued From page 34 k. On 12/21/22 it was noted a new order was received to start Trulicity 0.75 mg/0.5 ml subcantaneously, weekly. l. On 12/28/22 it was noted on 12/25/22 Tenant C1 was taken by car to the ER due to respiratory illness. Staff reported Tenant C1 was coughing/vomiting phlegm from her mouth and nose. Tenant C1's family reported staff did not crush medications as ordered. The staff reported she did crush medications as ordered. The note indicated the nurse at the hospital indicated Tenant C1 was diagnosed with respiratory failure, had pneumonia and hospice was being consulted. Continued record review of Tenant C1's file revealed evaluations were last completed on 8/11/22. Evaluations were not completed as needed with significant changes that occurred with Tenant C1's including: high and low blood sugars that required her to be seen or for EMS to respond, multiple diagnoses of pneumonia, new order changes with her insulin, including sliding scale insulin, new orders for Lasix and increased edema to her bilateral extremities, a fall with hitting her head and going out to the ER, a new order for an injectable medication and for PT related to her lymphedema. When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed all of the evaluations for the tenant listed above were provided.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be	A 290		

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A 290	Continued From page 35 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 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 1 of 2 current tenants reviewed (Tenant #2) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 3/21/23 to 3/23/23 of Tenant #2's file revealed Progress Notes dated 2/10/23 indicated Tenant #2 complained of a sore throat and test positive for COVID-19. Tenant #2 was in placed in quarantine for 10 days. The next entry in Progress Notes was dated 3/9/23. Nurse's notes were not documented by exception after Tenant #2's positive COVID-19 test, symptoms and isolation. 2. Record review on 3/22/23, 4/4/23 and 4/5/23 of Tenant C1's file revealed Progress Notes indicated the following: a. On 10/5/22 it was noted that on 10/3/22 Tenant C1's blood glucose reading was 39. Staff was advised to call emergency medical services (EMS) and they administered glucose. Tenant C1's blood glucose rose and she was given food. Her blood glucose reading was 146.	A 290		

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It was charted on 10/5/22 and the issue with her blood glucose occurred on 10/3/22.

b. On 11/14/22 it was noted on 11/11/22 Tenant C1 was sent to the emergency room (ER) for increased edema to the lower extremities. Orders were received to change Lasix back to 40 milligram (mg), twice daily and Keflex 500 mg, three times per day for five days. On 11/12/22 an order was received for Robitussin DM 10 milliters (ml), every six hours for a cough.

It was charted on 11/14/22 and the ER visit occurred on 11/11/22 and new order was received on 11/12/22.

c. On 11/28/22 it was noted new orders were received on 11/23/22 to discontinue amlodipine and a referral to physical therapy (PT) for lymphedema.

It was charted on 11/28/22 and the orders were received on 11/23/22.

d. On 12/21/22 it was noted on 12/15/22 Tenant C1 fell and hit her head and was sent to the ER. A new order was received doxycycline 100 mg, twice daily for 7 days.

It was charted on 12/21/22 and she fell and went to the to hospital on 12/15/22.

e. On 12/29/22 it was noted on 12/25/22 Tenant C1 was taken by car to the ER due to respiratory illness. Staff reported Tenant C1 was coughing/vomiting phlegm from her mouth and nose. Tenant C1's family reported staff did not crush medications as ordered. The staff reported she did crush medications as ordered. The note indicated the nurse at the hospital indicated

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A 290	Continued From page 37 Tenant C1 was diagnosed with respiratory failure, had pneumonia and hospice was being consulted. It was charted on 12/29/22 and it occurred on 12/25/22. Tenant C1 was discharged (death) on 1/1/23. An entry was not documented in nurse's notes related to her discharge from the Program. When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed all nurse's notes were provided for tenants listed above and the standard of practice for completion of the nurse's notes was the day of. When interviewed on 6/7/23 at 12:05 p.m. the Divisional Director of Health and Wellness said the Progress Notes should be charted as it occurred typically.	A 290		
A 340	481-69.25(2) Tenant Documents 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to maintain tenant records for a minimum or three years after death or transfer of the tenant. This pertained to 1 of 2 current tenants reviewed (Tenant #2) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 3/21/23 to 3/23/23 of Tenant	A 340		

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A 340	Continued From page 38	A 340		

#2's file revealed the Progress Notes dated 12/5/22 indicated on 12/4/22 Tenant #2 had bright red blood when using the bathroom. She was sent to the emergency room (ER) and was admitted for dehydration and a urinary tract infection (UTI).

