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
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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: 24 Number of tenants with cognitive disorder: 1 Total census of Assisted Living Program: 25 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	The Plan of Correction is attached.	
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 observation, interview and record review the Program failed to provide services that were adequate and appropriate related to meals and food service. This potentially affected all tenants (census of 25). Findings follow: 1. A tenant meeting was held with approximately 23 tenants and two visitors on 6/26/23 from 1:00 p.m. to 1:40 p.m. The tenants voiced complaints with the food served at meals and said the food needed improvement. One tenant brought two plates of food from the day prior to the meeting to	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 160	Continued From page 1	A 160		

show the food that was served to the tenants. It was supposed to be Swiss steak but there were no tomatoes on the steak. Another tenant showed a picture of the food from 6/25/23 and the chicken cordon bleu was burnt. A comment was shared that when pancakes were last served they were very thick and blackened on the bottom. The majority of the concerns voiced related to the preparation of the food served to the tenants and some complaints were voiced regarding the temperature of the hot foods. The tenants said the lunch meal was better than the evening meal. The tenants said there was only one person on second shift to serve the meal. More fresh fruit and less pasta were requested. The tenants said the pork was tough but the roast beef was tender. The tenants did not feel the cooks had enough training to prepare the food.

2. When observed on 6/27/23 after the lunch meal (before plates were cleared) there were multiple plates of food left with nearly the entire piece of pork or the the majority of the piece of pork, left on the plate. When observing the food left from the meal served, seven tenants voiced complaints with the pork and how they could not chew or cut the meat.

3. Record review on 6/27/23 of monthly Tenant Council Meeting documents for March, April and May 2023 indicated the tenants voiced concerns with the temperature of the hot foods not being warm enough and the with food needing improvement, including the evening meal not improving.

4. When interviewed on 6/27/23 at 12:17 p.m. the Director said the lunch meal had improved and the evening meal had been a little better. She said there were personnel changes made in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 160	Continued From page 2 the dietary department at the attached nursing facility in the last few weeks. That day tenants were offered chicken (related to the issue with the pork). About one time per week she heard complaints about food temperature. There were no tenants with any unintended weight loss. In summary, the majority of the tenants who attended the meeting felt the food served to them needed improvement. The tenants voiced various concerns and complaints with the food served, including the preparation of the food and the temperature of the food. The tenants did not receive adequate services related to the meals provided.	A 160		
A 355	481-67.9(4)d 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: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide nurse delegation training for a wound treatment to 2 of 2 staff reviewed who provided assistance with the wound (Staff A and Staff B). Findings follow:	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 355	Continued From page 3	A 355		

1. Record review on 6/26/23 and 6/27/23 of Tenant #2's file revealed a diagnosis of diabetes mellitus. An After Visit Summary for the Wound Healing Center dated 3/1/23 revealed there was a wound on the left lateral foot. The treatment was to cleanse with saline and dress with Mepilex border as needed. The orders indicated Tenant #2 could shower but to leave the dressing in place during the shower and cover the dressing with plastic to keep it dry and to keep the foot out of the water spray. The orders indicated no whirlpool bathing and to apply lotion to legs, feet and heels daily.

A Discharge Summary dated 3/22/23 was provided as Tenant #2's discharge from the wound clinic.

Continued record review revealed a Progress Note dated 6/9/23 sent to the primary care provider (PCP) indicating Tenant #2's wound to the outer left foot had worsened, serosanguineous drainage was noted and the foot appeared to be red, swollen and warm to the touch. Tenant #2 denied pain to the area. A request was made to see if the PCP wanted to order a treatment and request for a referral to the wound clinic. Orders were received for Silvadene cream, apply topically daily with Mepilex borders and for a wound clinic referral.

Progress Notes indicated the following:
a. On 6/12/23 the wound on Tenant #2's left foot had worsened over the weekend. The wound had opened more. The wound depth was not able to be measured as Tenant #2 had significant foot pain. A large amount of drainage was noted to the wound bed and dressing. Tenant #2's family was notified. The PCP was called for new orders.
b. On 6/12/23 it was noted the PCP wanted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 355	Continued From page 4	A 355		

Tenant #2 to be seen at urgent care as Tenant #2 could not be seen in the office that morning.
c. On 6/12/23 it was noted Tenant #2's family would take Tenant #2 to urgent care.
d. On 6/12/23 Tenant #2 was admitted to the hospital for cellulitis and a diabetic ulcer to the left foot.
e. On 6/22/23 Tenant #2 was discharged from the hospital and admitted to the attached nursing facility for skilled care.
f. On 6/26/23 it was noted Tenant #2 would continue to receive intravenous antibiotics for the next week. Tenant #2 had a follow up appointment at the wound clinic that morning.

