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 |
|---|---|---|---|
| | S0118 | A. BUILDING: _____ B. WING _____ | C 09/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WEST LIBERTY AL RESIDENCES** | **1000 NORTH MILLER STREET WEST LIBERTY, IA 52776** |

| (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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| A 000 | Initial Comments<br><br>Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site.<br><br>Number of tenants without cognitive disorder: 16<br>Number of tenants with cognitive disorder: 0<br>Total census of Assisted Living Program: 16<br><br>The investigation of Incident #102749-I was completed and no regulatory insufficiencies were identified.<br><br>The recertification visit conducted to determine compliance with certification for an Assisted Living Program was completed and the following regulatory insufficiencies were cited: | A 000 | | |
| A 150 | 481-67.2(3) Program Policies and Procedures<br><br>67.2(3) The program shall follow the policies and procedures established by the program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to follow the policy related to the completion of incident reports for 1 of 3 current (Tenant #1) and 1 of 1 former (Tenant C1)tenants reviewed. Findings follow:<br><br>1. When interviewed on 9-13-22 at 9:38 a.m. Staff F said on one occasion Tenant #1 went to the independent living building and afterwards an electronic wandering monitoring device was placed on him.<br><br>Record review on 9-13-22 and 9-14-22 revealed Tenant #1 scored a three on the AL BIMS (Brief | A 150 | The Plan of Correction 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 150 | Continued From page 1 | A 150 | | |

Interview for Mental Status) evaluation dated 6-2-22 which indicated severe impairment.

A Progress Note dated 7-14-22 indicated a telephone meeting was held with Program staff and Tenant #1's family regarding safety concerns. Tenant #1 had gone into other tenants' apartments as he thought it was his apartment. Staff assisted Tenant #1 and he also relied on another tenant who assisted him getting out for meals activities. An electronic wandering monitoring device was placed on Tenant #1 about two weeks prior when he left the building for a walk and went to the independent living apartments (where he lived previously). Tenant #1 "was lost and did not know how to return to his apartment."

No incident report related to the tenant's going to the independent living building and getting lost could be located.

2. Review of Tenant C1's file on 9-13-22 revealed Progress Notes indicating the following:
- On 10-21-21 staff heard a sound and responded. Staff observed Tenant C1 laying on his back in the hallway. He said he and his spouse were on their way to an activity when he fell. He had hit his head when he fell backwards. Tenant C1 had a history in prior years of a head injury with a bleed and the decision was made to send him out to the hospital for evaluation. Tenant C1 returned to the Program with a diagnosis of contusion and no new orders.
- On 11-10-21 Tenant C1 had fallen between the bed and the wall when he got of bed. It was noted as a "recurring situation et (and) place for falls." Family had moved the beds to prevent falls and the Tenant C1 and his spouse moved them back. No injuries were noted.

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| A 150 | Continued From page 2 | A 150 | | |

- On 11-15-21 Tenant C1 choked on toast in the dining room at breakfast. Staff performed the Heimlich Maneuver and the food was dislodged.
- On 12-18-21 Tenant C1 had a choking episode while at lunch and choked on hamburger. Staff said Tenant C1 "turned purple and was not breathing." Staff performed the Heimlich Maneuver and called a nurse. When the nurse responded Tenant C1 was coughing and his color was returning to baseline.
- On 12-29-21 a nurse was called by staff to Tenant C1's apartment. Tenant C1 was observed on the floor on his back with a pillow under his head (staff placed the pillow). Tenant C1 complained of pain to the right elbow and slight redness was noted. Tenant C1 was assisted up by staff.
- On 1-6-22 staff answered a page for Tenant C1's apartment and responded. Tenant C1 was laying on the floor. A small "bump" was noted to the back of his head. Tenant C1 had several reddened areas on the right shoulder and right side.

No incident reports could be located related to these falls and choking incidents.