Continued record review revealed hospital records reflected the following: Tenant #2 was admitted on 12/5/22 and discharged on 12/7/22. The hospital records indicated "the patient had severe excoriations and open skin wounds all over her perineal area as well as her rectal area on through her at the crack of her buttocks." She also appeared "severely dehydrated with eye sockets sunken" and appeared "severely" malnourished. The hospital records indicated the Assessment/Plan indicated skin breakdown "Due to constant sitting in the chair." Tenant #2 also was dehydrated and had a perineal rash. It was noted the rash was "Also due to pressure on the pedal areas from prolonged sitting." A wound clinic consult was ordered due to the redness in the groin and perineal area. The hospital records indicated the area was the perineal area, anterior and posterior. It was present upon admission. The skin abnormality type was a erythema, excoriation, and it was blanchable. The plan was to start Sensi-Care twice daily and as needed the perineal area. A Foley catheter was now in place. It appeared to be a rash or "even a burn from UTI."

Further record review revealed task records, documentation of cares and services including toileting cares, for Tenant #2 could not be located for November and December of 2022 and January of 2023.

2. Record review on 3/22/23, 4/4/23 and 4/5/23

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A 340	Continued From page 39 of Tenant C1's file revealed discharge date of 1/1/23. Continued record review revealed a task record, documentation of cares and services for Tenant C1 could not be located for November of 2022. 3. Record review on 3/22/23 of Tenant C2's file revealed revealed a discharge date of 12/28/22. Continued record review revealed a task record, documentation of cares and services for Tenant C2, could not be located for November 2022. Record review of an email from the Health and Wellness Director dated 3/22/23 indicated she could not locate task records as indicated above for Tenant #2 and Tenant C2. A typed statement from the Executive Director (undated) indicated staff communication logs prior to 12/28/22 could not be found. When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed all records requested that were available were provided including task records and communication logs.	A 340		
A 350	481-69.26(1) 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.	A 350		

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A 350	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed to develop service plans that reflected the identified needs of the tenants. This pertained to 1 of 2 current tenants reviewed (Tenant #2) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 3/21/23 to 3/23/23 of Tenant #2's file revealed a service plan was developed dated 12/8/22. The Progress Notes reflected the following on 12/5/22 it was noted on 12/4/22 Tenant #2 had bright red blood when using the bathroom. She was sent to the emergency room (ER) and was admitted for dehydration and a urinary tract infection (UTI). Continued record review revealed hospital records reflected the following: Tenant #2 was admitted on 12/5/22 and discharged on 12/7/22. The hospital records indicated "the patient had severe excoriations and open skin wounds all over her perineal area as well as her rectal area on through her at the crack of her buttocks." She also appeared "severely dehydrated with eye sockets sunken" and appeared "severely" malnourished. The hospital records indicated the Assessment/Plan indicated skin breakdown "Due to constant sitting in the chair." Tenant #2 also was dehydrated and had a perineal rash. It was noted the rash was "Also due to pressure on the pedal areas from prolonged sitting." A wound clinic consult was ordered due to the redness in the groin and perineal area. The hospital records indicated the area was the perineal area, anterior and posterior. It was present upon admission. The skin abnormality type was a erythema, excoriation, and it was blanchable. The plan was	A 350		

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A 350	Continued From page 41	A 350		

to start Sensi-Care twice daily and as needed the perineal area. A Foley catheter was now in place. It appeared to be a rash or "even a burn from UTI."

Further record review revealed a New Physician's Order document dated 12/9/22 indicated Hospice nurses were to change Foley catheter once monthly and as needed.

Continued record review revealed the service plan dated 3/9/23 reflected Tenant #2 had a catheter and Hospice changed the catheter. The 12/8/22 service plan, developed post hospitalization, reflected Tenant #2 received Hospice services; however, did not reflect the catheter despite the catheter placement at the hospital. The service plan failed to reflect the service needs of Tenant #2.

