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
	S0022	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNSYLVANIA PLACE MEMORY CARE	2 PENNSYLVANIA PL OTTUMWA, IA 52501

(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 impairment: 2 Number of tenants with cognitive impairment: 12 Total census: 14 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	A 000		
A 105	481-67.2 Program Policies and Procedures 481-67.2 Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to document Incident Reports for unusual/significant incidents, in accordance with	A 105	The POC is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 105	Continued From page 1	A 105		

their policy, for 2 of 3 tenants reviewed (Tenants #2, #3). Findings follow:

On 8/06/24 record review revealed Tenant #2 resided at the program with her significant other, Tenant #3. The record contained no incident report or documentation of an incident on 6/07/24 when Tenant #1 accused Tenant #2 of physical abuse.

On 8/07/24 record review revealed a progress note dated 6/07/24 for Tenant #3, which indicated Tenant #2 accused him of physical abuse. According to the progress note, staff heard Tenant #2 calling for help. Staff entered the apartment and found Tenant #2 sitting on the bed, with Tenant #3 standing nearby. Tenant #2 said Tenant #3 shook her and strangled her. Staff separated the two. Tenant #3 went to the emergency department for evaluation and had an adjustment to his medication.

No incident reports for either tenant could be located regarding this event on 6/07/24. No documentation of assessment for injuries could be located in Tenant #2's record.

On 8/07/24 at 12:20 p.m. the Registered Nurse verified she was unable to locate incident reports for Tenant #2 or Tenant #3 regarding the allegation of physical abuse on 6/07/24. She stated Tenant #2 had no injuries related to the incident, but could not find documentation of this.

Program policy regarding incident reports indicated staff would document unusual incidents involving tenants, using the incident report form. The person in charge at the time of the incident should prepare and sign the form. The incident report should be detailed and include statements

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A 105	Continued From page 2 from witnesses. A copy of the incident report should be kept on file for a minimum of three years.	A 105		
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 a thorough assessment after a significant change for 1 of 3 tenants reviewed (Tenant #1). Finding follows: On 8/06/24 record review revealed progress notes and a nurse review indicating Tenant #1 was hospitalized following a fall on 7/05/24. X-rays taken at that time indicated no fractures. Tenant #1 returned to the program on 7/11/24. The nurse review dated 7/11/24 noted Tenant #1 showed signs of pain and was not at her physical baseline, as evidenced by difficulty walking and	A 145		

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A 145	Continued From page 3 weight bearing, even with use of walker and gait belt. Tenant #1 was independently ambulatory prior to the hospitalization. Tenant #1's family transported her to a different hospital emergency department on 7/11/24, where x-rays revealed a pelvic fracture. Tenant #1 returned to the program, with plans for 1 to 1 staff, use of gait belt, walker, wheelchair, physical therapy and pain control. The fracture and interventions were a significant change for Tenant #1. The program developed an updated service plan dated 7/17/24, which reflected Tenant #1's change of condition and additional service needs. Comprehensive health, function and cognitive assessments dated on or around 7/11/24 could not be located in Tenant #1's record. On 8/06/24 at 2:15 p.m., the Registered Nurse (RN) confirmed the program failed to complete assessments related to Tenant #1's significant change as of 7/11/24.	A 145		

Pennsylvania Place
Ottumwa's Premier Retirement Community

October 1, 2024

Department of Inspections and Appeals
Attn: Deb Dixon
6200 Park Ave. Suite 100
Des Moines, Iowa 50321

Dear Ms. Dixon:

On behalf of Pennsylvania Place Memory Care in Ottumwa, Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to the recertification report for the onsite visit between 8/5/2024-8/7/2024.

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.

Policies and Procedures

1. Elements detailing how the program will correct each regulatory insufficiency
    - Tenant #2 will have incident reports completed for all accidents, incidents, and unusual occurrences per policy.
    - Tenant #3 will have incident reports completed for all accidents, incidents, and unusual occurrences per policy.
2. Measures taken to ensure the problem does not recur
    - Staff will be re-educated on completing incident reports for any accident, incident, or unusual occurrences per policy.
3. How the Program Plans to monitor performance to ensure compliance
    - The Executive Director, Director of Nursing, and/or Nurse Designee will provide ongoing education to staff at least annually on the accident, incident, and medication error reporting policy.
    - At the time the Executive Director, Director of Nursing, and/or Nurse Designee become aware of any accident, incident, or unusual occurrence, they will ensure staff complete an incident report per the policy.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before October 18, 2024.

Evaluation of Tenant

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenant #1 will have a health, functional, and cognitive evaluation of the tenant will be completed as needed, annually, or with significant change of condition.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing and/or RN Designee will be re-educated on regulatory requirements regarding evaluations to include health, functional, and cognitive evaluation as needed annually or with significant change.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or designee will perform ongoing internal audits of tenant charts will be completed at least quarterly to ensure compliance of tenant evaluations.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before October 18, 2024.

Thank you for your kind time and attention towards this matter. Please do not hesitate to contact me should you have further questions.

Best Regards,

Brenda K. Hostetler

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