3. Review of the Program's policy and procedure for Accidents and Incidents on 9-19-22 indicated all accidents or incidents that involved tenants, staff or visitors that occurred on the grounds would be investigated and reported to leadership staff. An Accident or Incident Report Form would be completed for all accident and incidents. The nurse supervisor or charge nurse or the department supervisor/director would complete an investigation of the incident. The Accident Investigation Report Form would be completed and would be submitted to the director of nursing within 12 hours after the incident.

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| A 150 | Continued From page 3<br><br>4. When interviewed on 9-19-22 at 2:57 p.m. the RN Coordinator confirmed an incident report was not completed related to the incident noted above with Tenant #1 and no incident repots were found for Tenant C1 from 10-1-21 to the time of discharge (1-31-22). | A 150 | | |
| A 345 | 481-67.9(4)b Staffing<br><br>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:<br><br>b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to complete nurse delegation training on all tasks within 30 days of employment for 5 of 5 staff reviewed (Staff A, B, C, D and E). Findings follow:<br><br>1. Record review on 9-12-22 and 9-13-22 of Staff A's training documents revealed a hire date of 8-1-22. No nurse delegations could be located.<br><br>2. Record review on 9-12-22 and 9-13-22 of Staff B's training documents revealed a hire date of 1-4-22. Nurse delegations were provided that were undated. The Program provided a date of 1-28-22 for the the undated delegations. The delegations lacked training on all tasks provided including dressing, hygiene and grooming. | A 345 | | |

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| A 345 | Continued From page 4<br><br>3. Record review on 9-12-22 and 9-13-22 of Staff C's training documents revealed a hire date of 5-12-22. No nurse delegations could be located.<br><br>4. Record review on 9-12-22 and 9-13-22 of Staff D's training documents revealed a hire date of 6-3-21. Nurse delegations were provided dated 6-11-22 and 6-15-22. The delegations lacked training on all tasks provided including dressing, hygiene and grooming.<br><br>5. Record review on 9-12-22 and 9-13-22 of Staff E's training documents revealed a hire date of 8-12-21 (attached nursing facility) and an assisted living start date of 3-27-22. Nurse delegations were dated 7-12-22, which was greater than 30 days from the Program's start date.<br><br>6. When interviewed on 19-22 at 2:57 p.m. the RN Coordinator confirmed nurse delegations were not found for Staff A and C. She also confirmed all nurse delegations for the staff listed above were provided. | A 345 | | |
| A 380 | 481-67.9(6) Staffing<br><br>67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to ensure dependent adult abuse training was completed within six months of | A 380 | | |

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| A 380 | Continued From page 5<br>employment as required by Iowa Code section 135B.16 for 1 of 2 staff reviewed employed greater than six months (Staff D). Findings follow:<br><br>1. Record review on 9-12-22 and 9-13-22 of Staff D's training documents revealed a hire date of 6-3-21. No evidence of dependent adult abuse training could be located.<br><br>2. When interviewed on 9-19-22 at 2:57 p.m. the RN Coordinator confirmed no dependent adult abuse training was found for Staff D. | A 380 | | |
| A 145 | 481-69.22(3) Evaluation of Tenant<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to complete evaluations as needed with significant change for 2 of 3 current (Tenants #1 and #2) and 1 of 1 discharged tenants (Tenant C1) reviewed. Findings follow: | A 145 | | |

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| A 145 | Continued From page 6 | A 145 | | |

1. When interviewed on 9-13-22 at 9:38 a.m. Staff F said on one occasion Tenant #1 went to the independent living building and afterwards an electronic wandering monitoring device was placed on him.

Record review on 9-13-22 and 9-14-22 revealed Tenant #1 scored a three on the AL BIMS (Brief Interview for Mental Status) evaluation dated 6-2-22 which indicated severe impairment.