2. Record review on 3/22/23, 4/4/23 and 4/5/23 of Tenant C1's file revealed Progress Notes indicated the following:

a. On 10/5/22 it was noted that on 10/3/22 Tenant C1's blood glucose reading was 39. Staff was advised to call emergency medical services and they administered glucose. Tenant C1's blood glucose rose and she was given food. Her blood glucose reading was 146.

b. On 10/5/22 it was noted a new order was received to discontinue current humalog orders and start sliding scale insulin per orders.

c. On 10/10/22 it was noted on 10/8/22 new orders were received including for a chest x-ray and Tessalon capsules, 100 milligram (mg) three times per day as needed for a cough.

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A 350	Continued From page 42 d. On 10/25/22 it was noted new orders were received to decrease Lasix to 40 mg, once daily, discontinue metolazone, daily weights, call if weight gain was greater than 3 pounds in 24 hours or 5 pounds in one week. e. On 11/14/22 it was noted on 11/11/22 Tenant C1 was sent to the emergency room (ER) for increased edema to the lower extremities. Orders were received to change Lasix back to 40 mg, twice daily and Keflex 500 mg, three times per day for five days. On 11/12/22 an order was received for Robitussin DM 10 milliliters (ml), every six hours for a cough. f. On 11/20/22 it was noted Tenant C1 was seen in the ER for an elevated blood glucose reading and pneumonia in both lungs. An order was received for azithromycin 250 mg, take 500 mg the first day and 250 mg for the next four days. g. On 11/21/22 it was noted a new order was received to change the sliding scale insulin to four times daily with scheduled blood glucose checks and add three units of scheduled Novolog, three times daily with meals. The orders indicated to hold if her intake was less than 50%, not to give insulin until the meal is complete and to ensure she ate. h. On 11/22/22 it was noted a new order was received to discontinue azithromycin and start Levaquin 750 mg, every other day, for seven doses. i. On 11/28/22 it was noted new orders were received on 11/23/22 to discontinue amlodipine and a referral to physical therapy (PT) for lymphedema.	A 350		

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A 350	Continued From page 43 j. On 12/21/22 it was noted on 12/15/22 Tenant C1 fell and hit her head and was sent to the ER. A new order was received doxycycline 100 mg, twice daily for 7 days. k. On 12/21/22 it was noted a new order was received to start Trulicity 0.75 mg/0.5 ml subcantaneously, weekly. l. On 12/28/22 it was noted on 12/25/22 Tenant C1 was taken by car to the ER due to respiratory illness. Staff reported Tenant C1 was coughing/vomiting phlegm from her mouth and nose. Tenant C1's family reported staff did not crush medications as ordered. The staff reported she did crush medications as ordered. The note indicated the nurse at the hospital indicated Tenant C1 was diagnosed with respiratory failure, had pneumonia and hospice was being consulted. Continued record review of Tenant C1's file revealed the service plan was last completed on 8/11/22. The service plan was not updated as needed with significant changes and did not reflect the service needs of Tenant C1 including: high and low blood glucose readings, multiple diagnoses of pneumonia, new order changes with her insulin, including sliding scale insulin, new orders for Lasix and increased edema to her bilateral extremities, a fall with hitting her head and going out to the ER, a new order for an injectable medication and for PT related to her lymphedema. Tenant C1's service plan was not updated as needed and did not reflect her needs. When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed all service plans for the tenants listed above were provided.	A 350		

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A 370	Continued From page 44	A 370		
A 370	481-69.26(3)a Service Plans 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. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain signed service plans when a significant change occurred. This pertained to 2 of 2 current tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. Record review on 3/20/23 of Tenant #1's file revealed a service plan was developed dated 2/13/23. The service plan reflected changes related to transfers from prior the service plan dated 9/1/22. The service plan was signed by the Corporate Nurse on 2/13/23 and the Executive Director on 2/15/23; however, lacked the signature of Tenant #1 or Tenant #1's legal representative. 2. Record review on 3/21/23 to 3/23/23 of Tenant #2's file revealed a service plan was developed dated 12/8/22. The Progress Notes reflected the following: a. On 12/5/22 it was noted on 12/4/22 Tenant #2 had bright red blood when using the bathroom. She was sent to the emergency room and was	A 370		

