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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 impairment: 1 Number of tenants with cognitive impairment: 13 Total census: 14 No regulatory insufficiencies were cited related to the investigation of Complaint #114420-C. The following regulatory insufficiencies were cited during the investigation of Complaints #112945-C, and #114783-C and the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000	See Attached POC 11/15/23	
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 established policy and procedure related the completion of incident reports. This pertained 1 of 6 current tenants reviewed (Tenant #1) to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 8/8/23 and 8/9/23 of Tenant #1's file reviewed an Internal Investigation document dated 4/14/23 indicated a staff observed another staff removed the pendant from	A 150		

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A 150	Continued From page 1	A 150		

Tenant #1 wrist on 4/12/23 at 9:00 p.m. and place it in the drawer by the nurse's station. It was noted the staff reported the other staff was frustrated by how many times Tenant #1 had been using her pendant.

Continued record review revealed an incident report was not completed for Tenant #1 related to the above incident.

2. Record review on 8/10/23 and 8/14/23 of Tenant C1's file revealed an electronic incident report dated 3/3/23 at 1:30 p.m. indicated staff reported Tenant C1 was running very fast in the hallway close to the kitchen and fell. She fell on her face and sustained a laceration above her eye and a skin tear on her elbow. The nurse cleansed and applied steri-strips on the skin tear. Tenant C1 was assisted up and to her apartment. The electronic incident report was completed by the Former Healthcare Coordinator. A handwritten incident report or witness statement completed by staff who witnessed the incident with Tenant C1 was not provided.

Continued record review revealed an electronic incident reported dated 3/7/23 at 1:30 a.m. indicated staff entered the apartment and noted that Tenant C1 had slid off the bed and onto the floor. She was laying on her left side. Staff assisted her up and changed her clothes as she was incontinent. The incident report was completed by a nurse educator. A handwritten incident report was not completed by the staff who found Tenant C1 on the floor.

Further record review revealed a electronic incident report dated 4/5/23 dated at 1:14 a.m. indicated staff reported Tenant C1's finger was bleeding during hourly checks that morning. The

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A 150	Continued From page 2	A 150		

finger had a deep cut. Tenant C1 reported her bed was unsteady and it resulted in the injury. It was noted Tenant C1 was sent to the hospital for treatment. It was noted the incident report was completed by the Former Healthcare Coordinator. A handwritten incident report was not completed by staff who found Tenant C1 on the floor.

Continued record review revealed a hospital document dated 4/5/23, indicated the date of service was 4/5/23 at 2:35 a.m. It was noted Tenant C1 fell out of bed, had a right thumb deformity. The report indicated she was found out of bed that evening with the right thumb injury and deformity. Tenant C1 had an "open fracture of base of distal phalanx with dislocation at the IP joint. There was also suspicion for second fracture at the base of the first metacarpal." A "bedside washout and laceration closure" was completed and a splint was placed for both fractures.

In summary, handwritten incident reports were not completed by the staff on 3/7/23 and 4/5/23, including when staff found Tenant C1 with her finger injury and deformity. A handwritten incident report or witness statement was not completed by staff who witnessed the incident with Tenant C1 on 3/3/23, when she sustained a laceration and skin tear.

3. Continued record review revealed the Program's policy and procedure regarding the completion of incident report indicated staff would notify the nurse or designee if a tenant fell or with an usual event. An incident report would be completed by the nurse or designee. The nurse would indicated a person in charge on the schedule to fill out an incident report in the nurse's absence. Witness would be provide a

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A 150	Continued From page 3 statement. The incident report would be submitted to the nurse. The nurse would follow up and enter it into the electronic system. The paper incident report forms were kept for three years, the electronic incident reports form were kept indefinitely. 4. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed all incident reports for the tenants listed above were provided.	A 150		
A 270	481-67.5(2)f(1) 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: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure medications were	A 270		

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A 270	Continued From page 4 administered only by individuals who complete an approved medication manager course. This pertained to 3 of 3 former staff reviewed (Staff G, K and L). Findings follow: 1. Record review on 8/15/23 revealed Staff G was hired on 2/13/23 and was no longer employed on 4/14/23. Review of Staff G's file revealed Staff G had not completed an approved medication manager course. 2. Record review on 8/15/23 revealed Staff K was hired 8/29/22 and was no longer employed on 7/16/23. Review of Staff K's file revealed Staff K completed an approved medication manager course dated 6/26/23. 3. Record review on 8/15/23 revealed Staff L was hired on 9/26/22 and was no longer employed on 7/6/23. Review of Staff L's file revealed Staff L had not completed an approved medication manager course. 4. Record review of medication administration records (MARs) for Tenants #1, #2, #3, #4, #5 and #6, including the months of February to June 2023, reflected Staff G, Staff K and Staff L signed off medications as administered during that time period. Staff K administered medications from February to June (prior to the completion of the medication manager certificate). 5. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director said Staff G and Staff L did not administer medications and Staff K was a medication manager.	A 270		
A 285	481-67.5(2)f(4) Medications	A 285		