Progress Notes indicated the following:
- On 7-14-22 a telephone meeting was held with Program staff and Tenant #1's family regarding safety concerns. Tenant #1 had gone into other tenants' apartments as he thought it was his apartment. Staff assisted Tenant #1 and he also relied on another tenant who assisted him getting out for meals activities. An electronic wandering monitoring device was placed on Tenant #1 about two weeks prior when he left the building for a walk and went to the independent living apartments (where he lived previously). Tenant #1 "was lost and did not know how to return to his apartment."
- On 8-23-22 speech therapy (ST) recommended mechanical soft/chopped meat with thin liquids. Staff were to encourage small bites/drinks and "reduced rate."

Further record review revealed an Order Audit Report indicated on 7-12-22 an order was received for ST to evaluate and treat.

The most recently completed health and functional evaluations for the tenant were dated 6-2-22 (30 day evaluations). The most recent cognitive evaluations were completed on 7-14-22 and 8-23-22. Evaluations were not completed as

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| A 145 | Continued From page 7 | A 145 | | |

needed with significant change related to leaving the building and getting lost, the placement of the electronic wandering monitoring device, going into other tenants' apartments or orders for ST and recommendations for his diet.

2. Review of Tenant #2's Progress Notes on 9-14-22 revealed he was hospitalized on 7-24-22 for an exacerbation of congestive heart failure. He eventually returned from the hospital and a stay at the adjacent nursing facility on 8-24-22. An assessment was completed at that time.

Further record review revealed discharge summaries dated 8-24-22 indicated for a buttock wound that had developed, staff were to apply a thick layer of Triad Cream three times per day as needed and to leave it open to air. Only the top layer of soiled cream could be wiped away when needed and then reapplied. Wiping away all the cream in between applications could cause "trauma" to the skin. For the left toe wound staff were to use antibiotic ointment daily and cover with a band-aid.

The assessments completed on 8-24-22 after his return to the program did not include any skin issues or treatment on the physical assessment. The functional assessment indicated to monitor his buttock as it was "sore." The evaluations completed did not reflect Tenant #2's skin issues and wound care.

3. Review of Tenant C1's file on 9-13-22 revealed Progress Notes indicating the following:
- On 10-21-21 staff heard a sound and responded. Staff observed Tenant C1 laying on his back in the hallway. He said he and his spouse were on their way to an activity when he fell. He had hit his head when he fell backwards.

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| A 145 | Continued From page 8 | A 145 | | |

Tenant C1 had a history in prior years of a head injury with a bleed and the decision was made to send him out to the hospital for evaluation. Tenant C1 returned to the Program with a diagnosis of contusion and no new orders.

- On 11-10-21 Tenant C1 had fallen between the bed and the wall when he got of bed. It was noted as a "recurring situation et (and) place for falls." Family had moved the beds to prevent falls and the Tenant C1 and his spouse moved them back. No injuries were noted.
- On 11-15-21 Tenant C1 choked on toast in the dining room at breakfast. Staff performed the Heimlich Maneuver and the food was dislodged.
- On 12-18-21 Tenant C1 had a choking episode while at lunch and choked on hamburger. Staff said Tenant C1 "turned purple and was not breathing." Staff performed the Heimlich Maneuver and called a nurse. When the nurse responded Tenant C1 was coughing and his color was returning to baseline.
- On 12-29-21 a nurse was called by staff to Tenant C1's apartment. Tenant C1 was observed on the floor on his back with a pillow under his head (staff placed the pillow). Tenant C1 complained of pain to the right elbow and slight redness was noted. Tenant C1 was assisted up by staff.
- On 1-6-22 staff answered a page for Tenant C1's apartment and responded. Tenant C1 was laying on the floor. A small "bump" was noted to the back of his head. Tenant C1 had several reddened areas on the right shoulder and right side.
- On 1-31-22 it was noted Tenant C1 would be transferred to the attached nursing facility with his spouse as a higher level of care was needed.