March medication administration records (MARs) from 3/17/23 to the end of the month reflected an order to cover the wound on the left inner foot with Mepilex to be changed on day shift on Tuesdays and Fridays. April and May 2023 also reflected the order was indicated above. Staff documented the completion of the treatment. It was also documented as completed on 6/2/23, 6/6/23 and 6/9/23. The June 2023 MAR reflected the new order for Silvadene External Cream 1%, to the left foot wound topically, on day shift (daily), and cover with Mepilex. It was started on 6/10/23 and was documented as completed on 6/10/23, 6/11/23 and 6/12/23, by Staff A and Staff B.

2. Review of Staff A's training on 6/26/23 and 6/27/23 revealed nurse delegated training was most recently completed dated 11/24/21. The training included a general treatment/dressing change delegation. The nurse delegated training did not include training related to Tenant #2's wound and treatment.

3. Review of Staff B's training on 6/26/23 and 6/2723 revealed nurse delegated training was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 355	Continued From page 5 most recently competed dated 8/22 (no year provided). The training included a general treatment/dressing change delegation. The nurse delegated training did not include training related to Tenant #2's wound and treatment. 4. When interviewed on 6/27/23 at 11:50 a.m. the Director of Nursing confirmed no new delegations were completed on 6/9/23 with the change in Tenant #2's wound and treatment.	A 355		
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 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 provide services in accordance with the training provided. This pertained to 1 of 1 staff observed that administered medications (Staff A). Findings follow: 1. When observed on 6/26/23 at the lunch medication pass (approximatley 10:25 a.m.), Staff A assisted Tenant #4 and Tenant #5 with blood glucose monitoring. Staff A first assisted Tenant #4, completed hand hygiene, donned gloves, took Tenant #4's blood glucose reading and touched several surfaces, including the medication cart, computer and medication cabinet, without doffing	A 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 361	Continued From page 6	A 361		

her gloves and completing hand hygiene. Staff A then doffed her gloves and completed hand hygiene. Staff A went to Tenant #5's apartment and completed hand hygiene, donned gloves, took Tenant #5's blood glucose reading and touched several surfaces, including the medication cart, computer and medication cabinet without doffing her gloves and completing hand hygiene. Staff A then doffed her gloves and completed hand hygiene. The gloves worn by Staff A while completing blood glucose checks were not doffed after the blood glucose check was completed and prior to touching other surfaces with contaminated gloves.

2. Record review on 6/26/23 of Tenant #4's June 2023 medication administration record (MAR) reflected Staff A initialed for the completion of Tenant #4's blood glucose check on 6/26/23 at 11:00 a.m.

Continued record review on 6/26/23 of Tenant #5's June 2023 MAR reflected Staff A initialed for the completion of Tenant #5's blood glucose check on 6/26/23 at 11:00 a.m.

3. Review of Staff A's nurse delegation documents on 6/26/23 reflected training on blood glucose checks was completed on 11/24/21. The Blood Sugar Monitoring training document indicated after completion of the blood sugar monitoring to remove the test strip out of the monitor, discard in the sharps container and remove and dispose of gloves. The document then indicated to wash hands with soap or water or use sanitizer.

4. When interviewed on 6/27/23 at 11:50 a.m. the Director of Nursing (DON) indicated she would expect staff wash or sanitize hands, put on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 361	Continued From page 7 gloves, complete the blood glucose check, dispose of materials in the sharps container, remove gloves and wash or sanitize hands before touching items, including the computer. The DON confirmed Staff A had received training on blood glucose monitoring.	A 361		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. 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 for 1 of 1 tenants reviewed with a wound (Tenant #2). Findings follow: 1. Review of Tenant #2's file on 6/26/23 and 6/27/23 revealed a diagnosis of diabetes mellitus. An After Visit Summary for the Wound Healing Center dated 3/1/23 revealed there was a wound on the left lateral foot. The treatment was to	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 8	A 145		

cleanse with saline and dress with Mepilex border as needed. The orders indicated Tenant #2 could shower but to leave the dressing in place during the shower and cover the dressing with plastic to keep it dry and to keep the foot out of the water spray. The orders indicated no whirlpool bathing and to apply lotion to legs, feet and heels daily.

A Discharge Summary dated 3/22/23 was provided as Tenant #2's discharge from the wound clinic.

Continued record review revealed a Progress Note dated 6/9/23 sent to the primary care provider (PCP) indicating Tenant #2's wound to the outer left foot had worsened, serosanguineous drainage was noted and the foot appeared to be red, swollen and warm to the touch. Tenant #2 denied pain to the area. A request was made to see if the PCP wanted to order a treatment and request for a referral to the wound clinic. Orders were received for Silvadene cream, apply topically daily with Mepilex borders and for a wound clinic referral.

