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
	S0157	A. BUILDING: _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE OF OELWEIN	1101 3RD STREET SW OELWEIN, IA 50662

(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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 15 Number of tenants with cognitive disorder: 8 Total Census: 23 Incident #123918-I and Complaint #124909-C were investigated and the following regulatory insufficiencies were identified:	A 000	The Plan of Correction is attached	
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 observation, interview, and record review the Program failed to follow its policy and procedure related to food labeling and storage. This potentially effected all tenants (census of 23). Findings follow: When observed on 11/21/24 at approximately 12:45 p.m. there were food items in the Program's kitchen that were opened and not labeled. In the refrigerator there was lettuce wrapped in aluminum foil that was not marked with the item, the date opened, or the discard date. There was also a fresh tomato wrapped in plastic wrap that was not marked with the item, the date opened, or the discard date. There was a plastic bag of food that was identified by the	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 150	Continued From page 1 Culinary Coordinator as leftover turkey that was marked to discard by 11/20/24 (still remained when observed on 11/21/24). In the freezer there were frozen chicken patties in a plastic bag with twist tie that were not marked with the item, date opened, or discard date. When interviewed on 11/21/24 at 12:37 p.m. the Culinary Coordinator said it was the cooks' responsibility to make sure foods were labeled when they were opened and ensure they were thrown out on the discard date. When interviewed on 11/20/24 at 4:04 p.m. Staff H said the tenants in memory care received "old" desserts and moldy bread. She said sometimes in the kitchen, desserts were not kept in the refrigerator. On 11/26/24 review of the Program's policy and procedure related to food storage, handling and labeling indicated all food in the refrigerator, freezer and storage areas would be labeled and include "produced on" and "use by" dates. All cooked foods, open containers, salads, desserts and fruits would be securely covered, labeled and dated. Products would be marked with the "received on" date and stored. New stock was to be placed behind prior food stock. All non-perishable items that were removed from the original packaging would be labeled with the name of the item and date opened. Items that were stored in refrigeration would be labeled with the item, date it was made and expiration date. It indicated to always securely cover foods. All items would be labeled with item name, date produced, use by date and staff's initials. It indicated to check labels daily and discard out dated items.	A 150		

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A 150	Continued From page 2 When interviewed on 11/26/24 at 11:28 a.m. the Executive Director confirmed food should be labeled and dated when opened and include the date by which it should be discarded.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure tenants were treated with consideration, respect, and full recognition of personal dignity. This pertained to 2 of 4 current tenants reviewed (Tenant #2 and Tenant #3) and 1 of 1 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 11/25/24 of an Internal Investigation document dated 10/3/24 indicated the tenants involved were Tenant #2, Tenant #3 and Tenant C1. The staff making the report was Staff B and witnesses included Staff A, Staff C and Staff D. The staff suspected of maltreatment was Staff G. The initial report was made on 10/3/24 at 1:00 p.m. to the Healthcare Coordinator. The description of the incident indicated Staff G was "verbally abusive" to tenants, she refused to respect their requests and violated their rights. It also indicated tenants had requested that she no longer provide care for	A 155		

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them. During the investigation two other incidents were reported, which involved Tenant #3 on 10/3/24 and Tenant C1 on 9/28/24. It indicated Staff G was suspended pending termination.

An incident summary indicated on 10/3/24 Staff G reported Tenant #3 refused a bath and wanted to see the nurse. At 8:30 a.m. the Healthcare Coordinator went to see Tenant #3 who was visibly agitated and upset. Tenant #3 said he would take a bath but he wanted to use the bathroom first. During an internal investigation it was reported that Staff G had been yelling at the tenant and would not listen to him. He requested assistance to change his protective undergarment and she ignored him and told to get up and go for his bath. The Healthcare Coordinator interviewed Tenant #3 after the report and he said, "It is just that girl. She is always mean and bossy, I don't want her."

Staff also reported Staff G yelled at Tenant #2 while completing his whirlpool and did not respect his wishes for water level. It was noted she could be heard outside of the door of the whirlpool room. Tenant #2 was interviewed and he requested that she never provide care for him again and that she was "mean." Tenant #2 reported that she upset him and made him mad.

During the internal investigation it was reported that on 9/28/24 at 11:30 a.m. Staff G woke up Tenant C1, who was on hospice and had recently fallen. Tenant C1 was in bed and requested to rest and said that she wanted to sleep. It was reported Staff G yelled at her to get out of bed, that she needed to eat, was incontinent and she "started pulling aggressively on her arm." It was reported Staff G said to Tenant C1 that "no one can hear you." Tenant C1 was transitioning to

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death and it was expected she would not eat. Staff were to supposed to keep her comfortable and were to support her.

2. Review of Tenant #2's file on 11/25/24 revealed an incident report indicating on 10/3/24 at 12:00 p.m. staff reported Staff G yelled at Tenant #2 in the whirlpool and did not respect his wishes for the water level. It could be heard outside of the door. When Tenant #2 was interviewed, he requested that she not provide care for him again. He said she upset him, made him mad and that she was "mean."

When interviewed on 11/25/24 at 12:25 p.m. Staff B said Staff G had a dual attitude, one when out in the dining room and one behind doors. She said just that morning she and Staff G tried to transfer Tenant #2 but were not able to stand him up. Staff G hollered at Tenant #2 to move his foot. In his apartment Staff G said to Staff B something to the effect of they just could not do it and the tenant should not be here. Tenant #2 asked Staff G why she was so mean. In regards to the whirlpool incident on 10/3/24, Staff B helped Staff G get Tenant #2 into the tub and then she left. She was sitting in the nearby nurse's station and said she could hear Staff G hollering. She could not hear the words but heard screaming and hollering by Staff G. She texted the Executive Director to come listen outside of the whirlpool room. Standing outside the door, they heard the words "stop" and "stop it." Staff G pushed Tenant #2's pendant for help. Staff B went into the room and Tenant #2 told Staff G she could leave. Staff G said she could not leave because it took two staff to transfer him.