The tenant's most recent evaluations were dated 7-5-21. Evaluations were not completed with

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| A 145 | Continued From page 9<br>Tenant C1's falls, choking episodes or increased level of care needs.<br><br>4. When interviewed on 9-19-22 at 2:57 p.m. RN Coordinator confirmed all evaluations for the tenants listed above were provided. | A 145 | | |
| A 350 | 481-69.26(1) Service Plans<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to update service plans as needed for 1 of 2 current (Tenant #1) and 1 of 1 former (Tenant C1) tenants reviewed and failed to ensure service plans were based on evaluations for 1 of 2 current tenants reviewed (Tenant #2). Findings follow:<br><br>1. When interviewed on 9-13-22 at 9:38 a.m. Staff F said on one occasion Tenant #1 went to the independent living building and afterwards an electronic wandering monitoring device was placed on him.<br><br>Record review on 9-13-22 and 9-14-22 revealed Tenant #1 scored a three on the AL BIMS (Brief Interview for Mental Status) evaluation dated 6-2-22 which indicated severe impairment. | A 350 | | |

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| A 350 | Continued From page 10 | A 350 | | |

Progress Notes indicated the following:
- On 7-14-22 a telephone meeting was held with Program staff and Tenant #1's family regarding safety concerns. Tenant #1 had gone into other tenants' apartments as he thought it was his apartment. Staff assisted Tenant #1 and he also relied on another tenant who assisted him getting out for meals activities. An electronic wandering monitoring device was placed on Tenant #1 about two weeks prior when he left the building for a walk and went to the independent living apartments (where he lived previously). Tenant #1 "was lost and did not know how to return to his apartment."
- On 8-23-22 speech therapy (ST) recommended mechanical soft/chopped meat with thin liquids. Staff were to encourage small bites/drinks and "reduced rate."

Further record review revealed an Order Audit Report indicated on 7-12-22 an order was received for ST to evaluate and treat.

The tenant's current service plan was dated 8-23-22. It reflected a handwritten entry for ST; however, the update was only provided on the current service plan dated 8-23-22 and was not reflected when the order was received on 7-12-22. The service plan was not updated to include Tenant #1's electronic wandering monitoring device, the time he left the building and was unable to return to his apartment or that he went into other tenants' apartments and interventions related to the behavior.

2. Review of Tenant C1's file on 9-13-22 revealed Progress Notes indicating the following:
- On 10-21-21 staff heard a sound and responded. Staff observed Tenant C1 laying on

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his back in the hallway. He said he and his spouse were on their way to an activity when he fell. He had hit his head when he fell backwards. Tenant C1 had a history in prior years of a head injury with a bleed and the decision was made to send him out to the hospital for evaluation. Tenant C1 returned to the Program with a diagnosis of contusion and no new orders.

- On 11-10-21 Tenant C1 had fallen between the bed and the wall when he got of bed. It was noted as a "recurring situation et (and) place for falls." Family had moved the beds to prevent falls and the Tenant C1 and his spouse moved them back. No injuries were noted.
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- On 1-31-22 it was noted Tenant C1 would be transferred to the attached nursing facility with his spouse as a higher level of care was needed.

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| | S0118 | A. BUILDING: _____ B. WING _____ | C 09/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST LIBERTY AL RESIDENCES | 1000 NORTH MILLER STREET WEST LIBERTY, IA 52776 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 350 | Continued From page 12<br><br>The tenant's most recent service plan prior to discharge was dated 7-5-21. The service plan had not been updated to reflected Tenant C1's fall history and interventions, the choking episodes and interventions and increased level of care needed.<br><br>3. Review of Tenant #2's Progress Notes on 9-14-22 revealed he was hospitalized on 7-24-22 for an exacerbation of congestive heart failure. He eventually returned from the hospital and a stay at the adjacent nursing facility on 8-24-22. An assessment was completed at that time.<br><br>Further record review revealed discharge summaries dated 8-24-22 indicated for a buttock wound that had developed, staff were to apply a thick layer of Triad Cream three times per day as needed and to leave it open to air. Only the top layer of soiled cream could be wiped away when needed and then reapplied. Wiping away all the cream in between applications could cause "trauma" to the skin. For the left toe wound staff were to use antibiotic ointment daily and cover with a band-aid.<br><br>The assessments completed on 8-24-22 after his return to the program did not include any skin issues or treatment. Although the service plan dated 8-24-22 reflected the orders for wound care, it was not based on the assessments completed.<br><br>4. When interviewed on 9-19-22 at 2:57 p.m. the RN Coordinator confirmed all service plans for tenants listed above were provided. | A 350 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST LIBERTY AL RESIDENCES | 1000 NORTH MILLER STREET WEST LIBERTY, IA 52776 |