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A 285	Continued From page 5 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 consistently administer medications as prescribed. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6). Findings follow: 1. Record review on 8/8/23 and 8/9/23 revealed Tenant #1's file indicated the May 2023 medication administration record (MAR) had over 10 omissions of medications and treatments not documented as administered or completed as ordered. The June 2023 MAR had over 10 omissions of medications and treatments not documented as administered or completed as ordered. The July 2023 MAR had 7 omissions of medications or treatments not documented as administered or completed as ordered. 2. Record review on 8/9/23 and 8/14/23 revealed Tenant #2's file indicated a hospice order was received dated 2/10/23 to start Lorazepam Intensol, 2 milligram (mg) milliters (ml), 0.25 ml, by mouth or sublingually (SL) twice daily for anxiety/restlessness. The order was noted 5/24/23 (ordered on 2/10/23). Review of the February 2023 MAR reflected an order dated	A 285		

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1/16/23 for lorazepam concentrate 0.25 ml, by mouth/SL every four hours as needed for anxiety/restlessness. The February MAR did not reflect the order or administration of scheduled Lorazepam Intensol as prescribed. The March, April and May 2023 MARs also did not reflect an order or administration of the medication as prescribed and a order to discontinue the medication was not provided.

Continued record review revealed a hospice order dated 5/23/23 to discontinue the lorazepam oral concentrate 2 mg/ml, 0.25 ml every 4 hours as needed and to start lorazepam 0.5 mg tablets, 1 tablet every 4 hours as needed for restlessness and agitation was ordered. An order was not provided to discontinue the Lorazepam Intensol scheduled twice daily (ordered on 2/10/23).

Further record review revealed a Progress Note dated 5/24/23 reflected an order was received on 2/13/23 for lorazepam 2 mg/ml, 0.25 ml, twice daily. The order was never entered and was not on the current hospice medication list. A fax was sent to hospice to request when it was discontinued.

Continued record review revealed a hospice order dated 4/13/23 indicated "RNCM" to assess stage 2 (sore) to lower left buttock weekly and as needed until healed. Program staff would complete wound care of applying menthol 0.44%-zinc oxide-20.6% topical ointment to her buttocks with each incontinent episode. The order was noted on 5/24/23 (ordered on 4/13/23).

Further record review revealed revealed the April 2023 MAR reflected an order dated 2/4/21 for Calmoseptine ointment, apply twice daily topically to perineal area as needed. The April 2023 MAR

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A 285	Continued From page 7	A 285		

did not reflect any doses of the Calmoseptine as needed administered. The MAR also did not reflect the new order for the topical medication to be applied to her buttocks with each incontinent episode.

Continued record review revealed the Medication Admin Audit Report for June 2023 reflected medications were documented as given; however, the times medications were given were not at the prescribed time. For example, on 6/14/23 Trazadone 50 mg tablet, take one tablet by mouth at bedtime order time of 8:00 p.m. was administered at 10:40 p.m. and documented at 10:40 p.m. Donepezil 10 mg, take one tablet at bedtime ordered at 8:00 p.m. was administered at 10:40 p.m. and documented at 10:40 p.m., Melatonin 3 mg, take one tablet at bedtime ordered at 8:00 p.m. and olanzapine 2.5 mg tablet , take one tablet twice daily, ordered at 8:00 p.m. were both documented as administered at 10:40 p.m.

3. Record review on 8/10/23 of Tenant #3's file revealed the May 2023 MAR had over 5 omissions of medications and treatments not documented as administered or completed as ordered. The June MAR had 4 omissions of medications and treatments not documented as administered or completed as ordered.

4. Record review on 8/9/23 of Tenant #4's file revealed the March 2023 MAR had over 5 omissions of medications and treatments not documented as administered or completed as ordered. The April MAR had over 10 omissions of medications and treatments not documented as administered or completed as ordered.

5. Record review on 8/14/23 of Tenant #5's file

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A 285	Continued From page 8 revealed the May 2023 MAR had over 5 omissions of medications and treatments not documented as administered or completed as ordered. The July 2023 MAR had over 5 omissions of medications and treatments not documented as administered or completed as ordered. 6. Record review on 8/14/23 of Tenant #6's file revealed the May 2023 MAR had over 5 omissions of medications and treatments not documented as administered or completed as ordered. The June 2023 MAR had 5 omissions of medications and treatments not documented as administered or completed as ordered. The July 2023 MAR had over 5 omissions omissions of medications and treatments not documented as administered or completed as ordered. 7. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed all of the MARs and orders for the tenants reviewed were provided.	A 285		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received nurse	A 345		