3. Review of Tenant #3's file on 11/25/24 revealed an incident report indicating on 10/3/24 at 8:00

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a.m. Staff G reported Tenant #3 refused a whirlpool and wanted to see the nurse. At 8:30 a.m. the Healthcare Coordinator went to see him. Tenant #3 was visibly agitated and upset and said he would take a whirlpool but wanted to use the bathroom first. He said he felt agitated and wondered if he needed a urinalysis. During an internal investigation it was reported Staff G had been yelling at him and would not listen to him. He requested assistance to change his protective undergarment and she ignored his request and yelled at him to get up for his whirlpool. Tenant #3 said Staff G was always mean and bossy and he did not want her providing his care.

When interviewed on 11/25/24 at 10:02 a.m. Staff A recalled the whirlpool incident happened on first shift. Staff G had come back to give Tenant #3 a whirlpool. Afterwards he spoke with the Healthcare Coordinator and reported Staff G rushed him and yelled at him. She said Tenant #3 was upset, because Staff G was mean to him in the whirlpool and he did not want her to help him with bathing. Staff A added that Staff G had been reported several times previously for being verbally abusive and making tenants do things they did not want to do. For example if they did not want to come out for meals or get dressed, she forced them to. It would be addressesd by administration and she would change for a little while, then go back to the same behaviors. A lot of tenants did not want Staff G to do their cares.

4. Review of Tenant C1's file on 11/25/24 and 11/26/24 revealed an incident report documenting on 9/28/24 at 11:30 a.m. staff witnessed Staff G wake up Tenant C1, who was on hospice and had previously fallen. Tenant C1 was in bed and requested to rest and sleep. Staff G yelled at her to get out of bed, said she needed to eat, she

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was incontinent and began pulling "aggressively" on her arm. It noted Staff G then said "no one can hear you." Tenant C1 was transitioning to death and it was expected that she would not eat and staff were to keep her comfortable. Tenant C1 died on 9/30/24.

When interviewed on 11/25/24 at 1:51 p.m. Staff C said she had come in that morning and a third shift staff reported Tenant C1 had fallen and would not be out for breakfast. She said before lunch, Staff G and Staff D (who was training) were in her apartment and she heard Tenant C1 screaming. Staff C went to the apartment and saw Staff D was by the door and Staff G had her hands around Tenant C1's arm. Tenant C1 was on the bed upright. Staff C asked what was going on and Staff G said Tenant C1 needed to get up to use the bathroom and get something to eat. Tenant C1 wanted to lay back down and go to sleep. Staff G maintained her hands on her and she pulled her up again. She said Staff G tried three times to forcefully get the tenant up as the tenant was crying. She said Staff G yanked her as Tenant C1 pushed back. Staff C asked why she could not be changed in bed and said she should not be forced to eat. Staff G removed her hands and said she had to eat with her medications. Tenant C1 was crying out and saying stop. Tenant C1 had fallen earlier that morning and although she hadn't suffered any injuries, she appeared to have some pain in her hip and back. Staff G called the triage nurse and told them she was refusing to get up. Triage told her to give the tenant more medication and try again in 30 minutes

A written statement by Staff D indicated she was training with Staff G and went to get Tenant C1 up for breakfast. It was known that she had fallen,

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had prior falls and would most likely be in pain. Staff G went to her bed and tried to wake her up. Tenant C1 slowly woke up and said she did not want to get up several times. Staff G said that they needed to get her up to go to the bathroom and scooped/grabbed her legs and pulled them to side of the bed and grabbed her by the arm to sit her up. Tenant C1 started screaming in pain and said she did not want to get up or eat. Staff G and Tenant C1 argued back and forth. Tenant C1 was crying in pain and pointed to her lower back where it hurt and screamed no. Staff D rubbed the top of her back by her shoulders and tried to hold her hands. She asked Staff G if she could go and get an ice pack and Staff G said no, she did not have an order for it. Staff D then asked if they could try to have her stand and turn into a wheelchair and then staff could push her to the bathroom and the table. Staff G agreed and Staff D went to get the wheelchair. When she returned Tenant C1 was still on the edge of the bed crying. Staff G called the triage nurse while staff was in there. Triage told her to lay her back down, administer her pain medications and attempt to get her up later. Staff G was mad and argued with the nurse. Staff G did let Tenant C1 lay down after many attempts to stand her up.

4. When interviewed on 11/26/24 at 2:36 p.m. the Healthcare Coordinator said Staff G reported Tenant #3 was angry, upset and refused his whirlpool. She went to visit with him and he said he would take it but wanted to use the bathroom first. On the same date the Executive Director said he heard Staff G yelling through the door of the whirlpool room. She said the Executive Director completed an internal investigation including staff interviews. It was reported by Staff C and Staff D that they observed Staff G try to make Tenant C1 get of bed. The Healthcare

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Coordinator said it was Staff G's way or the highway. She said tenants were allowed to get breakfast at any time and sleep as late as they wanted. She said Staff G would be fine when the Healthcare Coordinator was there but on weekends would do her own thing and staff would report it her via text message.

When interviewed on 11/26/24 at 11:28 a.m. the Executive Director said there was a report Staff G was not very nice to Tenant #3 and he did not want her to do his cares anymore. The same day Staff B reported Staff G was being short and aggressive when giving Tenant #2 a whirlpool. Staff B walked out of the whirlpool as she was frustrated. The Executive Director heard Staff G's raised voice but could not make out the words. Tenant #2 made a comment that it was a pattern for Staff G to talk to here this way. He said Staff G's behaviors were described as scolding, short, raised voice, firm and not respectful. He was made aware of a concern with Tenant C1 by Staff C. He said Tenant C1 was not coming out for breakfast and was hurt. Staff G was moving her and it concerned Staff C as she could tell Tenant C1 was hurting. He said Staff G had been terminated. Staff G had received training on tenant rights, been a long term employee and knew what she was doing.

