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
	S0092	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE PATH AT THE KENSINGTON	2210 AVE H FORT MADISON, IA 52627

(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: 3 Number of tenants with cognitive impairment: 14 Total census: 17 The following regulatory insufficiencies were cited during the investigation into Complaint #122670-C.	A 000		
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.	A 365	An all staff meeting was held August 22nd discussing communication. All current staff know to utilize the observation area in ECP, all new staff will be trained by the RN on how and when to record observations. The ED/RN both are reading observations daily to ensure communication is up to date.	

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

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A 365	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure staff communicated changes in tenant status to the registered nurse affecting 1 of 2 current tenants reviewed (Tenant #1). Findings follow: Record review on 8/14/24 revealed an assessment for Tenant #1 completed on 5/22/24 when she returned to the program from skilled care. The assessment identified Tenant #1 was independent with eating and required no assistance from staff. Tenant #1 required no assistance with personal hygiene. Staff were to provide monitoring and cueing to ensure Tenant #1 executed the proper toilet methods. Staff administered medication to Tenant #1. The assessment included a section for pain management but no information was entered in this area. Tenant #1 was noted to have good verbal skills and displayed positive interactions with others. On 8/14/24 at 1:05 PM, the Memory Care Manager recalled during the past month Tenant #1 would not feed herself. Staff had to put their hands over Tenant #1's hand to move the silverware from the plate to her mouth. Staff provided Tenant #1 with health shakes due to her weight loss. She felt as if Tenant #1 gave up on 8/10/24. When Tenant #1 moved to the memory care unit, she would mumble words. Now she moaned and groaned when staff attempted to communicate with her. For example, Tenant #1 could not use words to verbalize pain, but would moan loudly	A 365		

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A 365	Continued From page 2	A 365		

when she was in pain.

When interviewed on 8/14/24 at 1:35 PM, Staff A reported Tenant #1's ability to feed herself worsened over the past two weeks. On 8/9/24, Staff A took Tenant #1 to the dining room to eat. She attempted to feed Tenant #1 some mandarin oranges but Tenant #1 spit these out. Staff A texted the nurse to inform her Tenant #1 was barely eating. Tenant #1's walking was also worse of late. Tenant #1 was dragging her feet, where in the past she would pick up her foot and move it. Over the weekend, Tenant #1 would not bear weight. Staff were unable to get her dressed.

On 8/15/24 at 8:30 AM, Staff B observed Tenant #1's health steadily declining. For about a week she had to take Tenant #1 to the bathroom in a wheelchair due to her weakness. Then over the last couple of days, Tenant #1 received toileting assistance in bed.

On 8/15/24 at 1:55 PM, Staff C said on 8/10/24, she beared Tenant #1's weight when dressing the tenant and pulling up her pants. The staff agreed on 8/11/24 to let Tenant #1 stay in bed and not get dressed.

On 8/14/24 at 4:05 PM, Staff D stated for the past 1-2 weeks, staff provided incontinence care to Tenant #1 in bed as she was in such pain. Staff also fed Tenant #1 in her room rather than in the dining room as she cried out in pain. Staff D indicated she had not been taught to write concerns about tenants in the observation log.

On 8/15/24 at 1:43 PM, Staff E said she would call the nurse if there was a critical situation, as the nurse was always on-call. However, if

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A 365	Continued From page 3 something was not emergent, she would leave a note for the nurse in her box. She would only write an observation note about a fall. A review of observation notes for Tenant #1 revealed the only entries by a caregiver (other than about a fall) occurred on 8/10/24. A caregiver documented Tenant #1 refused supper and her pills. On 8/14/24 at 2:47 PM, the Director of Nursing reported she checked the observation notes daily to learn of tenant changes. She was not aware staff provided hand over hand feeding to Tenant #1. Staff failed to report changes in tenant status in the observation notes.	A 365		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	A 135	We were not aware that when moving a resident from AL to MC that we had to treat it as a whole new move in. Moving forward any transfer to MC from AL will have an evaluation prior to moving. The RN will ensure this is done.	

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A 135	Continued From page 4 program failed to evaluate the health, cognitive and functional status of 1 of 2 current tenants reviewed prior to admission (Tenant #1). Findings follow: Record review of progress notes on 8/14/24 revealed Tenant #1 moved to the program on 5/29/24. Pre-admission evaluations for Tenant #1 could not be located. The Executive Director confirmed this finding on 8/15/24 at 10:26 AM.	A 135		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to evaluate the health, cognitive and functional status of 1 of 2 current tenants reviewed within 30 days of occupancy (Tenant #1). Findings follow: Record review of progress notes on 8/14/24 revealed Tenant #1 moved to the program on 5/29/24. Evaulations of Tenant #1's health, cognitive and functional status within 30-days of occupancy could not be located.	A 140	We were not aware that when moving a resident from AL to MC that we had to treat as a whole new move in. Moving forward any transfer to MC from AL will have an evaluation within 30 days of moving to MC. The RN will ensure this is done.	