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A 345	Continued From page 9 delegated training within 30 days of employment. This pertained to 4 of 7 staff reviewed (Staff A, B, F and G). Findings follow: 1. Record review on 8/7/23 of Staff A's file revealed a hire date of 3/21/23. Nurse delegations were dated 5/8/23, which was greater than 30 days from Staff A's employment. 2. Record review on 8/7/23 of Staff B's file revealed a hire date of 6/5/23. Nurse delegations were dated 7/14/23 for medications and treatments; which was greater than 30 days from Staff B's employment. The nurse delegation training for Staff B did not include training on activities of daily living (ADLs). 3. Record review on 8/7/23 of Staff F's file revealed a hire dated 1/30/23. Nurse delegations were dated 3/6/23; which was greater than 30 days from Staff F's employment. 4. Record review on 8/9/23 of Staff G's file revealed a hire date of 2/13/23 and a termination date of 4/14/23. Nurse delegations were not completed within 30 days of employment or during the time Staff G was employed. 5. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed all nurse delegation documents for the staff listed above were provided.	A 345		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation	A 361		

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A 361	Continued From page 10 shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on observation, interview and record review the Program failed to have staff provide services in accordance with the training provided. This pertained to 1 of 1 tenant observed on medication pass that had blood glucose monitoring and insulin administration (Tenant #7) and 1 of 1 staff observed administering medications (Staff H). Findings follow: 1. Observation on 8/7/23 during the lunch medication pass revealed Staff H administered medications to three tenants, including Tenant #7. Staff H donned gloves, prepared the supplies needed for the task and took Tenant #7's blood glucose reading, which was 91. Staff H recorded her blood glucose reading on the electronic tablet without doffing gloves and completing hand hygiene. There was blood visible during the blood glucose monitoring check completed for Tenant #7. Staff H then administered Tenant #7's scheduled insulin, doffed her gloves, and signed off the insulin administration. 2. Record review on 8/14/23 of Tenant #7's medication administration record reflected on 8/7/23 Staff H signed off the blood glucose check and scheduled insulin ordered at 11:30 a.m. 3. Record review on 8/14/23 of Staff H's training documents revealed Staff H had completed nurse delegations for glucometer test procedures and insulin pen administration dated 3/11/22. Staff H also had a medication manager certificate dated	A 361		

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A 361	Continued From page 11 1/3/22. 4. Continued record review revealed Glucometer Tests Procedure nurse delegation document indicated the following: to put on gloves, gather and preparation supplies, complete the blood glucose reading, turn off the meter, dispose of the lancet and test strip in the biohazard receptacle, provide the tenant with the results, remove gloves, wash hands with soap and water, compare results and report any abnormalities and record results. Further record review revealed the Insulin Pen administration nurse delegation indicated to wash hands or use a hand sanitizer and to put on gloves prior to insulin administration. After the insulin was administered, to place the syringe unit in the sharps container, then it indicated to removed gloves and wash hands with soap and water. 5. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director said for blood glucose checks staff would be expected to wash their hands, put on gloves, complete the task, remove gloves and wash their hands. She confirmed Staff H had nurse delegation training.	A 361		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by:	A 380		

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A 380	Continued From page 12 Based on interview and record review the Program failed to ensure staff received required dependent adult abuse training within six months of employment. This pertained to 2 of 3 staff hired greater than six months (Staff D and Staff E). Findings follow: 1. Record review on 8/7/23 of Staff D's file revealed a hire date of 2/7/23. Staff D did not complete dependent adult abuse training completed when the file reviewed or within six months of employment. 2. Record review on 8/7/23 of Staff E's file revealed a hire date of 12/12/22. Staff E did not complete dependent adult abuse training completed when the file reviewed or within six months of employment. 3. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed all dependent abuse training was provided for the staff listed above.	A 380		
A 420	481-67.19(3)d Record Checks 67.19(3)d If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program.	A 420		

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A 420	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interivew and record review the Program failed to obtain an evaluation of a founded child abuse prior to employment. This pertained to 1 of 1 staff reviewed that had a record that required evaluation (Staff E). Findings follow: 1. Record review on 8/7/23 of Staff E's file revealed a hire date of 12/12/22. A Single Contact License & Background check document completed on 12/6/22 indicated to initiate the record check evaluaiton process related to teh child abuse registry. An evaluation was completed an letter dated 2/2/22 indicated Staff E could work at the Program with Staff E's prior employment with the Program. The evaluation approval was not obtained prior to Staff E's employment on 12/12/22. 2. Continued record review revealed time card records indicated Staff E first worked on 12/15/23 at 6:52 a.m. 3. When interviewed on 8/15/23 at the Executive Director confirmed all background check information was provided for the staff reviewed.	A 420		
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	A 145		

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A 145	Continued From page 14	A 145		

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.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to consistently complete evaluations as needed with significant change in tenant condition. This pertained to 1 of 1 current reviewed that sustained a fall with fracture (Tenant #5). Findings follow:

1. Record review on 8/14/23 of Tenant #5's file revealed Progress Notes indicated the following:

a. On 7/24/23 staff assisted Tenant #5 with her shower, when staff turned around to get the towel, Tenant #5 was falling to the floor. Tenant #5 got up independently and laid down in bed. Tenant #5's family was notified.