5. When interviewed on 11/26/24 at 1:11 p.m. Staff G said Tenant #2 was really out of it the morning of 10/3/24. He had knocked over his side table and she told the other staff she was not sure about the whirlpool because he was not right. A whirlpool was offered and he said yes. She and another staff assisted him into the whirlpool and the other staff left. She said Tenant #2's eyes were closed and he did not seem right. The water level was enough that were was water

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on the back wall and water everywhere. The tenant's eyes remain closed and he was not speaking in full sentences. She started to get him out of the whirlpool and he started reaching for knobs and turned on the water. She said he was messing with everything. She kept telling him to open his eyes and she requested help. She said the other staff went and got the Executive Director. She had requested help and they stood outside of the whirlpool room. Staff G said she was telling Tenant #2 to open his eyes. The other staff came in and she requested assistance with dressing Tenant #2. The same day she went to memory care to assist Tenant #3 and went to his apartment. He was in the bathroom and calling for help. His protective undergarment was wet, so she changed it and asked if he wanted a whirlpool. He said he could not take a whirlpool when he was mentally off. He said he needed to see a doctor and she offered to get the nurse. The Healthcare Coordinator told him there was a staff ready to give him a whirlpool and he said okay. There were no problems with the whirlpool. She walked him back to memory care after the whirlpool. She said she always liked Tenant #3 and he was very special to her. She said regarding Tenant C1, she went in to get her up and she was laying in bed. Staff G said the tenant's arm was behind her back and she tried to help Tenant C1 get up and she started to cry out. She called the triage nurse. She was told to administer medications per the instructions, monitor her and give her time. Staff G said she never pulled on her arm.

6. Review of a Counseling Documentation Form indicated the date of the occurrence was 9/28/24 and 10/3/24. The corrective action indicated Staff G was terminated due to policy/safety violation and conduct/behavior. It was signed and dated

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A 155	Continued From page 10 10/8/24 by the Executive Director and Healthcare Coordinator.	A 155		
A 365	481-67.9(4)g 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: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to communicate in writing occurrences that differed from a tenant's normal health, functional, and cognitive status and failed to retain the documentation at least three years. This pertained to 1 of 1 tenants reviewed who had been hospitalized (Tenant #1). Findings follow: 1. When interviewed on 11/20/24 at 11:05 a.m.	A 365		

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A 365	Continued From page 11 Staff A said Tenant #1's oxygen had been dropping a lot in the past three weeks. She had shortness of breath (SOB) and a dry cough. Her lowest oxygen saturation level was 73%. In the past week it was in the 70% to 80% range on a daily basis. Her anxiety was bad, she became helpless and wanted staff to do more for her. She said on Sunday she could tell Tenant #1 was struggling when she helped her to the bathroom and to her chair. She was SOB and wheezing. Tenant #1 requested to go to the doctor daily but the Healthcare Coordinator (HCC) would not allow it and said her family declined. She said the nurse pushed everything off with her and attributed it all to her anxiety. Staff A said she did not complete any Staff to Nurse Communication sheets for Tenant #1. When interviewed on 11/20/24 at 11:34 a.m. Staff B said Tenant #1 had lots of anxiety and she was SOB, and had gurgling and rattling which was quite loud. She stayed in her apartment, and ate meals there. Her oxygen was low at times, such as in the 80%'s. It was 83% to 84% and it was normally in the upper 90%'s. Staff notified the nurse and she said it was anxiety and said her medications were working. They were to have the tenant breathe in through her nose and out through her mouth. She said Tenant #1 had requested most days the previous week to go to the doctor. The HCC would tell her it was her anxiety and she needed to calm down. She had respiratory symptoms for a couple of weeks. The tenant woke up on third shift and told staff she could not breathe. One time on the toilet she said she was just going to sit there and die. She did not know if a Staff to Nurse Communication form was completed. When interviewed on 11/20/24 at 3:07 p.m. Staff	A 365		

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A 365	Continued From page 12 E said Tenant #1 had low oxygen and it had been reported to triage and in communication to the nurse. A couple of weeks prior her oxygen was in the low 80%'s and she said she did not feel right. Staff E called triage and they talked to her. Tenant #1 declined to be sent to the emergency room and was told to follow up with her primary care provider (PCP) on Monday. In the past few weeks she had medication changes, was unstable, pale, dehydrated and shaking. It was reported to the HCC on multiple occasions. Staff were told the tenant was having panic or anxiety attacks and to spend more time and help her more. The tenant was having low oxygen saturation and she could not complete activities of daily living by herself. She was not taking care of her apartment, was not able to shower or use the bathroom, and was paging for help. Tenant #1 was not eating. Over time her color was off. Multiple times Staff E reported it to the HCC as did many other staff. She said she filled out four to five Staff to Nurse Communication sheets and also had made verbal reports to the HCC. Some staff were taking pictures of the Staff to Nurse Communication sheets for their records. She was not if sure the HCC read the sheets. When interviewed on 11/20/24 at 12:22 p.m. Staff F said Tenant #1 could not catch her breath, was nervous and anxious. She was breathing heavy. On Sunday she was pretty restless, was shaking and kept asking what was wrong. She had complaints her mouth was dry. Staff helped her dress and walk to the bathroom. Tenant #1 usually came out for meals but in the past couple of weeks she ate in her apartment and did not eat as much as usual. Staff F did not complete any Staff to Nurse Communication sheets for Tenant #1.	A 365		

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A 365	Continued From page 13 When interviewed on 11/20/24 at 4:04 p.m. Staff H said Tenant #1 had a family member pass away recently, and had different medications prescribed for anxiety and depression. She was very scared, anxious and tearful. She was tired and weak, wanted staff to provide stand by assistance and she ate very little. In the last month and a half she was very anxious. She said something was said to the HCC who said her medications were changed and she was working through it. She wrote one Staff to Nurse Communication sheet and told the HCC. 2. Review of Tenant #1's file on 11/20/24 and 11/21/24 revealed Progress Notes indicating the following: - On 11/18/24 it was noted staff reported they heard Tenant #1 gasping and crackling lung sounds from the hallway. Tenant #1 was shaky, weak and disoriented. Her oxygen saturation was 78%. Staff was instructed to call an ambulance. Tenant #1 was transported by ambulance to the hospital. - On 11/18/24 it was noted Tenant #1 was admitted to the hospital for pneumonia, was on oxygen and intravenous (IV) antibiotics. Continued record review revealed there were no Staff to Nurse Communication forms provided for Tenant #1. 3. The Program's policy and procedure for Other Resident Occurrences indicated staff would use the RN Communication Form to communicate in writing any occurrences that were different from the tenant's normal health, cognitive, and functional status. Staff would receive training on tenant concerns that required written notification to the nurse and the written communication would be retained for not less than three years and	A 365		