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A 140	Continued From page 5 The Executive Director confirmed this finding on 8/15/24 at 10:26 AM.	A 140		
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 evaluate 1 of 2 current tenants reviewed when they experienced a significant change (Tenant #1). Findings include: Record review on 8/14/24 revealed an assessment for Tenant #1 completed 5/22/24, when she returned to the program from skilled care. The assessment identified Tenant #1 was independent with eating and required no assistance from staff. Tenant #1 required no assistance with personal hygiene. Staff administered medication to Tenant #1. The assessment included a section for pain	A 145	The RN will ensure that all residents are reevaluated when there is a significant change. The ED will ensure this is being done.	

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A 145	Continued From page 6	A 145		

management but no information was entered in this area. Tenant #1 was noted to have good verbal skills and displayed positive interactions with others.

On 8/14/24 at 1:05 PM, the Memory Care Manager recalled during the past month Tenant #1 would not feed herself. Staff had to put their hands over Tenant #1's hand to move the silverware from the plate to her mouth. Staff provided Tenant #1 with health shakes due to her weight loss.

When Tenant #1 moved to the memory care unit, she would mumble words. Now she moaned and groaned when staff attempted to communicate with her. For example, Tenant #1 could not use words to verbalize pain, but would moan loudly when she was in pain.

When interviewed on 8/14/24 at 1:35 PM, Staff A stated Tenant #1's ability to feed herself worsened over the past two weeks. On 8/9/24, Staff A took Tenant #1 to the dining room to eat. She attempted to feed Tenant #1 some mandarin oranges but Tenant #1 spit these out. Staff A texted the nurse to inform her Tenant #1 was barely eating. Tenant #1's walking was also worse of late. Tenant #1 dragged her feet, where in the past she would pick up her foot and move it. Over the weekend, Tenant #1 would not bear weight. Staff were unable to get her dressed.

On 8/15/24 at 8:30 AM, Staff B reported Tenant #1's health steadily declined. For about a week she had to take Tenant #1 to the bathroom in a wheelchair due to weakness. Then over the last couple of days, Tenant #1 received toileting assistance in bed.

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A 145	Continued From page 7 The program nurse did not re-evaluate Tenant #1's health, cognitive or functional status following changes in her ability to feed herself, communicate, ambulate or manage pain. On 8/15/24 at 2:45 PM, the Executive Director confirmed Tenant #1 should have been re-evaluated following her change in condition.	A 145		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to develop a service plan prior to admission for 1 of 1 tenants reviewed who moved in over the prior three months (Tenant #1). Findings follow: Record review of progress notes on 8/14/24 revealed Tenant #1 moved to the program on 5/29/24. A pre-admission service plan for Tenant #1 could not be located. The Executive Director confirmed this finding on 8/15/24 at 10:26 AM.	A 355	We were not aware that when moving a resident from AL to MC that we had to treat as a new move in. Moving forward the RN will ensure that a new care plan is developed when transferring a resident to MC from AL.	

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A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to develop a service plan within 30-days of admission for 1 of 1 tenants reviewed who moved in over the past three months (Tenant #1). Findings follow: Record review of progress notes on 8/14/24 revealed Tenant #1 moved to the program on 5/29/24. The program failed to develop a service plan for Tenant #1 within 30-days of her move in. The Executive Director confirmed this finding on 8/15/24 at 10:26 AM.	A 360	We were not aware that when moving	
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by:	A 395		

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A 395	Continued From page 9	A 395		

Based on interview and record review, the program failed to ensure the identified needs of 1 of 2 current tenants reviewed (Tenant #1) and 1 of 1 discharged tenants reviewed (Tenant C1) were included on the service plan. Findings follow:

1. Record review on 8/14/24 revealed an assessment for Tenant #1 completed on 5/22/24 when she returned to the program from skilled care. The assessment identified Tenant #1 was independent with eating and required no assistance from staff. Tenant #1 required no assistance with personal hygiene. Staff were to provide monitoring and cueing to ensure Tenant #1 executed the proper toileting methods. Staff administered medication to Tenant #1. The assessment included a section for pain management but no information was entered in this area. Tenant #1 was noted to have good verbal skills and displayed positive interactions with others.

On 8/14/24 at 1:05 PM, the Memory Care Manager recalled during the past month Tenant #1 would not feed herself. Staff had to put their hands over Tenant #1's hand to move the silverware from the plate to her mouth. Staff provided Tenant #1 with health shakes due to her weight loss.

Tenant #1 spent most of her time in her apartment. Tenant #1 was incontinent. She always had diarrhea. Tenant #1 would attempt to remove her feces from her rectum with her hand. Staff would help Tenant #1 wash her hands to ensure there was no feces under her nails.

