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
	S0160	A. BUILDING: _____ B. WING _____	04/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER POND ASSISTED LIVING	1400 6TH AVE N. WELLMAN, IA 52356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 3 Total census of Assisted Living Program: 7 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program. There were no deficiencies cited during the onsite infection control survey completed on 4/12/21.	A 000	✓ 7/20/21	
A 135	481-67.2(1)f Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: f. A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to keep incident reports on hand for current or former tenants. Findings include: A review of a Physician Progress Note dated 3/30/21 for Tenant #2 indicated he had a fall the	A 135	Plan of Correction is attached DD	

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A 135	Continued From page 1 previous day. The program was unable to provide an incident report for this fall. A review of the entrance form provided by the program on 4/6/21 revealed former Tenant C1 had been hospitalized in the three months prior to the recertification visit. The Director of Nursing reported Tenant C1 had a number of falls resulting in her hospitalization. The Director of Nursing was unable to provide any incident reports for these falls. A review of the program's Incident/Falls Checklist revealed after checking on the tenant and resolving the situation, staff were to complete the incident report form and leave in on the Assisted Living Nurse's desk for her to review. On 4/8/21 at 12:39 PM the Director of Nursing confirmed she was unable to locate any incident reports for Tenant C1, Tenant #2, or any other tenants.	A 135		
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 ensure tenants were treated with respect and dignity affecting 2 of 5 tenants interviewed (Tenant #3 and Tenant #4). Findings	A 155		

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A 155	Continued From page 2 follow: During a tenant meeting on 4/7/21 at 10:00 AM, Tenant #3 expressed concerns with the programs Covid-19 practices. She described one situation in which she was receiving a shower with the assistance of a caregiver. Tenant #3 stated she was nude when the Director of Nursing entered the bathroom to give her a Covid-19 test. Tenant #3 said the Director of Nursing insisted on giving her the test even though she was undressed in the shower. Tenant #3 was upset about this. She also reported a situation in which the nurse tested another tenant for Covid-19 when she was sitting on the toilet. On 4/7/21 at 12:56 PM, Tenant #4 reported she was sitting on the stool when the Director of Nursing knocked on her apartment door and then entered. Tenant #4 announced she was on the toilet and expected the Director of Nursing to wait for her to finish. However, the nurse entered the bathroom and performed the Covid-19 test. Tenant #4 did not recall the Director of Nursing asking her if she minded having the test done while in the restroom. On 4/7/21 at 3:00 PM, the Director of Nursing reported she did not recall testing these tenants for Covid when they were indisposed, although she said there were other nurses who also did the tests. The Director of Nursing said it was not appropriate to perform the test on a tenant who was in the shower or using the toilet.	A 155		
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	A 270		

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A 270	Continued From page 3 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 observation, interview and record review the program failed to ensure 5 of 5 staff reviewed who administered medications were qualified to do so (Staff A, Staff C, Staff D and Staff E, Staff F). Findings follow: Staff F (an Assisted Living Attendant) was observed administering medication to tenants on 4/7/21 between 7:45 AM and 8:25 AM. Staff F confirmed she had not completed a medication manager course at that time. Record review of staff files on 4/6/21 for Staff A, Staff C, Staff D and Staff E (all Assisted Living Attendants) revealed no record of certificates from a department approved medication aide or manager course.	A 270		

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A 270	Continued From page 4 The Director of Nursing confirmed these findings on 4/6/21 at 1:05 PM.	A 270		
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 the registered nurse completed delegation training within 30 days for 2 of 2 reviewed hired in 2020 (Staff B and Staff E). Findings follow: Review of Staff B's file revealed a hire date of 8/31/20. The Director of Nursing did not document she was thoroughly trained until 11/24/20. Review of Staff E's file revealed a hire date of 2/4/20. No delegation training records were in her file. The Director of Nursing confirmed these findings on 4/7/21 at 7:30 AM. (This is a repeat regulatory insufficiency form the recertification visit completed on 1/15/19)	A 345		

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A 140	Continued From page 5	A 140		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete evaluaitons within 30 days of occupancy for 1 of 2 tenants reviewed (Tenant #1). Findings follow: Record review on 4/6/21 revealed Tenant #1 moved into the program on 3/1/21. There were no evaluations of Tenant #1 completed following his admission to the program. The Director of Nursing confirmed this finding on 4/7/21 at 3:00 PM. (This is a repeat regulatory insufficiency form the recertification visit completed on 1/15/19)	A 140		
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	A 350		