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A 365	Continued From page 14 would be accessible to the Department upon request. 4. When interviewed on 11/21/24 at 11:07 a.m. the HCC said she had not received any prior reports from staff regarding Tenant #1's oxygen saturation concerns, SOB or respiratory symptoms. She had received verbal reports from staff regarding her not wanting to eat. They talked all of the time about her medications and anxiety. There were verbal reports regarding her fear of walking and fear of being alone which was part of her anxiety. She said Staff to Nurse Communication sheets went to her mailbox and she followed up on them. She received one to two sheets daily and staff completed them on a regular basis. She had not recieved any Staff to Nurse Communication sheets for Tenant #1. In summary, multiple staff reported various changes or unusual occurrences with Tenant #1 as noted above. Two staff reported they had filled out Staff to Nurse Communication sheets as required, however the HCC stated she never received them. Staff to Nurse Communication sheets were either not completed and/or not retained as required related to Tenant #1.	A 365		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed	A 145		

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A 145	Continued From page 15 practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 3 of 4 current tenants reviewed (Tenants #1, #3, #4). Findings follow: 1. When interviewed on 11/20/24 at 11:05 a.m. Staff A said Tenant #1's oxygen had been dropping a lot in the past three weeks. She had shortness of breath (SOB) and a dry cough. Her lowest oxygen saturation level was 73%. In the past week it was in the 70% to 80% range on a daily basis. Her anxiety was bad, she became helpless and wanted staff to do more for her. She said on Sunday she could tell Tenant #1 was struggling when she helped her to the bathroom and to her chair. She was SOB and wheezing. When interviewed on 11/20/24 at 11:34 a.m. Staff B said Tenant #1 had lots of anxiety and she was SOB, and had gurgling and rattling which was quite loud. She stayed in her apartment, and ate meals there. Her oxygen was low at times, such as in the 80's. It was 83% to 84% and it was normally in the upper 90%'s. Staff notified the nurse and she said it was anxiety and said her medications were working. They were to have the tenant breathe in through her nose and out through her mouth. She said Tenant #1 had	A 145		

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A 145	Continued From page 16	A 145		

requested most days the previous week to go to the doctor. The HCC would tell her it was her anxiety and she needed to calm down. She had respiratory symptoms for a couple of weeks. The tenant woke up on third shift one time and told staff she could not breathe. One time on the toilet she said she was just going to sit there and die.

When interviewed on 11/20/24 at 3:07 p.m. Staff E said Tenant #1 had low oxygen and it had been reported to triage and in communication to the nurse. A couple of weeks prior her oxygen was in the low 80%'s and she said she did not feel right. In the past few weeks she had medication changes, was unstable, pale, dehydrated and shaking. The tenant was having low oxygen saturation and she could not complete activities of daily living by herself. She was not taking care of her apartment, was not able to shower or use the bathroom, and was paging for help. Tenant #1 was not eating. Over time her color was off.

When interviewed on 11/20/24 at 12:22 p.m. Staff F said Tenant #1 could not catch her breath, was nervous and anxious. She was breathing heavy. On Sunday she was pretty restless, was shaking and kept asking what was wrong. She had complaints her mouth was dry. Tenant #1 usually came out for meals but in the past couple of weeks she ate in her apartment and did not eat as much as usual.

When interviewed on 11/20/24 at 4:04 p.m. Staff H said Tenant #1 had a family member pass away recently, and had different medications prescribed for anxiety and depression. She was very scared, anxious and tearful. She was tired and weak, wanted staff to provide stand by assistance and she ate very little. In the last month and a half she was very anxious.

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A 145	Continued From page 17 Review of Tenant #1's file on 11/20/24 and 11/21/24 revealed Progress Notes indicated the following: - On 10/9/24 staff reported Tenant #1 complained of SOB with exercise. Her oxygen saturation was 81-82%. During rest her oxygen saturation was 91-92% and she denied any cough or cold. Staff reported the vitals to the triage nurse. Tenant #1 refused to be seen in the emergency department (ED) and she was encouraged to see her primary care provider (PCP) if symptoms continued. - On 10/10/24 the previous night Tenant #1 had SOB and refused to go to the ED. That morning she was agreeable to go to urgent care. She returned and was diagnosed with anxiety. - On 10/18/24 an appointment was arranged for Tenant #1 to see her PCP regarding help with her anxiety. - On 11/8/24 Buspar was discontinued by the PCP. New medications were being delivered from pharmacy. - On 11/18/24 staff reported they heard Tenant #1 gasping and crackling lung sounds from the hallway. Tenant #1 was shaky, weak and disoriented. Her oxygen saturation was 78%. Staff was instructed to call an ambulance. Tenant #1 was transported by ambulance to the hospital. - On 11/18/24 Tenant #1 was admitted to the hospital for pneumonia, was on oxygen and intravenous (IV) antibiotics. - On 11/25/24 Tenant #1 was being treated for pneumonia and they switched antibiotics, added steroids and nebulizers. She remained on oxygen. They reported her anxiety was the main issue. She had panic attacks and was not able to participate in therapies. Tenant #1's family did want to increase or change her psych medications.	A 145		

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A 145	Continued From page 18 When interviewed on 11/21/24 at 11:07 a.m. the HCC said Tenant #1 had a family member pass away and she was told by someone she was grieving incorrectly. Slowly her anxiety increased. The PCP made medication changes and gradually her anxiety increased. Her symptoms were out of control, she was was not eating, her anxiety increased and she was shaking. The PCP visited and wanted her services increased, it was discussed with Tenant #1's family and they were not going to pay for it. Tenant #1 then transferred care to a new PCP and more medication changes occurred. Tenant #1's most recent comprehensive evaluation (cognitive, health and function) were dated 5/1/24. Evaluations were not completed as needed with significant changes in condition as noted above. 2. Review of Tenant #3's file on 11/25/24 and 11/26/24 revealed Progress Notes indicating the following: - On 9/5/24 it was noted Tenant #3 plans to return from the hospital tomorrow and a re-admission comprehensive assessment was completed. - On 9/11/24 Tenant #3 was re-evaluated by OT upon return to the Program and PT and speech therapy (ST) would evaluate later that week. - On 9/19/24 it was noted Tenant #3 was actively participating in therapies. - On 9/25/24 Tenant #3 was discharged from OT but continued with PT. - On 10/31/24 Tenant #3 had met his goals and was discharged from therapy. - On 11/18/24 Tenant #3 fell walking in his apartment with his walker. He had two abrasions on his left knee.	A 145		

