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
	S0004	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MEADOW PLACE, L L C	17396 KINGBIRD AVE MASON CITY, IA 50401

(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: 27 Number of tenants with cognitive impairment: 28 Total census: 55 No regulatory insufficiencies were cited during the investigation of Incident #125270-I, Complaint #125344-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia. The following regulatory insufficiency was cited during the investigation of Complaint #121860-C.	A 000		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interviews and record review, program staff failed to provide services in accordance with the training provided for 1 of 1 tenants reviewed (Tenant 4). Findings include:	A 361	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 361	Continued From page 1 Record review on 3/4/25 revealed a physician order review dated 9/17/24 for Tenant 4 which included an order for monthly vitals to be obtained (to include blood pressure, breathing rate, oxygen saturation, pulse, temperature, and weight) with an effective date of 6/5/24. The service plan for Tenant 4 dated 6/25/24 further identified the order for monthly vitals. The service plan listed the following goal under the Care and Service Statement: "The resident's care and service needs will be met" and included the following Caregiver Statement: "Orientation to the service plan (tasks that need to perform on my shift), and resident needs. I have been trained on the tasks I will be performing. If any questions arise during the provision of service, I will check with the nurse on-call." During an interview with the RN Health Care Coordinator on 3/4/25, she stated staff was responsible for entering obtaining and entering monthly vitals into the electronic health system but staff sometimes had issues in completing/obtaining monthly vitals or would perform the task of vitals but fail to enter them into the electronic record. Further review on 3/5/24 of a staff Delegation task training form entitled "Vital Signs" identified staff may be required to take a resident's vital signs and included the protocol for completing the task. Review of monthly vitals documentation provided for Tenant 4 revealed monthly vitals had been obtained/completed for the months of July 2024 to February 2025 with the exception of the months of November 2024 and December 2024 which were not documented as being completed. The RN Health Care Coordinator confirmed at 11:35 am the November/December 2024 vitals	A 361		

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A 361	Continued From page 2 were not documented by staff as being obtained/completed. On 3/6/25 at 12:15 pm the Executive Director and Health Care Coordinator confirmed the above findings.	A 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0004	DATE SURVEY COMPLETED: **3/6/2025**

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Regulation and Reg Number** 481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided.	**Tag #** **A 361**	**What initial correction was made?** **All Resident Assistant staff will be retrained in the collection and recording of monthly vitals by 4/10/2025.**	**How will we ensure and maintain compliance going forward?** **1. Staff will use the Vital Sheet to record all resident vitals each month.** **2. Resident Vital Sheets will be given to the Nurse or designee to upload the information into the EHR.** **3. The Nurse or designee will review all residents' monthly vitals by the 10th of each month.**	**Implementation Date: 3/6/2025** **Completion Date:** Ongoing **Responsible Party: Director, Nurse, or designee**

Compliance Date:___4/20/2025_____

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.