When Tenant #1 moved to the memory care unit, she would mumble words. Now she moaned and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 395	Continued From page 10	A 395		

groaned when staff attempted to communicate with her. For example, Tenant #1 could not use words to verbalize pain, but would moan loudly when she was in pain.

On 8/14/24 at 1:35 PM, Staff A reported she helped Tenant #1 to the bathroom. Tenant #1 wore briefs due to her bladder and bowel incontinence. Staff A would check on Tenant #1 and find her fine. She might return a short time later and find Tenant #1 had feces under her nails. Both the Director of Nursing (DON) and Memory Care Manager were aware of this, according to Staff A.

Staff A believed Tenant #1's transition to the memory care program was difficult. Tenant #1 initially would not feed herself, but then started to do so. Tenant #1's ability to feed herself worsened over the past two weeks. On 8/9/24, Staff A took Tenant #1 to the dining room to eat. She attempted to feed Tenant #1 some mandarin oranges but Tenant #1 spit these out. Staff A texted the nurse to inform her Tenant #1 was barely eating. Tenant #1's walking was also worse of late. Tenant #1 was dragging her feet, where in the past she would pick up her foot and move it. Over the weekend, Tenant #1 would not bear weight. Staff were unable to get her dressed.

Tenant #1 moaned since entering the program following a hip fracture. Tenant #1 would moan with walking or repositioning. Tenant #1 would make louder moaning sounds in her apartment, generally because she needed to go to the bathroom or was in pain.

On 8/15/24 at 8:30 AM, Staff B reported Tenant #1's health steadily declined. For about a week

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A 395	Continued From page 11	A 395		

she had to take Tenant #1 to the bathroom in a wheelchair due to her weakness. Then over the last couple of days, Tenant #1 received toileting assistance in bed.

Tenant #1's service plan failed to address her toileting needs and methods for staff to ensure her hands were clean, ability to feed herself, communication skills and how to properly address her pain.

2. A review of progress notes for Tenant C1 revealed on 5/7/24, the DON called the tenant's primary care provider (PCP) due to increased agitation and aggression. On 5/8/24, the program received new medication orders to address Tenant C1's aggression. Tenant C1's PCP was called again on 5/30/24 due to continued agitation in the mornings and afternoons. On 6/26/24, Tenant C1 became violent and hit at Staff C with a clothes hanger when she attempted to administer medication. On 7/3/24, Staff C documented Tenant C1 became combative when she attempted to administer medication. Later in the day, Tenant C1 stabbed a fork in the memory care manager's door.

Tenant C1 was scheduled to see a neurologist on 7/10/24. When the DON and Memory Care Manager attempted to get her ready for the appointment, Tenant C1 knocked the DON into the wall multiple times and kicked the memory care manager.

Tenant C1 was found on the floor on 7/22/24, resulting in complaints of bilateral knee pain. Tenant C1 was admitted to the medical surgical floor, but became anxious, aggressive and agitated. Tenant C1's family decided to have her return to the program where she was to utilize a

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PRIMROSE PATH AT THE KENSINGTON	2210 AVE H FORT MADISON, IA 52627

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A 395	Continued From page 12	A 395		

wheelchair. Tenant C1 remained in the wheelchair for about ten minutes and then got up. Staff tried to convince her to return to the wheelchair when she made a fist at the employee.

On 8/15/24 at 1:55 PM, Staff C reported when Tenant C1 first moved to the program, she believed the tenant's aggression was related to her adjusting to the move. After 1-2 months, Staff C believed Tenant C1 needed a further assessment. Tenant C1 wasn't always aggressive, but there were times it took three staff to assist her into the bathtub due to the physical violence. Staff C described a time when staff were trying to assist Tenant C1 into the bath as she was covered in feces and the tenant hit the Memory Care Manager so hard her earrings came out. Once they got Tenant C1 into the bathtub, she refused to remove her underclothes. Tenant C1 got in the water, removed her soiled underwear and threw them into Staff C's face. There were times Tenant C1 threw feces at staff. Tenant C1 would chase staff members and grab them by the wrist with her nails when she caught them.

On 8/14/24 at 4:05 PM, Staff D recalled Tenant C1 did not understand what was going on around her and would punch staff when they tried to help her with basic things.

On 8/14/24 at 2:47 PM, the DON reported some days, Tenant C1 was not aggressive. Tenant C1 was often aggressive on shower days. She would also become physically aggressive when staff attempted to put her socks on.

Tenant C1's service plan, dated 7/23/24, noted it might be required for multiple people to help with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0092	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE PATH AT THE KENSINGTON	2210 AVE H FORT MADISON, IA 52627

(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 395	Continued From page 13 bathing or showering. If Tenant C1 became resistant, staff were to leave the room or attempt to give the shower later. Tenant C1's service plan did not clearly address her physical aggression or how staff might intervene when displayed. On 8/15/24 at 2:45 PM, the Executive Director confirmed these findings.	A 395		