b. On 7/25/23 Tenant #5 was seen by her primary care provider (PCP) and new orders were received for back pain/contusion of mid lower back including: to ice every 4 to 6 hours for 10 minutes, Tylenol extra strength, two tablets every eight hours for seven days and then as needed. Topical Voltaren gel was also ordered to apply two to three times per day for seven to ten days.

c. On 7/26/23 staff reported Tenant #5 was in pain that morning and did not want to sit up to take her Tylenol. Tenant #5's family was notified

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A 145	Continued From page 15	A 145		

by a nurse and family said that on 7/24/23 Tenant #5 was seen by her PCP. An x-ray was ordered and it showed an old compression fracture but no new fractures.

d. On 7/28/23 staff reported Tenant #5 complained of back and right side pain. Tenant #5 said it was a sharp pain, bruising was noted to her back from the fall. Tenant #5's family reported she had pain yesterday too.

e. On 7/28/23 Tenant #5's family visited and was agreeable for the nurse to reach out to the PCP's office regarding a lidocaine patch to help with back pain.

f. On 7/28/23 a new order was received for lidocaine patch to the lower back and for a urinalysis with culture and sensitivity and to encourage fluids.

g. On 7/28/23 at 11:00 p.m. Tenant #5 had a fall and was sent out to the hospital. It was noted Tenant #5 had a compression fracture of the lumbar and rib fracture. After discharge back to the Program, the hospital called and requested Tenant #5 return, as they noticed the fractures and wanted to keep her for observation. Family declined to sent her back to the hospital

h. On 7/31/23 a change of condition was completed related to Tenant #5 fall with lumbar fracture and rib fracture. Tenant #5 had a decrease in services.

Continued record review revealed hospital documents dated 7/29/23 reflected Tenant #5 had stomach pain since the afternoon. It indicated radiology results indicated "Acute fractures of the L1, L2, L3 transverse processes. Right posterior

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A 145	Continued From page 16 11 and 12 th rib fractures. Compression deformity of T2 vertebral body." The report indicated the preliminary report did not include information related to the rib, transverse fractures or diverticulitis (it was added to final report). The hospital records indicated the Supervising Physician Statement indicated the provider became aware of the final results of the computerized tomography (CT) on 8/4/23 and was not able to examine Tenant #5. No history was given when she was transported to the hospital regarding falling and Tenant #5 denied falling (however she had cognitive impairment). The notes indicated Tenant #5 was prescribed Keflex for a urinary tract infection and was discharged back to the Program. After discharge the staff physician radiologist called and informed that the initial read (of CT scan) missed the fractures and diverticulitis. Further record review revealed a Comprehensive Assessment was dated 7/31/23 and it was completed for fall that resulted in a lumbar compression fracture and rib fracture. An evaluation was completed on 7/31/23; however, an evaluation was not completed after the fall on 7/24/23, PCP visit and new orders for back pain and treatment. Tenant #5 sustained a second fall late on 7/28/23 and was sent out to the hospital for evaluation. It was determined she sustained rib and lumbar compression fractures. Evaluations were not completed as needed with significant change. 2. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed all evaluations were provided for all tenants reviewed.	A 145		

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A 350	Continued From page 17	A 350		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently update service plans as needed and failed to develop service plans reflect the identified needs of tenants. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5, #6). Findings follow: 1. Record review on 8/8/23 and 8/9/23 of Tenant #1's file revealed the Medication Review Report signed on 6/1/23 reflected orders for compression hose on in morning and off at night and Nitroglycerin 0.4 milligram (mg), take one dose as needed every five minutes as needed (max dose three doses in 15 minutes). Continued record review revealed a Progress Note dated 6/3/23 reflected staff reported Tenant #1's tongue and lips had a thick white coating. Orders were received for a Nystatin swish. Further record review revealed May, June and July 2023 medication administration records (MARs) reflected refusals of the compression hose. The June MAR reflected the order for Nystatin Mouth/Throat suspension, give 5 ml by	A 350		

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mouth four times per day for thrush (swish in mouth and spit out).

Continued record review revealed the service plan dated 7/25/23 reflected Tenant #1 refused the compression hose; however, Tenant #1 had refused the compression hose months before it was reflected on the service plan. The service plans dated 5/11/23 and 6/8/23 were not updated to reflect the refusals of the compression hose. The service plan also did not reflect Tenant #1 had thrush and was prescribed Nystatin swish for treatment or the order for the Nitroglycerin medication.

2. Record review on 8/9/23 and 8/14/23 of Tenant #2's revealed a hospice order dated 4/13/23 indicated Registered Nurse Care Manager to assess stage 2 (sore) to lower left buttock weekly and as needed until healed. Program staff would complete wound care of applying menthol 0.44%-zinc oxide-20.6% topical ointment to her buttocks with each incontinent episode. The order was noted on 5/24/23 (ordered on 4/13/23).