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A 145	Continued From page 19 Tenant #3's most recent cognitive, health and functional evaluations were dated 9/5/24. Evaluations were not completed with significant change as noted above with the orders for PT and OT. 3. Review of Tenant #4's file on 11/26/24 revealed Progress Notes indicating the following: - On 11/7/24 Tenant returned from hospital very weak and deconditioned. He was fatigued and was now incontinent of urine and bowel and using adult briefs. He was admitted to hospice with a diagnosis of end stage cardiac disease. - On 11/7/24 staff reported Tenant #4 had used his pendant the majority of the night and had been pulling down his protective undergarment and urinating on his bed. Staff continued to clean him up and change bedding. - On 11/15/24 Tenant #4 was vomiting, had diarrhea and was not taking his medications. His blood pressure was 161/101 and pulse was 58. - On 11/17/24 staff reported to triage that Tenant #4 was observed on the floor and said he slid out of the chair when he tried to get up. - On 11/18/24 it was noted Tenant #4 vomited large amounts, was confused and wanted to go to bed. - On 11/19/24 staff reported to triage that Tenant #4 was found on the floor during rounds. He complained of head pain and said he hit his head on the heat register. He had skin tears to his bilateral arms. His oxygen saturation was 84% on 2 liters of oxygen. Hospice was called and was on her way to assess him. - On 11/22/24 it was noted Tenant #4's skin tears were being managed by the hospice nurse. - On 11/22/24 it was noted Tenant #4 remained on hospice and a private care duty staff stayed with the tenant from 7:00 p.m. to 7:00 a.m.	A 145		

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A 145	Continued From page 20 The tenant's file contained two Staff to Nurse Communication forms documenting: - On 11/15/24 it was noted Tenant #4 took off his clothes all night, urinated and defecated on himself and dug in his anus. - On 11/15/24 it was noted at a 12:00 a.m. check staff turned on a closet light and saw he was painting himself with bowel movement. It was all over his body. He became agitated when staff got him up for a shower. All of his pajamas were in the wash so he was given a large tee shirt to sleep in. Tenant #4's most recent cognitive, health and functional evaluations were dated 11/7/24 at the time of admission to hospice. Evaluations were not completed as needed with the significant changes as noted above. 4. When interviewed on 11/26/24 at 2:36 p.m. the Healthcare Coordinator confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 155	481-69.23(1)b Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharge a tenant who	A 155		

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A 155	Continued From page 21 exceeded retention criteria. This pertained to 1 of 4 current tenants reviewed (Tenant #2). Findings follow: 1. When interviewed on 11/20/24 at 11:05 a.m. Staff A said Tenant #2 took two people for transfers every time. When interviewed on 11/20/24 at 11:34 a.m. Staff B said Tenant #2 took two people, if not three, people for transfers. When interviewed on 11/20/24 at 3:07 p.m. Staff E said Tenant #2 took two people for transfers as the tenant was non-weight bearing. When interviewed on 11/20/24 at 12:22 p.m. Staff F said Tenant #2 took two people for transfers every time. It was hard for him to stand as he had knee pain. When interviewed on 11/20/24 at Staff I said Tenant #2 took people for transfers and it was sometimes a struggle with two. She said he could not bend his knees. 2. Review of Tenant #2's file on 11/25/24 and 11/26/24 revealed the following: A Vender Communication Form (PT/OT) signed and dated by a physical therapist assistant on 9/4/24 indicating Tenant #2 had a fall over the weekend. There were no significant injuries except skin lacerations. He had increased weakness and need for assistance to stand since the fall. Tenant #2 now needed the assistance of two for all transfers to and from the wheelchair. They would continue to assess. Tenant #2's Progress Notes indicated the	A 155		

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following:
- On 9/11/24 it was noted occupational therapy (OT) recommended the assistance of two people for whirlpools twice per week.
- On 10/2/24 Tenant #2 was discharged from physical therapy (PT) and they recommended the assistance of two staff for all transfers and no gait recommended. It was noted Tenant #2 was unable to meet his goals and there was no rehabilitation potential.
- On 10/2/24 it was noted Tenant #2's pivot was poor and at times absent. A discussion was had with Tenant #2's family regarding his decline, congestive heart failure, the need for oxygen and poor pulmonary function. Hospice was recommended and the family felt it was appropriate. It was planned to meet with corporate management staff to complete a waiver.
- On 10/9/24 hospice was there to complete the intake.
- On 11/20/24 staff reported Tenant #2 could no longer pivot transfer and he refused to use the hospital bed.

The tenant's file contained a copy of a Request For Waiver of Administrative Rule dated 11/8/24 related to a two person assist with transfers. The waiver had not been processed with a final decision at the time of the exit interview on 11/26/24.

3. When interviewed on 11/21/24 the Healthcare Coordinator said Tenant #2 would be discharged the next day. Hospice had made a referral to a nursing home. During an interview on 11/26/24 at 2:36 p.m. the Healthcare Coordinator said Tenant #2 had required the assistance of two people for transfers and she had applied for a waiver; however he was now bed bound and staff were

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A 155	Continued From page 23 providing cares for him, so he was not being discharged. She could not tell how long he had required the assistance of two staff for transfers but believed it was less than 21 days. In summary, Tenant #2 required the routine assistance of two staff or more prior to the waiver application submission date of 11/8/24. There was documentation to use the assistance of two staff for whirlpools and transfers to and from the wheelchair post fall in September. On 10/2/24 he was discharged from PT, transfers were recommended as a two person assist with no gait recommended. On 10/9/24 he was admitted to hospice. On 11/8/24 a waiver was submitted to the Department regarding him requiring the assistance of two staff for transfers. Staff interviews indicated Tenant #2 had required the assistance of two or more staff for transfers. Tenant #2 exceeded the criteria for retention for an extended time period prior to the request for the waiver.	A 155		
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	A 350		