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A 350	Continued From page 6 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 update service plans annually and as needs changed for 1 of 2 (Tenant #2). Findings follow: Tenant #2 had a progress note dated 11/8/20 indicating the Director of Nursing talked with Tenant #2's son about the tenant going out the program door after it was locked. She noted Tenant #2 had more confusion and was becoming unfit for the assisted living program and should move to the memory care program. The son said he would talk with the family. According to a Physician Progress Note, Tenant #2 was seen for an unsteady gait on 2/26//21. Tenant #2 reported he was fine, however staff told the provider Tenant #2 had been very unsteady and they were worried he was going to fall. Tenant #2 stated he had chronic low back pain. He was referred for physical therapy and occupational therapy. A Therapy recommendation form was completed on 3/12/21 indicating Tenant #2 needed a four wheeled walker for improved gait. Tenant #2's primary care provider wrote an order for the walker on 3/15/21. A Physician Progress Note dated 3/30/21 indicated Tenant #2 had a fall the previous day. The provider encouraged Tenant #2 to continue utilizing his walker when ambulating. She asked staff to remind Tenant #2 to utilize his walker.	A 350		

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A 350	Continued From page 7 Tenant #2 most recent service plan was dated 4/16/19. An annual service pan could not be located. The service plan indicated Tenant #2 was independent with transferring and mobility. It made no mention of him using a walker or ever receiving physical therapy or occupational therapy. The plan did not address the need for staff to prompt Tenant #2 to use his walker. The plan did not address Tenant #2's increasing confusion or going out the door of the program. The Director of Nursing confirmed these findings on 4/7/21 at 3:00 PM. (This is a repeat regulatory insufficiency form the recertification visit completed on 1/15/19)	A 350		
A 420	481-69.27(1)a 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: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by:	A 420		

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A 420	Continued From page 8 Based on interview and record review the program failed to complete nurse reviews every 90 days for 1 of 2 tenants reviewed who received health-related care (Tenant #2). Findings follow: Record review revealed Tenant #2 was admitted on 7/16/18. His most recent service plan was dated 4/16/19 revealed he received health related cares. Only one nurse review, dated 10/17/19, was located in his chart. The Director of Nursing confirmed this finding on 4/7/21 at 3:00 PM.	A 420		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to provide training on safe food handling as required to 5 of 5 staff reviewed responsible for food service (Staff A, Staff B, Staff C, Staff D and Staff E). Findings follow: Record review on 4/6/21 revealed Staff A was hired on 4/16/19 and had an orientation on safe food handling on 4/17/19. There was no documentation of an annual in-service training on food protection in her file. Staff B was hired on 8/31/20. She was first	A 465		

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A 465	Continued From page 9 trained on safe food handling on 11/24/20. Staff C was hired on 3/22/21. There was no training in her file on sanitation and safe food handling. Staff D was hired on 3/8/19. She had an orientation on safe food handling hoever there was no documentation of an annual in-service training on safe food handling in her file. Staff E was hired on 2/4/20. She was first trained on safe food handling on 4/7/21. The Director of Nursing confirmed these findings on 4/7/21 at 7:30 AM.	A 465		

PLAN OF CORRECTION

Provider/Supplier Name:	Silver Ponds Assisted Living
Street Address, City, Zip:	516 13th Street Wellman, Iowa 52356
Date of Survey:	4/6/2021-4/12/2021

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.	6/23/2021
A 135	Silver Ponds shall have copies of incident reports on the program premises and available for a minimum of 3 years ✓	
	I. All direct care staff received education on the completion of Tenant Fall Reports & Incident Reporting on 6/3/2021 thru 6/10/202. II. System change occurred for AL Manager and or Delegating RN to enter all incidents into PCC/Electronic Health Record for maintaining permanent Record on 6/3/2021. AL Manager and Delegating RN received education on Reporting Policy, Completion of Incident Reports in Electronic Health Record on 6/3/2021 III. Administrator or designee will complete audits to ensure that problem does not recur. IV. Silver Ponds Quality Assurance Team will review audits routinely to ensure compliance.	
		Compliance Date 6/23/2021
A155	Silver Ponds treats all tenants with consideration, respect, & full recognition of personal dignity and autonomy. ✓	
	I. All staff including Delegating RN and Assisted Living manager received dignity education on or before 6/11/2021	
	II. System Changes include hiring of an Assisted Living Manager to provide routine oversite and monitoring of program.	
	III. Administrator or designee will complete routine audits of tenant's concerns related to dignity & discuss dignity related care provisions to ensure problem does not recur	