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A 370	Continued From page 45 admitted for dehydration and a urinary tract infection. b. On 12/8/22 it was noted a change of condition service plan was completed to add hospice services, a red area on her buttocks and a new order for Calmoseptine. Continued record review revealed the service plan dated 12/8/22 did not reflect a health or human services professional signature or the signature of Tenant #2 or Tenant #2's legal representative. When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed all service plans for the tenants listed above were provided.	A 370		
A 430	481-69.27(1)c Nurse Review 69.27(1) 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: 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 to complete a nurse review as needed with a change in a tenant's health status.	A 430		

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This pertained to 2 of 5 sample tenants (Tenant C1 and Tenant #1). Findings follow:

1. Record review on 3/22/23, 4/4/23 and 4/5/23 of Tenant C1's file revealed Progress Notes indicated the following:

a. On 10/25/22 it was noted new orders were received to decrease Lasix to 40 milligram (mg) once daily, discontinue metolazone, daily weights, call if weight gain was greater than 3 pounds in 24 hours and 5 pounds in one week.

b. On 11/14/22 it was noted on 11/11/22 Tenant C1 was sent to the emergency room for increased edema to the lower extremities. Orders were received to change Lasix back to 40 mg, twice daily and Keflex 500 mg, three times per day for five days.

c. On 11/28/22 it was noted new orders were received on 11/23/22 to discontinue amlodipine and a referral to physical therapy (PT) for lymphedema.

Continued record review revealed hospital records indicated Tenant C1 was seen in the emergency room (ER) on 11/11/22 and she had a 12 pound weight gain that day. Tenant C1 was brought to the ER by her family member in a personal car due to concerns of leg swelling and weight gain. The family member said her legs looked significantly more swollen and weeping. The report indicated upon arrival to the ER the wraps "completely soaked." Staff weighed her that evening and she had a 12 pound gain from that morning. Tenant C1's Lasix dose was recently decreased. The clinical impression indicated acute cystitis without hematuria, acute chronic heart failure. Cephalexin 500 milligram,

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take one capsule, three times daily for five days was ordered.

2. When interviewed on 4/6/23 at 4:31 p.m. Staff F said she noticed Tenant C1's skin was open, she documented it on a white sheet and turned it in. She said one time when she was giving Tenant C1 a bath, it was noted Tenant C1 had blood on her legs. The blood was new. Staff F showed the medication aide and took pictures for the nurse. Her wraps were removed and her skin was open. The Corporate Nurse was contacted and said to leave the wraps and he would look at it. She said she believed she documented the issue with Tenant C1's on the task sheet. She thought it possibly occurred in December.

When interviewed on 4/6/23 at 1:15 p.m. Staff H said at one point Tenant C1's legs were open and bleeding. She said it was reported. She did not know when it occurred.

When interviewed on 4/4/23 at 4:13 p.m. Tenant C1's family member said he/she was told in November 2022 there was blood on Tenant C1's legs. There was no incident report and information was really vague. Staff found it when they gave her a bath. The family said Tenant C1's primary care provider was not notified. Tenant C1 had just been to the ER and been treated for a urinary tract infection and edema.

Continued record review of Tenant C1's file revealed there was no notation of the incident as described above by staff and Tenant C1's family. Staff reported the issue with Tenant C1's legs; however, a nurse review was not completed with a change noted in Tenant C1's health status. A nurse review was not completed as needed for Tenant C1 when a change in her health status

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occurred.

When interviewed on 6/7/23 at 11:48 a.m. the Executive Director confirmed all nurse reviews were provided for the tenant listed above.

3. Record review of Tenant #1's Unusual Occurrence Report dated 2/13/23 indicated Tenant #1 had an injury to her right upper extremity and complained of pain. Tenant #1 said Staff A was always rough with her and today she pulled Tenant #1 out of bed and was so rough. There was a bruise approximately 2.5-3 inches by 1 inch on the top of her right wrist. The report indicated a cool cloth and Tylenol were offered to Tenant #1 and she declined.

Record review on 3/21/23 of Tenant #1's file revealed a Nursing Assessment was completed on 2/13/23 for a routine review. The assessment completed failed to address the Tenant #1's physical injury as noted above. A documented assessment of Tenant #1's bruising and injury was not completed when the injury occurred to assess and document the injury or after the occurrence and when it was healed. Nurse reviews were not completed for Tenant #1 related to physical injury that was reported on 2/13/23.

When interviewed on 4/5/23 at 3:15 p.m. the Health and Wellness Director confirmed all nurse reviews were provided including for the tenant listed above.