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A 350	Continued From page 24 by: Based on interview and record review the Program failed to update service plans as needed to reflect the identified needs of tenants. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. When interviewed on 11/20/24 at 11:05 a.m. Staff A said Tenant #1's oxygen had been dropping a lot in the past three weeks. She had shortness of breath (SOB) and had a dry cough. Her lowest oxygen saturation was 73%. It was in the 70 to 80's almost daily in the past week. Her anxiety was bad, she became helpless and wanted staff to do more for her. When interviewed on 11/20/24 at 11:34 a.m. Staff B said Tenant #1 had lots of anxiety and was SOB, and had gurgling and rattling which was quite loud. She stayed in her apartment, and ate meals there. Her oxygen was low at times. It was 83% to 84% and it was normally in the upper 90's. Staff notified the nurse and she said it was anxiety and her medications were working. They were to have the tenant breathe in through her nose and out through her mouth. When interviewed on 11/20/24 at 3:07 p.m. Staff E said Tenant #1 had low oxygen and it had been reported to triage and in communication to the nurse. A couple of weeks prior her oxygen was in the low 80's and she said she did not feel right. Staff E called triage and they talked to her. Tenant #1 declined to be sent to the emergency room and was told to follow up with her primary care provider (PCP) on Monday. In the past few weeks she had medication changes, was unstable, pale, dehydrated and shaking. It was reported to the Health Care Coordinator (CC) on multiple occasions. Staff were told the tenant was	A 350		

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(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
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having panic or anxiety attacks and to spend more time and help her more. The tenant was having low oxygen saturation and she could not complete activities of daily living by herself. She was not taking care of her apartment, was not able to shower or use the bathroom by herself, and was paging for help. Tenant #1 was not eating.

When interviewed on 11/20/24 at 12:22 p.m. Staff F said Tenant #1 could not catch her breath, was nervous and anxious. She was breathing heavy. Tenant #1 usually came out for meals but in the past couple of weeks she ate in her apartment and did not eat as much as usual.

When interviewed on 11/20/24 at 4:04 p.m. Staff H said Tenant #1 had a family member pass away, and different medications were prescribed for anxiety and depression. She was very scared, anxious and tearful. She was tired, weak, ate very little, and wanted staff to provide stand by assistance. In the past month and a half she was very anxious. Staff H said something was said to the HCC who stated the tenant's medications had been changed and she was working through it.

Review of Tenant #1's file on 11/20/24 and 11/21/24 revealed Progress Notes indicated the following:
- On 10/9/24 staff reported Tenant #1 complained of SOB with exercise. Her oxygen saturation was 81-82%. During rest her oxygen saturation was 91-92% and she denied any cough or cold. Staff reported the vitals to the triage nurse. Tenant #1 refused to be seen in the emergency department (ED) and she was encouraged to see her PCP if symptoms continued.
- On 10/10/24 the previous night Tenant #1 had

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SOB and refused to go to the ED. That morning she was agreeable to go to urgent care. She returned and was diagnosed with anxiety.
- On 10/18/24 an appointment was arranged for Tenant #1 to see her PCP regarding help with her anxiety.
- On 11/8/24 Buspar was discontinued by the PCP. New medications were being delivered from pharmacy.
- On 11/18/24 staff reported they heard Tenant #1 gasping and crackling lung sounds from the hallway. Tenant #1 was shaky, weak and disoriented. Her oxygen saturation was 78%. Staff was instructed to call an ambulance. Tenant #1 was transported by ambulance to the hospital.
- On 11/18/24 Tenant #1 was admitted to the hospital for pneumonia, was on oxygen and intravenous (IV) antibiotics.
- On 11/25/24 Tenant #1 was being treated for pneumonia and they switched antibiotics, added steroids and nebulizers. She remained on oxygen. They reported her anxiety was the main issue. She had panic attacks and was not able to participate in therapies. Tenant #1's family did want to increase or change her psych medications.

When interviewed on 11/21/24 at 11:07 a.m. the HCC said Tenant #1 had a family member pass away and had been told she was grieving incorrectly. Slowly her anxiety increased. Her PCP made medication changes but her anxiety increased. Her symptoms were out of control, she was not eating, her anxiety increased and she was shaking. The PCP visited and wanted her services increased. It was discussed with Tenant #1's family but they were not going to pay for it. Tenant #1 then transferred care to a new PCP and more medication changes occurred. She was doing better and her appetite had improved. She

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had received verbal reports regarding the tenant's fear of walking and fear of being alone. She said the service plan could not be changed regarding increased services as Tenant #1's family did not want it.

Tenant #1's most recent service plan was dated 5/1/24. The service plan was not updated as needed with significant changes in condition as noted above.

2. When interviewed on 11/21/24 the HCC said Tenant #2 had an indwelling catheter. Staff reported he had blood in his catheter bag but it was really discolored output related to medications he was prescribed. However, there was often shreds and blood clots in the bag after the monthly change.

On 11/24/24 and 11/25/24 review of Tenant #2's file revealed service plans updated on 10/10/24, 11/15/24 and 11/22/24. The service plans indicated Tenant #2 had an indwelling catheter; however, did not reflect his output was frequently discolored due to medications administered and blood clots after a catheter change.

3. Review of Tenant #3's file on 11/25/24 and 11/26/24 revealed Progress Notes indicating the following:
- On 9/5/24 it was noted Tenant #3 plans to return from the hospital tomorrow and a re-admission comprehensive assessment was completed.
- On 9/11/24 Tenant #3 was re-evaluated by OT upon return to the Program and PT and speech therapy (ST) would evaluate later that week.
- On 9/19/24 it was notedTenant #3 was actively participating in therapies.
- On 9/25/24 Tenant #3 was discharged from OT

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but continued with PT.
- On 10/31/24 Tenant #3 had met his goals and was discharged from therapy.
- On 11/18/24 Tenant #3 fell walking in his apartment with his walker. He had two abrasions on his left knee.

Tenant #3's most recent service plan was dated 9/6/24. The service plan was not updated with significant change as noted above with the orders for PT and OT and the discontinuation of those therapies.

