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
	S0056	A. BUILDING: _____ B. WING _____	C 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT ASSISTED LIVING	1499 OFFICE PARK RD WEST DES MOINES, IA 50265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 20 Number of tenants with cognitive impairment: 2 Total census: 22 The following regulatory insufficiencies were cited during the investigation of Complaint #116338-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000		
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 medication and treatments as prescribed to 2 of 4 tenants reviewed (Tenant #3 and Tenant #4). Findings follow:	A 285	The Plan of Correction is attached.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 285	Continued From page 1 1) Review of a Medication Review Report for Tenant #3, signed by her primary care provider on 7/10/23, revealed she was prescribed one hydrocodone-acetaminophen tablet (5-325mg) three times a day for pain related to osteoarthritis. Medication Administration Records (MARs) noted if and when a tenant took prescribed medication. Tenant #3 took hydrocodone at midnight, 8:00 AM and 4:00 PM daily. A July 2023 MAR noted Tenant #3 did not receive the 4:00 PM dose of hydrocodone-acetaminophen. It was documented on the August 2023 MAR, Tenant #3 did not receive hydrocodone at all on 8/1/23 and missed the 12:00 AM dose on 8/2/23. On 1/4/24, Tenant #3 did not receive her midnight dose of hydrocodone. A review of progress notes revealed Tenant #3's hydrocodone was not available from 7/31/23 - 8/2/23 as staff were waiting to receive the medication from the pharmacy. On 4/3/24 at 1:15 PM Tenant #3 reported she was happy with the services she received with the exception of when staff forgot to give her pain medication. Tenant #3 stated she had been taking pain medication for 30 years. Her body was used to the medication and she was in terrible pain when she missed it. Tenant #3 recalled a time, about a month ago, when a staff member was reportedly sleeping and did not provide her with the midnight dose of hydrocodone even though she pushed her pendant for assistance multiple times. 2) Tenant #4 had a Medication Review Report signed by her PCP on 1/22/24 identifying she was to utilize a flutter valve two times a day for Chronic Obstructive Pulmonary Disease.	A 285		

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A 285	Continued From page 2 According to the National Institute of Health, a flutter valve is a handheld device designed to facilitate clearance of mucus in hypersecretory lung disorders. The order for the flutter valve had been in place since 7/22/21. A review of Tenant #4's February 2024 MAR revealed Tenant #4 used the flutter valve 11 days as prescribed. Tenant #4 used the flutter valve as prescribed only 1 day in March 2024. Staff documented in the progress notes for Tenant #4 the flutter valve was not utilized because the device was unavailable or they could not find the device. On 4/3/24 at 11:35 AM, Staff F reported Tenant #4 kept her flutter valve in her room. Staff have been unable to locate the device. Staff F reported she needed to contact the doctor about Tenant #4 not having the device. On 4/3/24 at 1:45 PM the Provisional Administrator confirmed these findings.	A 285		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete background checks	A 400		

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A 400	Continued From page 3 prior to hire for 4 of 5 employees reviewed (Staff A, Staff B, Staff C and Staff D). Findings follow: Record review on 4/3/24 of personnel records revealed Staff A was hired on 3/18/22. The program requested a Single Contact License and Background (SING) check for Staff A on 10/7/22, over 9 months after she was hired. Staff A did not have a history of abuse or criminal charges. Staff B was hired on 8/2/23. The program requested a SING check for Staff B on 4/3/24, over 8 months after she was hired. Staff B did not have a history of abuse or criminal charges. Staff C was hired on 1/8/24. The program requested a SING check for Staff C on 4/3/24, over one month after she was hired. Staff C did not have a history of abuse or criminal charges. Staff D was hired on 1/15/24. The program requested a SING check for Staff D on 4/3/24, over 2 months after she was hired. Staff D did not have a history of abuse or criminal charges. The Provisional Administrator confirmed these findings on 4/3/24 at 10:15 AM.	A 400		

PINE ACRES
REHABILITATION AND CARE CENTER

This is a credible allegation of compliance with Heritage Court Assisted Living. We assert that all correctives described in this plan of correction have been implemented. Regarding the specific deficiencies, we have outlined our corrective actions and continued interventions to ensure compliance with regulations and our action plan. Heritage Court Assisted Living staff is committed to delivering high-quality healthcare to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Heritage Court Assisted Living is substantially compliant as set forth below. We are confident that we will be found in substantial compliance upon resurvey. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Heritage Court Assisted Living has completed the following interventions due to the complaint findings exiting 04/03/2024. The facility will be in substantial compliance by 06/24/2024

Action Plan

A 285 - 481-67.5 – Medications

Corrective Action

1. What specific action needs to be taken for the identified residents?

   a. Tenant #3 no longer receives routine hydrocodone, Tenant #4 no longer utilizes a flutter valve.

   b. RN Clinical Coordinator reviewed MAR to ensure PRN hydrocodone is given as needed per the resident's request.

   c. An assisted living-wide audit was completed on or before 06/14/24 to ensure that all medications are on the MAR and confirmed.

Identification of Others

1. Are there other residents who may be at risk for the same deficient practices?
   a. Residents are at risk of being affected by the alleged deficient practice.
   b. Residents with daily routine medication orders can potentially be affected by this practice.

Systemic Changes to Prevent Future Occurrence

1. The RN Clinical Coordinator or designee will verify orders x5 per week in clinical morning meetings starting on 6/24/2024 to ensure that orders are correctly put on the MAR.
2. The RN Clinical Coordinator or designee will verify that the medications have been received from pharmacy x5 starting on 6/24/2024 to ensure that orders are carried out as prescribed.

3. The RN Clinical Coordinator or designee will educate all staff on the process for processing orders, obtaining labs, and confirming physician orders on or about 6/14/2024.

Monitoring

1. How will compliance be sustained?
    a. The RN Clinical Coordinator or Designee will audit 5 random tenets for accuracy of medication orders on the MAR using the PCP orders to check the orders for accuracy. Audits will occur weekly for 6 weeks.
    b. Audit results and additional corrected action will be reported and discussed in QAPI if needed, and further corrections will be made in the monthly meeting for 3 months or until sustained compliance is achieved.

Compliance Date: 06/24 /2024

A 400- 481-67 – Record Checks

Corrective action

1. What specific action needs to be taken for the identified area?
    a. All employee's background checks have been rerun and updated in the employee file.
    b. The RN Clinical Coordinator or designee will complete all background checks before the working date.

Identification of others

1. Are there other areas that may be at risk for the same deficient practices?
    a. New Staff risk being affected by the alleged deficient practice.
        i. An Assisted Living-wide review will be conducted on or about 6/14/2024 by the RN Clinical Coordinator or Designee to ensure that all background checks are completed and in the employee file.

Systemic changes

1. What changes will be made based on the root cause analysis results?

a. The RN Clinical Coordinator or Designee will ensure that background checks for new employees are received and in the employee file by or before 6/14/24.

Monitoring

2. How will compliance be sustained?
    a. The RN Clinical Coordinator /Designee or HR will audit 5 random employees for completed onboarding documentation before they work on the floor for 6 weeks.
    b. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections in the monthly meeting for 3 months or until sustained compliance is achieved.

Compliance Date: 06/24/2024

ok