Continued record review revealed the service plan dated 12/22/22 was not updated and did reflect the stage 2 sore on Tenant #2's lower left buttock or the application of the topical ointment.

3. Record review on 8/10/23 of Tenant #3's file revealed Progress Notes indicated the following:

a. On 5/22/23 it was noted Tenant #3 was aggressive towards tenants and staff. Tenant #3 was physical towards staff. She screamed at tenants and staff to get out of her house. Staff attempted to calm her without success. Tenant #3 attempted to hit another tenants and staff

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intervened. Tenant #3 started hitting staff, used foul language and said she was going to kill someone. Tenant #3 was transported to the hospital via ambulance.

b. On 6/8/23 it was noted Tenant #3 asked staff to leave the building. She put her hand on staff and staff asked her to remove her hand. Staff walked away but she chased staff and staff ran into the bathroom. Another staff responded and saw Tenant #3 attempting to hit staff. That staff attempted to distract Tenant #3 and she began hitting and kicking the staff. The third staff also attempted to redirect her to her apartment and Tenant #3 attacked and pushed her and she nearly fell. The three staff called the nurse and Tenant #3's family was called several times and family came to the building to help calm Tenant #3.

c. On 6/10/23 it was noted Tenant #3 was aggressive towards staff as staff attempted to prevent her from attacking other tenants. Tenant #3 started hitting and grabbed staff's finger and twisted it. She also tried to take another tenant's blanket.

d. On 6/12/23 it was noted Tenant #3 chased and screamed at another tenant and his family member. Staff intervened and the family member was able to get him to his apartment.

Continued record review revealed the service plan 6/13/23 reflected Tenant #3 had behaviors and provided interventions; however, the service plan did not reflect the extent of the physical behaviors as noted above and interventions.

4. Record review on 8/9/23 of Tenant #4's file revealed the July 2023 Documentation Survey

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Report reflected staff provided toileting and incontinence care. Staff checked and changed Tenant #4 every hour. Tenant #4 was also repositioned every two hours. The report also reflected staff assisted with denture care.

Continued record review revealed a Progress Note dated 3/15/23 indicated Tenant #4 told the nurse she was ready to die. The nurse asked if Tenant #4 was in pain and she said no. Tenant #4's hospice nurse was made aware.

Further record review the signed service plan dated 1/18/23 provided did not reflect the check and change toileting assistance every hour, the repositioning every two hours or the denture care. The service plan also did not reflect the comment Tenant #4 made to nurse regarding being ready to die.

5. Record review on 8/14/23 of Tenant #5's file revealed Progress Notes indicated the following:

a. On 7/24/23 it was noted staff was assisting Tenant #5 with her shower, when staff turned around to get the towel, Tenant #5 was falling to the floor. Tenant #5 got up independently and laid down in bed. Tenant #5's family was notified.

b. On 7/25/23 it was noted Tenant #5 was seen by her primary care provider (PCP) and new orders were received for back pain/contusion of mid lower back including: to ice every 4 to 6 hours for 10 minutes, Tylenol extra strength, two tablets every eight hours for seven days and then as needed. Topical Voltaren gel was also ordered to apply two to three times per day for seven to ten days.

c. On 7/26/23 it was noted staff reported Tenant

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#5 was in pain that morning and did not want to sit up to take her Tylenol. Tenant #5's family was notified by a nurse and family said that on 7/24/23 Tenant #5 was seen by her PCP. An x-ray was ordered and it showed an old compression fracture but no new fractures.

d. On 7/28/23 it was noted staff reported Tenant #5 complained of back and right side pain. Tenant #5 said it was a sharp pain, bruising was noted to her back from the fall. Tenant #5's family reported she had pain yesterday too.

e. On 7/28/23 it was noted Tenant #5's family visited and was agreeable for the nurse to reach out to the PCP's office regarding a lidocaine patch to help with back pain.

f. On 7/28/23 it was noted a new order was received for lidocaine patch to the lower back and for a urinalysis with culture and sensitivity and to encourage fluids.

g. On 7/28/23 at 11:00 p.m. it was noted Tenant #5 had a fall and was sent out to the hospital. It was noted Tenant #5 had a compression fracture of the lumbar and rib fracture. After discharge back to the Program, the hospital called and requested Tenant #5 return, as they noticed the fractures and wanted to keep her for observation. Family declined to sent her back to the hospital

h. On 7/31/23 it was noted a change of condition was completed related to Tenant #5 fall with lumbar fracture and rib fracture. Tenant #5 had a decrease in services.

Continued record review revealed hospital documents dated 7/29/23 reflected Tenant #5 had stomach pain since the afternoon. It indicated

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radiology results indicated "Acute fractures of the L1, L2, L3 transverse processes. Right posterior 11 and 12 th rib fractures. Compression deformity of T2 vertebral body." The report indicated the preliminary report did not include information related to the rib, transverse fractures or diverticulitis (it was added to final report). The hospital records indicated the Supervising Physician Statement indicated the provider became aware of the final results of the computerized tomography (CT) on 8/4/23 and was not able to examine Tenant #5. No history was given when she was transported to the hospital regarding falling and Tenant #5 denied falling (however she had cognitive impairment). The notes indicated Tenant #5 was prescribed Keflex for a urinary tract infection and was discharged back to the Program. After discharge the staff physician radiologist called and informed that the initial read (of CT scan) missed the fractures and diverticulitis.