Progress notes for 6/12/23 indicated the tenant's wound on the left foot had worsened over the weekend. Following a visit to urgent care, the tenant was admitted to the hospital for cellulitis and a diabetic ulcer to the left foot.

Continued record review revealed evaluations were last completed on 2/7/23 and 5/5/23. Evaluations were not completed as needed related to Tenant #2's left foot wound and when it was noted the left foot wound had worsened on 6/9/23, the PCP was notified and new orders were received. Evaluations were not completed with significant change for Tenant #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 9 2. When interviewed on 6/27/23 at 11:50 a.m. and 12:28 p.m. the Director of Nursing confirmed the above finding.	A 145		
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 update service plans as needed to reflect the service needs of the tenants. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Review of Tenant #1's file on 6/26/23 and 6/27/23 revealed April, May and June (through 6/22/23) medication administration records (MARs) reflected an order for Novolog Injection Solution 100 units/milliliters, 20 units, before meals scheduled at 7:30 a.m., 11:30 a.m. and 5:30 p.m. The April 2023 MARs reflected three doses that were administered for the month. The April 2023 MAR reflected routine refusals of her insulin during the month. The May 2023 MARs reflected all doses were refused except one dose on 5/18/23, which reflected partial administration. The June 2023 MARs reflected all doses were refused except two doses, one on 6/13/23 and	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 350	Continued From page 10	A 350		

one on 6/19/23, which reflected partial administration of the medication.

Continued record review revealed a fax to the primary care provider (PCP) dated 4/27/23 indicated Tenant #1 had been refusing her Novolog because she said she did not need it. The PCP responded and indicated to offer it but not to force it.

A Therapy Referral Tracking Form indicated a verbal order was received for physical therapy (PT) dated 4/17/23. A Discharge Notice From Therapies document reflected Tenant #1 was discharged from PT on 5/23/23.

Tenant #1's service plan dated 3/6/23 was not updated with the initiation and discharge from PT. The service plan dated 6/6/23 reflected Tenant #1 at times refused her Novolog insulin; however, the service plan did not reflect the refusals until 6/6/23 despite routine refusals of her Novolog insulin in April and May 2023.

2. Review of Tenant #2's file on 6/26/23 and 6/27/23 revealed a diagnosis of diabetes mellitus. An After Visit Summary for the Wound Healing Center dated 3/1/23 revealed there was a wound on the left lateral foot. The treatment was to cleanse with saline and dress with Mepilex border as needed. The orders indicated Tenant #2 could shower but to leave the dressing in place during the shower and cover the dressing with plastic to keep it dry and to keep the foot out of the water spray. The orders indicated no whirlpool bathing and to apply lotion to legs, feet and heels daily.

A Discharge Summary dated 3/22/23 was provided as Tenant #2's discharge from the wound clinic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 350	Continued From page 11	A 350		

Continued record review revealed a Progress Note dated 6/9/23 sent to the primary care provider (PCP) indicating Tenant #2's wound to the outer left foot had worsened, serosanguineous drainage was noted and the foot appeared to be red, swollen and warm to the touch. Tenant #2 denied pain to the area. A request was made to see if the PCP wanted to order a treatment and request for a referral to the wound clinic. Orders were received for Silvadene cream, apply topically daily with Mepilex borders and for a wound clinic referral.

Progress Notes indicated the following:
a. On 4/23/23 it was noted a new order was received for compression hose on 4/21/23.
b. On 6/12/23 it was noted the wound on Tenant #2's left foot had worsened over the weekend. The wound had opened more. The wound depth was not able to be measured as Tenant #2 had significant foot pain. A large amount of drainage was noted to the wound bed and dressing. Tenant #2's family was notified. The PCP was called for new orders.
c. Progress notes for 6/12/23 indicated the tenant's wound on the left foot had worsened over the weekend. Following a visit to urgent care, the tenant was admitted to the hospital for cellulitis and a diabetic ulcer to the left foot.

Tenant #2's service plans dated 2/7/23 and 5/5/23 did not reflect the compression hose. The service plan dated 2/7/23 reflected the wound clinic, a wound on Tenant #2's calf and a history of skin breakdown. The service plan also reflected staff assisted Tenant #2 with bathing. However, the service plan did not reflect Tenant #2's left foot wound and treatment. It also did not reflect the instructions for the wound and bathing. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0110	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON SQUARE	502 PINEHAVEN DR MONTICELLO, IA 52310

(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 350	Continued From page 12	A 350		

service plan dated 5/5/23 did not reflect the left foot wound. The service plan was not updated as needed when it was noted Tenant #2's left foot wound had worsened on 6/9/23, the PCP was notified and new orders were received.