✓ 7/20/21

✓ DD 7/16/21

	IV. Silver Ponds Quality Assurance Team will review audits routinely to ensure ongoing compliance.	
		Compliance Date 6/23/2021
A270	Silver Ponds will only allow qualified staff to administer medications	
	I. All staff assigned to provide medication oversite will have completed medication manager course by 6/25/2021. Education to all staff that hey are not allowed to pass medication without having either RN/LPN licensure or Medication Manager Certifications on 6/3/2021 thru 6/11/2021.	
	II. Delegating RN will complete competency for Medication Manager Certification prior to final test by utilization of IHCA Online Medication Manager Online Program which requires uploading of competency prior to completion of final test and issuance of certification. Tracking of Employees Certified to pass medications will be posted on the Medication Administration Record book and in Silver Pond Office Staff received education on the medication administration guidelines on ALF on 6/3-6/112021	
	III. Administrator or designee will conduct routine auditing of Medication Administration Records & Staff Assignments to ensure problem does not recur	
	IV. Silver Ponds Quality Assurance Team will review audits to ensure compliance	
		Compliance Date 6/23/2021
A345	Silver Ponds completes Delegation RN competency prior to 30 days of beginning employment.	
	I. Verification that all employed ALF staff currently have competency training completed occurred on 6/11/2021	
	II. System changes to require competency training to occur in the orientation process before assignment in ALF is in place and Audited upon any new hire by ALF Manager effective 6/3/2021	
	III. Administrator or designee will complete audits of any new hires prior to being assigned to ALF to ensure problem does not recur	
	IV. Silver Ponds Quality Assurance Team will review audits to ensure compliance.	
		Compliance Date 6/23/2021
A140	Silver Ponds completes evaluation of tenants functional, cognitive and health status within 30 days of occupancy	
	I. Tenant#2 has received evaluation and health status	
	II. All tenants are protected from this practice by hiring an Assisted Living Manager. Assisted Living Manager has received education and establishment of required intervals for evaluation	

		& placement of evaluations in electronic health record for alerts related to need for assessment of tenants & system of tracking. Direct care staff received education 6/7-6/11/2021 on reporting changes in health status to AL Manager.	
	III.	Delegating RN & Assisted Living Manager will conduct audits of tenants for changes and electronic health record for	
	IV.	Silver Ponds QAPI Team will review evaluation dashboards in Electronic Health Record to ensure solutions are permanent	
			Compliance Date 6/23/2021
A350	Silver Ponds program will update service plans annually and as needed with change in needs on tenant		
	I.	Tenant #2 and all Tenants of Silver Ponds have had their Service Plans Updated	
	II.	All residents with potential to be affected by this practice by hiring of Assisted Living Manager that is responsible for reviewing electronic dashboard in EHR for annual service plan update requirements.	
	III.	Assisted Living Manager and Delegating RN received education and establishment of additional tracking guidelines for updating service plans annually.	
	IV.	Administrator or Designee will audit service plans routinely to ensure compliance	
	V.	QAPI Team will review audits quarterly and as needed	
			Compliance Date 6/23/2021
A420	Silver Ponds completes Nurse Reviews Every 90 days		
	I.	Tenant #2 has received quarterly nurse review	
	II.	All tenants receive quarterly nurse review by hiring AL Manager & quarterly tracking system established via electronic health record	
	III.	AL Manager and Delegating RN received education 6/7-6/11 on required Nurse Review intervals for Tenants and training in entering & scheduling assessments in Electronic Health Record.	
	IV.	Administrator or Designee will conduct routine audits to ensure compliance	
	V.	QAPI Team will review auditing to ensure solutions are permanent	
			Compliance Date 6/23/2021
A465	Silver Ponds personnel receive training on safe food handling		
	I.	Personnel of Silver Ponds has received education on safe food handling 6/7/21 thru 6/11/21	

	II. All staff will receive safe food handling prior to employment per orientation process & annually managed by AL Manager. AL Manager and Delegating RN received education on orientation process & annual training required to include safe food handling	
	III. Administrator will complete audits routinely to ensure compliance	
	IV. QAPI Team will review audits to ensure that compliance is permanent	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.