Further record review revealed a service plan dated 7/31/23, post fall that resulted in a lumbar compression fracture and rib fracture. The service plan was updated on 7/31/23; however, an the service plan was not updated after the fall on 7/24/23, PCP visit and new orders for back pain and treatment. Tenant #5 sustained a second fall on 7/28/23 and was sent out to the hospital for evaluation. It was determined she sustained rib and lumbar compression fractures.

6. Record review on 8/14/23 of Tenant #6's file revealed the service plan dated 6/2/23 reflected staff administered Tenant #6's medications, assisted with blood glucose monitoring and administered insulin, including sliding scale insulin.

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A 350	Continued From page 23 Continued record review revealed the July 2023 MAR reflected an order for Insulin aspart Solution Pen Injector 100 unit/ML, inject per sliding scale subcantaneously before meals. It also reflected blood glucose monitoring with each scheduled time at 7:30 a.m., 11:00 a.m. and 4:00 p.m. There were over 30 documented refusals in July 2023. Further record review revealed the service plan dated 6/2/23 did not reflect Tenant #6's refusals of sliding scale insulin and blood glucose monitoring and interventions. 7. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed all service plans were provided for the tenants listed above.	A 350		
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 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6) and 2 of 2 discharged tenants reviewed (Tenant C1 and C2).	A 370		

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A 370	Continued From page 24 Findings follow: 1. Record review on 8/8/23 and 8/9/23 of Tenant #1's file revealed service plans were updated with a change in condition on 5/11/23, 6/8/23 and 7/25/23. The service plans provided were not signed and lacked signatures by all parties. 2. Record review on 8/9/23 and 8/14/23 of Tenant #2's file revealed an annual service plan was developed dated 12/22/22. A health care professional signed the service plan on 12/22/22. The service plan was not signed by Tenant #2 or her legal representative. 3. Record review on 8/10/23 of Tenant #3's file revealed a service plan was updated as with a change in condition on 6/13/23 related to increased aggression. The service plan provided was not signed and lacked signatures by all parties. 4. Record review on 8/9/23 of Tenant #4's file revealed a service plan was developed dated 1/18/23 related to admission to hospice. The service was signed by a health care professional; however, lacked the signature of Tenant #4 or her legal representative. 5. Record review on 8/14/23 of Tenant #5's file revealed a service plan was developed dated 7/31/23 for a fall with fractures. The service plan provided was not signed and lacked signatures by all parties. 6. Record review on 8/14/23 of Tenant #6's file revealed an annual service plan was developed dated 6/2/23. The service plan provided was not signed and lacked signatures by all parties.	A 370		

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A 370	Continued From page 25 7. Record review on 8/10/23 and 8/14/23 of Tenant C1's file revealed service plans were updated with a change in condition on 1/19/23 and 4/27/23. The service plans were not signed and lacked signatures by all parties. 8. Record review on 8/10/23 of Tenant C2's service plan revealed the service plan was updated on 1/30/23 with admission to hospice. The service plan provided was not signed and lacked signatures by all parties. 9. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed all signed service plans for the tenants listed above were provided.	A 370		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed eight hours of dementia training within 30 days of hire. This pertained to 6 of 7 staff files reviewed (Staff A, B, D, E, F and G). Findings follow: 1. Record review on 8/7/23 of Staff A's file revealed a hire date of 3/21/23. Staff A did not complete eight hours of dementia specific training and education within 30 days of employment.	A 545		

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A 545	Continued From page 26 2. Record review on 8/7/23 of Staff B's file revealed a hire date of 6/5/23 Staff B did not complete eight hours of dementia specific training and education within 30 days of employment. 3. Record review on 8/7/23 of Staff D's file revealed a hire date of 2/7/23. Staff D did not complete eight hours of dementia specific training and education within 30 days of employment. 4. Record review on 8/7/23 of Staff E's file revealed a hire date of 12/12/22. Staff E did not complete eight hours of dementia specific training and education within 30 days of employment. 5. Record review on 8/7/23 of Staff F's file revealed a hire date of 1/30/23. Staff F did not complete eight hours of dementia specific training and education within 30 days of employment. 6. Record review on 8/9/23 of Staff G's file revealed a hire date of 2/13/23. Staff G did not complete eight hours of dementia specific training and education within 30 days of employment. 7. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed all dementia training for the staff list above was provided.	A 545		
A 675	481-69.33(6) Transportation 481-69.33(231C) Transportation. When transportation services are provided directly or under contract with the program: 69.33(6) The driver shall have a valid and appropriate Iowa driver ' s license or commercial driver's license as required by law for the vehicle	A 675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0111	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN DEER PLACE	1500 1ST AVE N CORALVILLE, IA 52241

(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 675	Continued From page 27	A 675		

being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the Program failed to ensure staff that transported tenants in vehicles had the appropriate driver license for the vehicles used for transport. This pertained 1 of 1 staff who was listed as a driver (Staff J). Findings follow:

1. Record review on 8/2/23 of the employee list indicated Staff J was indicated on the employee list as a driver with a hire date of 2/10/23.