3. Review of Tenant #3's file on 6/26/23 and 6/27/23 revealed Progress Notes indicated the following:
a. On 1/3/23 Tenant #3 was admitted to hospice services.
b. On 3/20/23 it was noted Tenant #3 was discharged from hospice on 3/15/23 per her request

Continued record review revealed a verbal order was received for speech therapy (ST) on 3/20/23. A Discharge Notice From Therapies was dated 5/13/23 indicated Tenant #3 was discharged from ST.

Tenant #3's service plan dated 1/3/23 reflected hospice services; however, the service plan was not updated until 4/3/23 to reflect the discharge from hospice services. The service plan was also not updated with initiation and discharge from ST.

4. When interviewed on 6/27/23 at 11:50 a.m. and 12:28 p.m. the Director of Nursing confirmed the above finding.

Pennington Square
assisted living
kind • compassionate • care

Department of Inspections and Appeals
Attn: Deb Dixon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of Pennington Square Assisted Living, I respectfully submit our Plan of Correction for your approval. This response is specific to the recertification report for the onsite visit between 06/22/2023-06/27/2023.

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Tenant Rights

1. Elements detailing how the Program will correct each regulatory insufficiency

- All tenants will be provided with meal and food services that are adequate and appropriate.
- Re-education was provided to dietary staff on cooking process for pork on ____8/7/23____.
- Re-education was provided to dietary staff on overcooking (burning) foods on ____8/7/23__.
- A food council meeting was held on _8/3/23__ open to all tenants.

2. Measures taken to ensure the problem does not recur

- Staff follow up with tenants at the end of each meal to confirm if there are any concerns and record them for the Executive Director, Administrator, and/or Dietary Manager who review the log each business day and address any concerns immediately.

3. How the Program plans to monitor performance to ensure compliance

- Food Council will meet monthly and be open to all tenants to attend.
- Executive Director, Administrator, Dietary Manager, and/or Designee will perform ongoing audits of rotating meals, including evening meal, at least weekly to ensure meal and food service is adequate and appropriate.

- Education will be provided to dietary staff who prepare meals upon hire with re-education at least annually and as needed.

4. The date by which the regulatory insufficiency will be corrected

- The regulatory insufficiency will be corrected on or before September 1, 2023.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency

- Staff A and Staff B will have nurse delegation training provided related to Wound Care treatments if they are providing assistance with the wound.
- The wound care for Tenant #2 is being completed by Home Health and/or Director of Nursing since their return to the Program from skilled nursing facility.

2. Measures taken to ensure the problem does not recur

- The Director of Nursing will be re-educated on Nurse Delegation Procedures according to Chapter 67.9(4).
- Any staff member providing care will receive nurse delegation on service plan tasks upon hire and at the time of specific need such as with wound care orders.

3. How the Program plans to monitor performance to ensure compliance

- The Director of Nursing and/or designee will audit staff files to ensure delegation has been completed.
- Staff who have not completed any necessary nurse delegation will be removed from the schedule until completed.

4. The date by which the regulatory insufficiency will be corrected

- The regulatory insufficiency will be corrected on or before September 1, 2023.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency

- Staff A was re-delegated on blood glucose monitor training on _____8/16/23_____.

2. Measures taken to ensure the problem does not recur

- All Medication Managers will be re-delegated on blood glucose monitor training.

3. How the Program plans to monitor performance to ensure compliance

- The Director of Nursing and/or designee will complete ongoing audits of Medication Manager blood glucose monitoring at least annually and as needed.
- Re-education will be provided immediately per the annual audits and ongoing as needed.

4. The date by which the regulatory insufficiency will be corrected

- The regulatory insufficiency will be corrected on or before September 1, 2023.

Service Plans

1. Elements detailing how the program will correct each regulatory insufficiency
    - The service plan for Tenant #1 will be updated timelier with their preferences including refusal of medications.
    - The service plan for Tenant #1 will be updated with their preference for Outside Service providers.
    - The service plan for Tenant #2 will be updated to reflect the left foot wound requiring treatment and instructions for bathing/showering.
    - The service plan for Tenant #2 will be updated to reflect the use of Compression Hose.
    - The service plan for Tenant #3 will be updated to reflect their preference for Outside Service providers.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing will be re-educated regarding Service Plans and the regulatory requirements contained in Chapter 69.26.
    - Service plans will be developed for each tenant and will be based on evaluation, individualized for each tenant, updated whenever changes are needed and at least annually in accordance with regulation.
3. How the Program Plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Nurse Designee will review the service plans for all tenants receiving personal or health-related cares at least quarterly and when changes are needed.
    - The Director of Nursing and/or Nurse Designee will review the service plans of all tenants at least annually and when changes are needed.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before September 1, 2023.

If you have any questions regarding this Plan of Correction, please contact me at 319-465-2013.

Respectfully submitted,

Chelsea Takes
Assisted Living Director ok