4. Review of Tenant #4's file on 11/26/24 revealed Progress Notes indicating the following:
- On 11/7/24 Tenant returned from hospital very weak and deconditioned. He was fatigued and now incontinent of urine and bowel and using adult briefs. He was admitted to hospice with a diagnosis of end stage cardiac disease.
- On 11/7/24 staff reported Tenant #4 had used his pendant the majority of the night and had been pulling down his protective undergarment and urinating on his bed. Staff continued to clean him up and change bedding.
- On 11/15/24 Tenant #4 was vomiting, had diarrhea and was not taking his medications. His blood pressure was 161/101 and pulse was 58.
- On 11/17/24 staff reported to triage that Tenant #4 was observed on the floor and said he slid out of the chair when he tried to get up.
- On 11/18/24 it was noted Tenant #4 vomited large amounts, was confused and wanted to go to bed.
- On 11/19/24 staff reported to triage that Tenant #4 was found on the floor during rounds. He complained of head pain and said he hit his head on the heat register. He had skin tears to his bilateral arms. His oxygen saturation was 84% on 2 liters of oxygen. Hospice was called and was on

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A 350	Continued From page 29 her way to assess him. - On 11/22/24 it was noted Tenant #4's skin tears were being managed by the hospice nurse. - On 11/22/24 it was noted Tenant #4 remained on hospice and a private care duty staff stayed with the tenant from 7:00 p.m. to 7:00 a.m. Tenant #4's most recent service plan was dated 11/7/24. Admission to hospice was added on that date, however the plan was not updated as needed with the significant changes as noted above. 5. When interviewed on 11/26/24 at 2:36 p.m. the Healthcare Coordinator confirmed all service plans were provided for the tenants reviewed.	A 350		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews as needed with changes in health status. This pertained to 1 of 1 tenants reviewed who was	A 430		

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could not breathe. One time on the toilet she said she was just going to sit there and die. She did not know if a Staff to Nurse Communication form was completed. She said the HCC did not follow up on concerns reported to her.

When interviewed on 11/20/24 at 3:07 p.m. Staff E said Tenant #1 had low oxygen and it had been reported to triage and in communication to the nurse. A couple of weeks prior her oxygen was in the low 80%'s and she said she did not feel right. Staff E called triage and they talked to her. Tenant #1 declined to be sent to the emergency room and was told to follow up with her primary care provider (PCP) on Monday. In the past few weeks she had medication changes, was unstable, pale, dehydrated and shaking. It was reported to the HCC on multiple occasions. Staff were told the tenant was having panic or anxiety attacks and to spend more time and help her more. The tenant was having low oxygen saturation and she could not complete activities of daily living by herself. She was not taking care of her apartment, was not able to shower or use the bathroom, and was paging for help. Tenant #1 was not eating. Over time her color was off. Staff E reported it to the HCC multiple times. The HCC brushed it off even though almost all staff reported. She said the HCC did not follow up on concerns reported.

When interviewed on 11/20/24 at 12:22 p.m. Staff F said Tenant #1 could not catch her breath, was nervous and anxious. She was breathing heavy. On Sunday she was pretty restless, was shaking and kept asking what was wrong. She had complaints her mouth was dry. Staff helped her dress and walk to the bathroom. Tenant #1 usually came out for meals but in the past couple of weeks she ate in her apartment and did not eat

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as much as usual. Staff F said the HCC did not follow up on concerns reported by staff.

When interviewed on 11/20/24 at 4:04 p.m. Staff H said Tenant #1 was in the hospital for pneumonia. The tenant had a family member pass away, and different medications were prescribed for anxiety and depression. She was very scared, anxious and tearful. She was tired, weak, ate very little, and wanted staff to provide stand by assistance. In the past month and a half she was very anxious. Staff H said something was said to the HCC who stated the tenant's medications had been changed and she was working through it.

When interviewed on 11/21/24 at 11:07 a.m. the HCC said Tenant #1 had a family member pass away and had been told she was grieving incorrectly. Slowly her anxiety increased. Her PCP made medication changes but her anxiety increased. Her symptoms were out of control, she was not eating, her anxiety increased and she was shaking. The PCP visited and wanted her services increased. It was discussed with Tenant #1's family but they were not going to pay for it. Family wanted one of her medications discontinued. Tenant #1's family called the PCP's office and was told she needed to get used to the medications. Tenant #1 then transferred care to a new PCP and more medication changes occurred. She was doing better and her appetite had improved. She was then notified that Tenant #1 went to the hospital and had a diagnosis of pneumonia.

2. Review of Tenant #1's file on 11/20/24 and 11/21/24 revealed Progress Notes indicated the following:
- On 10/9/24 staff reported Tenant #1

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complained of SOB with exercise. Her oxygen saturation was 81-82%. During rest her oxygen saturation was 91-92% and she denied any cough or cold. Staff reported the vitals to the triage nurse. Tenant #1 refused to be seen in the emergency department (ED) and she was encouraged to see her primary care provider (PCP) if symptoms continued.
- On 10/10/24 the previous night Tenant #1 had SOB and refused to go to the ED. That morning she was agreeable to go to urgent care. She returned and was diagnosed with anxiety.
- On 10/18/24 an appointment was arranged for Tenant #1 to see her PCP regarding help with her anxiety.
- On 11/8/24 Buspar was discontinued by the PCP. New medications were being delivered from pharmacy.
- On 11/18/24 staff reported they heard Tenant #1 gasping and crackling lung sounds from the hallway. Tenant #1 was shaky, weak and disoriented. Her oxygen saturation was 78%. Staff was instructed to call an ambulance. Tenant #1 was transported by ambulance to the hospital.
- On 11/18/24 Tenant #1 was admitted to the hospital for pneumonia, was on oxygen and intravenous (IV) antibiotics.
- On 11/25/24 Tenant #1 was being treated for pneumonia and they switched antibiotics, added steroids and nebulizers. She remained on oxygen. They reported her anxiety was the main issue. She had panic attacks and was not able to participate in therapies. Tenant #1's family did want to increase or change her psych medications.

Further review revealed new orders received included:
- On 10/18/24 an order for Magnesium Bisglycinate 100 milligram (mg) tablet - take 100

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mg by mouth every night at bedtime was received.
- On 10/18/24 an order for Buspar 10 mg tablet - take two tablets each morning and afternoon and one tablet each evening was received.
- On 10/28/24 an order for Miralax 17 gram (gm) packet, take 17 gm packet by mouth for one dose was received. If needed, give a double dose (34 gm) with eight ounces of warm liquid. If no bowel movement on the morning on 10/29/24 repeat the double dose of Miralax.
- On 11/1/24 an order Buspar 10 (mg) take one tablet by mouth three times daily was received.
- On 11/8/24 an order for Buspar was discontinued. Orders to start fluoxetine 20 mg every day in the p.m., clonazepam 0.5 mg twice daily in the a.m. and at bedtime, clonazepam 0.5 every afternoon as needed and Sienna-S 8.6/50 mg twice daily as needed were received.
- On 11/11/24 an order for clonazepam 0.5 mg tablet, take 1 tablet by mouth twice per day for anxiety was received. May have an additional dose in the afternoon. This was noted as discontinued on the medication administration records (both scheduled and as needed doses) on 11/12/24 and 11/13/24.
- On 11/13/24 an order for lorazepam 0.5 mg tablet, take 1/2 tablet by mouth twice per day for 30 days was received. May have an additional dose in the afternoon.