2. Continued record review revealed Staff J had a Class C State of Iowa Driver License. Staff J did not have a Chauffeur's license with passenger endorsement as required.

3. When observed on 8/7/23 the Program had two vehicles, a mini-bus and a mini-van, both accommodated less than 16 people.

4. When interviewed on 8/15/23 at 1:29 p.m. the Executive Director confirmed Staff J was the driver. She said he drove the memory care tenants every other week on scenic drives and rarely drove them to appointments. She said she had spoken with Staff J about getting the required license.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0111	DATE SURVEY COMPLETED: 8/17/2023

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Regulation and Reg Number** 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 established policy and procedure related the completion of incident reports. This pertained 1 of 6 current tenants reviewed (Tenant #1) to 1 of 2 discharged tenants reviewed (Tenant C1).	Tag#A150	Incident reports completed for Tenant #1 and C1 on 9/8/23. RN (Registered Nurse), Health Care Coordinator was educated on the incident reporting policy and procedures on 08/16/2023.	All current staff will be reeducated on incident reporting by 11/15/23. Upon hire training will be provided on the policy and procedures for incident reporting.	Implementation Date: 9/7/23 Completion Date: ongoing Responsible Party: Director or designee
Tag# 2	**Regulation and Reg Number** 481-67.5(2)f(1) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When	Tag # A270	Staff G is no longer employed at Brown Deer Place as of 4/14/23. Staff K is no longer employed at Brown Deer Place as of 7/16/23	Staff members who are not med delegated will not administer or document medication administration in the EMAR (electronic medication administration record).	Implementation Date: 8/30/2023 Completion Date: ongoing

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	medications are administered traditionally by the program: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: A 270 Based on interview and record review the Program failed to ensure medications were		Staff L is no longer employed at Brown Deer Place as of 7/6/23	An audit of medication managers currently passing medications was completed on 11/10/23 to ensure compliance.	Responsible Party: Director or designee

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	administered only by individuals who complete an approved medication manager course. This pertained to 3 of 3 former staff reviewed (Staff G, K and L).				
Tag# 3	**Regulation and Reg Number** 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 consistently administer medications as prescribed. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6).	Tag#A285	Education provided to the Memory Care Coordinator regarding auditing of EMAR documentation and f/u on 11/3/23 All staff will be re-educated on proper documentation by 11/15/23.	Upon hire, staff will be trained in proper documentation processes. The new RN, Health Care Coordinator will be trained upon hire regarding order processing and follow through.	Implementation Date: 9/7/23 Completion Date: ongoing Responsible Party: Director or designee
Tag# 4	**Regulation and Reg Number** 481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse	Tag#A345	Staff A, B, and F-delegations were completed on 10/6/23 with the new RN, Health Care Coordinator.	The new RN, Health Care Coordinator will be trained upon hire on delegation expectations and process.	Implementation Date: 9/7/23 Completion Date:

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	shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: A 345 Based on interview and record review the Program failed to ensure staff received nurse delegated training within 30 days of employment. This pertained to 4 of 7 staff reviewed (Staff A, B, F and G).		Staff G's employment ended on 4/14/23. An audit of all the staff's Delegation will be completed by 11/15/23 to ensure compliance. All current staff have been re-delegated by the new RN, Health Care Coordinator as of 10/6/23.	An audit of the staff's Delegation will be completed by 11/15/23 to ensure compliance.	ongoing Responsible Party: Director or designee
Tag# 5	**Regulation and Reg Number** 481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be	Tag # A361	All current staff will be re-trained in glove use, hand washing, and re-delegated by 11/15/23.	All new hires will be trained and delegated by the RN, Health Care Coordinator on proper glove use and hand washing. Periodic observation will be completed by the director or designee of handwashing and glove use to ensure compliance.	Implementation Date: 9/8/2023 Completion Date: ongoing Responsible Party: Director or designee

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	provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on observation, interview and record review the Program failed to have staff provide services in accordance with the training provided. This pertained to 1 of 1 tenant observed on medication pass that had blood glucose monitoring and insulin administration (Tenant #7) and 1 of 1 staff observed administering medications (Staff H).				
Tag#6	**Regulation and Reg Number** 481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received required dependent adult abuse training	Tag # A380	Staff D completed DAA (Dependent Adult Abuse) training on 9/21/2023 Staff E was terminated on 10/23/2023	Upon hire the community will determine if each staff member's DAA training is in compliance with the standard, if not, the DAA training will be completed within 6 months of hire. An audit of all staff's DAA training will be completed by 11/15/23 to ensure compliance.	Implementation Date: 8/30/23 Completion Date: ongoing Responsible Party: Director or designee