| (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 430 | Continued From page 13 | A 430 | | |
| A 430 | 481-69.27(1)c Nurse Review<br><br>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:<br><br>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;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to complete nurse reviews every 90 days for 2 of 3 tenants reviewed who received personal or health-related care (Tenants #2 and #3). Findings follow:<br><br>1. Review of Tenant #2's file review on 9-13-22 and 9-14-22 revealed a 90 day review completed on 3-17-22. A 90 day review was not completed in June 2022, when it was due. The next evaluation completed was dated 8-24-22 and it was for a change of condition.<br><br>2. Review of Tenant #3's file on 9-14-22 revealed a 90 day review completed on 3-18-22. The next 90 day nurse review was dated 7-5-22, which was greater than 90 days from the last review.<br><br>3. When interviewed on 9-19-22 at 2:57 p.m. the RN Coordinator confirmed all nurse reviews were provided. | A 430 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0118 | A. BUILDING: _____ B. WING _____ | C 09/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST LIBERTY AL RESIDENCES | 1000 NORTH MILLER STREET WEST LIBERTY, IA 52776 |

| (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 465 | Continued From page 14 | A 465 | | |
| A 465 | 481-69.28(5) Food Service<br><br>69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to ensure 2 of 5 staff reviewed completed an orientation on safe food handling prior to handling food (Staff C and E). Findings follow:<br><br>1. Review of Staff C's training documents on 9-12-22 and 9-13-22 revealed a hire date of 5-12-22. An orientation on safe food handling could not be located.<br><br>2. Review of Staff E's training documents on 9-12-22 and 9-13-22 revealed a hire date of 8-12-21 (attached nursing facility) and an assisted living start date of 3-27-22. A Certificate of Completion for Food Safety Fundamentals was dated 7-6-22. The certificate was dated over three months from Staff E's Program start date of 3-27-22.<br><br>3. When interviewed on 9-19-22 at 2:57 p.m. the RN Coordinator confirmed no additional food safety training was found for the staff listed above. | A 465 | | |

December 9, 2022

West Liberty AL Residences
1004 N. Miller Street
West Liberty, IA 52776

Iowa Department of Inspection & Appeals
Deb Dixon, Program Coordinator, Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

**Incident #102749-I**
Tenant Rights: Not Substantiated

**Recertification visit**

To Whom it May Concern,

Please consider this our plan of correction pertaining to regulatory insufficiencies cited during 9/12/22 to 9/19/22 recertification and incident investigation completed by the department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapter 481-69.

**A150**
**481-67.2(3) Program Policies and Procedures**
67.2(3) The program shall follow the policies and procedures established by the program.

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
   a. Administrator or designee will ensure an incident report is completed for Tenant #1 returning to prior apartment.

2. Measures taken to ensure the problem does not recur.
   a. Administrator or designee will provide an in-service to staff to ensure understanding of incident report indicators and processes.

3. How the Program plans to monitor performance to ensure compliance.
   a. Administrator or designee will talk with a random sample of PCA and/or medication manager staff weekly for six weeks and as needed as determined by the Administrator to ensure incident reports have been completed for all known unusual occurrences.

4. The date by which the regulatory insufficiency will be corrected.
   a. The regulatory insufficiency will be corrected by 12/26/22.