3. Review of Tenant #1's hospital records indicated on 11/18/24 she arrived via ambulance with complaints from staff of a low oxygen saturation. Staff heard her coughing and wheezing and she complained of SOB. The tenant said she had "crud in my throat." She did not know when it started. She presented with an acute cough, SOB, most consistent with an upper respiratory infection (URI), bronchitis and

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A 430	Continued From page 35 pneumonia. The plan indicated multifocal pneumonia and to admit her for supplemental oxygen and IV antibiotics and hypoxia. Tenant #1 had a Quarterly Review dated 10/18/24. It indicated she had no change in function and no recent medication changes. Her depression and anxiety were not well controlled. Tenant #1 was eating meals with no weight loss. She participated in activities and was interactive with other tenants. Tenant #1 was seen on 10/18/24 with her PCP related to her mental health. No nurse reviews completed since that day related to her changes in health status including multiple medication changes, increased anxiety, low oxygen saturation, SOB, cough, change in her PCP, changes noted with eating and her wanting more assistance was completed. When interviewed on 11/26/24 at 2:36 p.m. the Healthcare Coordinator confirmed all nurse reviews were provided for Tenant #1.	A 430		

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Tag #1	**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: A 150 Based on observation, interview, and record review the Program failed to follow its policy and procedure related to food labeling and storage. This potentially effected all tenants (census of 23)	**A150**	A kitchen meeting was held resetting the expectations on 11/27/24. New MRD labels were obtained and implemented on 12/4/24.	All new culinary staff will be educated in new hire training on proper food labelling. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date: 11/26/24** **Completion Date:** On Going **Responsible Party: Director and/or designee**

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Tag #2	**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: A 155 Based on interview and record review the Program failed to ensure tenants were treated with consideration, respect, and full recognition of personal dignity. This pertained to 2 of 4 current tenants reviewed (Tenant #2 and Tenant #3) and 1 of 1 discharged tenants reviewed (Tenant C1)	**A155**	Staff G's employment was terminated on 10/8/2024. Initial staff training on Resident Rights was completed on 9/17/24. All staff were re-trained on resident rights on 12/18/24.	All new hires will receive training on resident rights in new hire orientation. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date: 12/12/24** **Completion Date:** Ongoing **Responsible Party:** Director or designee

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Tag#3	**481-67.9(4)g 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: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to communicate in writing occurrences that differed from a tenant's normal health, functional, and cognitive status and failed to retain the documentation at least three years. This pertained to 1 of 1 tenants reviewed who had been hospitalized (Tenant #1).	**A365**	All staff were re-educated on 12/18/24 on use/expectations of Staff-to-nurse communication form. HCC will receive re-education on use/expectations of Staff-to-nurse communication form and follow up requirements by 3/26/25.	All new hires will be trained on use/expectations of staff-to-nurse communication form in new hire training. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date:** 12/12/24 **Completion Date:** Ongoing **Responsible Party:** Director and/or designee

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Tag #4	**Evaluations** **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. This pertained to 3 of 4 current tenants reviewed (Tenants #1, #3, #4).	**A145**	Tenant 4 passed away on 12/12/2024. Tenant 1 did not return to the community after hospitalization on 11/18/24 and passed away at the hospital on 12/3/24. Tenant 3 had a comp assessment done on 9/6/24 that did have PT on it, however PT got deleted when finalizing the ISP. Residents ISP will be updated to reflect PT and OT services by 3/26/2025. HCC will receive re-education on ISP expectations, timepoints of updating and how to activate a new ISP by 3/26/2025. HCC and Director will receive re-education on waiver application process and expectations by 03/26/2025.	Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date:** 12/12/24 **Completion Date:** Ongoing **Responsible Party:** Director and/or designee

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Tag #5	**481-69.23(1)b Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained.** A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer, or evacuation This REQUIREMENT is not met as evidenced by: A 155 Based on interview and record review the Program failed to discharge a tenant who exceeded retention criteria. This pertained to 1 of 4 current tenants reviewed (Tenant #2).	**A155**	Tenant 2 had a DIAL waiver application completed and submitted to DIAL on 11/8/2024. Tenant 2 passed away on 11/27/2024. HCC and Director will receive re-education on Admission and Retention Criteria of tenants by 3/26/2025.	Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date:** 12/12/24 **Completion Date:** Ongoing **Responsible Party:** Director and/or designee
Tag #6	**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 identified needs of tenants. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4).	**A350**	Tenant 2 passed away on 11/27/2024. Tenant 1 did not return to the community after hospitalization on 11/18/24 and passed away at the hospital on 12/3/24. Tenant 4 passed away on 12/12/2024. Tenant 3 had a comp assessment done on 9/6/24 that did have PT on it, however PT got deleted when finalizing the service plan. Residents service plan will be updated to reflect PT and OT services by 3/26/2025. An audit of all current tenants' charts was completed on 2/18/25 to ensure all	Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date**: 12/12/24 **Completion Date:** Ongoing **Responsible Party:** Director and/or designee

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			service plans reflect each tenants' health status and care needs appropriately. HCC will receive re-education on COC expectations and timepoints by 3/26/2025.		
Tag# 7	**481-69.27(1)c Nurse Review 69.27(1)** If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: A 430 Based on interview and record	**A430**	Tenant 1 did not return to the community after hospitalization on 11/18/24 and passed away at the hospital on 12/3/24. HCC will receive re-education on nurse review expectations and timepoints of completion by 3/26/2025.	Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date**: 12/12/24 **Completion Date:** 2/18/2025 **Responsible Party:** Director and/or designee

	review the Program failed to complete nurse reviews as needed with changes in health status. This pertained to 1 of 1 tenant reviewed who was hospitalized (Tenant #1).				

Compliance Date: 03/26/2025

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