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	within six months of employment. This pertained to 2 of 3 staff hired greater than six months (Staff D and Staff E).				
Tag#7	**Regulation and Reg Number** 481-67.19(3)d Record Checks 67.19(3)d If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain an evaluation of a founded child abuse prior to employment. This pertained to 1 of 1 staff reviewed that had a record that required evaluation (Staff E).	Tag # A420	Staff E was terminated on 10/23/2023. An Audit will be completed for all staff by 11/15/2023 to ensure proper documentation of background checks.	Background checks will be completed with any extended background check requirements met prior to hire. Periodic audits will be completed to ensure compliance by the Director or Designee.	Implementation Date: 8/30/2023 Completion Date: Ongoing Responsible Party: Director or Designee

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Tag #8	**Regulation and Reg Number** 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently complete evaluations as needed with significant change in tenant condition. This pertained to 1 of 1 current reviewed that sustained a fall with fracture (Tenant #5).	Tag # A145	Tenant# 5's Evaluation/ISP updates were completed on 7/31/2023. The new RN, Health Care Coordinator will be trained upon hire on evaluations and ISP (Individualized Service Plan) requirements and the timing of these related to significant changes.	The new RN, Health Care Coordinator will be trained upon hire on evaluations and ISP requirements and the timing of these related to significant changes. Director or Designee will complete audits to ensure compliance weekly, monthly, as needed, as determined by the Director or Designee.	Implementation Date: 9/14/23 Completion Date: ongoing Responsible Party: Director or designee
Tag# 9	**Regulation and Reg Number** 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	Tag # A350	An audit of all current residents was completed on 9/22/23 to ensure residents' needs are accurately reflected on the Service Plan. Tenants #1, #2, #3, #4, #5, #6- Service plans were reviewed for	The new RN, Health Care Coordinator will be trained upon hire on evaluations and ISP requirements and the timing of these related to significant changes. Director or Designee will complete audits to ensure compliance weekly,	Implementation Date: 9/14/23 Completion Date: ongoing Responsible

	service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: A 350 Based on interview and record review the Program failed to consistently update service plans as needed and failed to develop service plans reflect the identified needs of tenants. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5, #6).		accuracy to reflect the residents' needs on 9/22/2023.	monthly, as needed, as determined by the Director or Designee.	Party: Director or designee
Tag#10	**Regulation and Reg Number** 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: A 370 Based on interview and record review the Program failed to obtain signed service plans when a significant change occurred. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6) and 2 of 2 discharged tenants reviewed (Tenant C1 and C2).	Tag # A370	An audit of the current residents will be completed on 11/15/23 to ensure signature compliance for the ISP's. The new RN, Health Care Coordinator will be trained upon hire on evaluations and ISP requirements and the timing of these related to significant changes.	The new RN, Health Care Coordinator will be trained upon hire on evaluations and ISP requirements and the timing of these related to significant changes. Director or Designee will complete audits to ensure compliance weekly, monthly, as needed, as determined by the Director or Designee.	Implementation Date: 9/14/23 Completion Date: ongoing Responsible Party: Director or designee
Tag#11	**Regulation and Reg Number** 481-69.30(1) Dementia Specific	Tag # A545	An audit will be completed for all current staff by 11/15/2023,	Upon hire, staff will complete the required dementia training within 30	Implementation Date: 9/7/23

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	Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: A 545 Based on interview and record review the Program failed to ensure staff completed eight hours of dementia training within 30 days of hire. This pertained to 6 of 7 staff files reviewed (Staff A, B, D, E, F and G).		to ensure all staff have the required dementia training completed within 30 days of hire. Staff E was terminated on 10/23/2023. Staff G's employment ended on 4/14/23.	days. Periodic audits will be completed to ensure all staff have the required dementia training completed within 30 days of hire by the Director or Designee.	Completion Date: ongoing Responsible Party: Director or designee
Tag#12	**Regulation and Reg Number** 481-69.33(6) Transportation 481-69.33(231C) Transportation. When transportation services are provided directly or under contract with the program: 69.33(6) The driver shall have a valid and appropriate Iowa driver ' s license or commercial driver's license as required by	Tag # A675	Staff J's employment ended on 10/10/2023. An audit will be completed for those who provide transportation for residents by 11/15/2023, to ensure the appropriate licensure requirements are met.	Upon hire and annually, any employee who provides transportation for residents, verification of the appropriate license will be completed by the Director or Designee.	Implementation Date: 8/30/2023 Completion Date: ongoing Responsible Party: Director or designee

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	law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure staff that transported tenants in vehicles had the appropriate driver license for the vehicles used for transport. This pertained 1 of 1 staff who was listed as a driver (Staff J).				

Compliance Date:_____12/8/2023_____

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