**A345**
**481-67.9(4)b Staffing**
67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:
b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
    a. Administrator and RN Coordinator have reviewed and updated the Delegation packet to ensure dressing, hygiene and grooming services provided by the Program are included and Program staff have received training on such tasks.

2. Measures taken to ensure the problem does not recur.
    a. Administrator has implemented a checklist to ensure that all program staff complete Delegation training within 30 days after hire.

3. How the Program plans to monitor performance to ensure compliance.
    a. Administrator or designee will audit all newly hired program staff weekly for eight weeks and as needed as determined by the Administrator to verify the training checklist has been completed.

4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will be corrected by 12/26/22.

**A380**
**481-67.9(6) Staffing**
67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16.

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
    a. All current Program staff have completed Dependent Adult Abuse Training Course.

2. Measures taken to ensure the problem does not recur.
    a. Administrator has implemented a checklist to ensure that all program staff complete Dependent Adult Abuse Training within six months of hire.
    b. New position created (HR Assistant) to complete audits and verification of training completion.

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

a. Administrator or designee will audit all newly hired program staff weekly for eight weeks and as needed as determined by the Administrator to verify the training checklist has been completed.

4. The date by which the regulatory insufficiency will be corrected.
   a. The regulatory insufficiency will be corrected by 12/26/22.

**A145**
**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.

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
   a. A review of assessments utilized by the Program has been completed and updates have been made to ensure resident specific information is included within the assessment and individualized service plan.

2. Measures taken to ensure the problem does not recur.
   a. Administrator or designee will review that all current residents' individualized service plans are appropriate.

3. How the Program plans to monitor performance to ensure compliance.
   a. Administrator or designee will review a random sample of residents' comprehensive assessments to ensure that individualized service plans reflect comprehensive assessment findings weekly for five weeks and as needed as determined by the Administrator.

4. The date by which the regulatory insufficiency will be corrected.
   a. The regulatory insufficiency will be corrected by 12/26/22.

**A350**
**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.

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

a. A review of assessments utilized by the Program has been completed and updates have been made to ensure resident specific information is included within the assessment and individualized service plan.

2. Measures taken to ensure the problem does not recur.
   a. Administrator or designee will review that all current residents' individualized service plans are appropriate.

3. How the Program plans to monitor performance to ensure compliance.
   a. Administrator or designee will review a random sample of residents' comprehensive assessments to ensure that individualized service plans reflect comprehensive assessment findings weekly for five weeks and as needed as determined by the Administrator.

4. The date by which the regulatory insufficiency will be corrected.
   a. The regulatory insufficiency will be corrected by 12/26/22.

**A430**
**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.

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
   a. A review of assessments utilized by the Program has been completed and updates have been completed.

2. Measures taken to ensure the problem does not recur.
   a. Administrator or designee will ensure current residents' 90-day nurse reviews are up to date.

3. How the Program plans to monitor performance to ensure compliance.
   a. Administrator or designee will audit a random sample of residents' assessment status for eight weeks and as needed as determined by the Administrator.

4. The date by which the regulatory insufficiency will be corrected.
   a. The regulatory insufficiency will be corrected by 12/26/22.

**A 465**
**481-69.28(5) Food Service**
69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection.

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
    a. All current Program staff have completed the Food Service Training Course.

2. Measures taken to ensure the problem does not recur.
    a. Administrator has implemented a checklist to ensure that all program staff complete Food Service Training prior to handling food and annually.
    b. New position created (HR Assistant) to complete audits and verification of training completion.

3. How the Program plans to monitor performance to ensure compliance.
    a. Administrator or designee will audit all newly hired program staff weekly for eight weeks and as needed as determined by the Administrator to verify the training checklist has been completed.

4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will be corrected by 12/26/22.

*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Program 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.*

Sincerely,

Clifford McFerren
Administrator

Bobbie Barclay
RN Coordinator

ok 1/9/23