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
	S0168	A. BUILDING: _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS ASSISTED LIVING	**512 13TH STREET WELLMAN, IA 52356**

(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: 2 Number of tenants with cognitive disorder: 4 Total census: 6 The following regulatory insufficiencies were cited as a result of investigation 105449-C :	A 000		
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 interview and record review the Program failed to follow the its policy and procedure related to the completion of incident report for 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow: Review of the Program's Incident Reporting policy and procedure indicated all incidents or accidents involving tenants, visitors, staff or vendors that occurred on the grounds would be reported to the Administrator and would be investigated. An incident report would be completed by the end of the shift. Any staff that witnessed the incident or accident would complete a witness statement and would report it to their supervisor. The Administrator, Director of Nursing and Assisted Living Manager would be notified of all incidents. A missing tenant would be an example of a State	A 150		

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A 150	Continued From page 1 Reportable Incident. A blank copy of the Incident Tenant Report was provided with the policy. 1. Review of an undated statement completed by the Administrator indicated in July of 2022 the former Assisted Living Director (ALD) told her Tenant #1 left the building with the intention of walking back to his residence. Interview with Staff on 2/1/23 at 11:17 a.m. and 2/2/23 at 10:39 a.m. revealed she had written an incident report regarding the elopement. When interviewed on 2/1/23 at 1:17 p.m. and 2/2/23 at 10:51 a.m. Staff E stated she believed she had completed a witness statement about this incident. Neither of these documents could be located. When interviewed on 2/2/23 at 3:09 p.m. the Administrator said two to three days before Tenant #1's elopement he left the building and was outside on the front porch. Staff had eyes on him. Regarding Tenant #1's elopement, the former ALD told her staff had eyes on him and he was safe. Later on the former ALD told her Tenant #1 had been off the property and was by the park. She was told staff had eyes on him and Staff E drove him back to the building. The Administrator was not sure of the date of Tenant #1's elopement. She said there were no staff statements. Review of Tenant #1's file on 2/1/23 and 2/2/23 failed to locate documentation or incident report related to when Tenant #1 left the building and was observed on the front porch or of an elopement that occurred in July 2022. The only written documentation of an elopement provided by the Program was the Administrator's undated statement.	A 150		

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A 150	Continued From page 2 Review of incident reports indicated Tenant #1 had falls on 11/12/22, 12/8/22 (twice), 12/20/22, 12/22/22 and 1/19/23. On 11/12/22 Tenant #1 sustained a skin tear with the fall and on 12/8/22 it was noted Tenant #1 fell and hit his head. An incident report dated 12/15/22 indicated on 12/8/22, 12/10/22, 12/11/22 and 12/12/22 Tenant #1 urinated in inappropriate places including the hallway and the back of the recliner. The reports were incomplete and lacked information required on the form including documentation of vital signs, doctor and family notification, nursing signatures and nursing assessments. 2. Review of Tenant #2's file on 2/1/23 and 2/2/23 incident reports for falls on 12/3/22, 12/5/22, 12/22/22, 12/26/22, 12/30/22 and 1/7/23. The reports were incomplete and lacked information required on the form including documentation of vital signs, doctor and family notification, nursing signatures and nursing assessments. 3. On 2/2/23 at 2:40 p.m. the Assisted Living Manager confirmed all incident reports for the tenants reviewed were provided and an incident report was not found for Tenant #1 related to the elopement. She said the expectation was that staff would fill out the incident report thoroughly.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate.	A 160		

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A 160	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to provide adequate and appropriate services to 1 of 1 tenants reviewed who had eloped (Tenant #1). Findings include: Review of an undated statement completed by the Administrator revealed that in July of 2022 the Assisted Living Director (ALD) at that time told her Tenant #1 had left the building with the intention of walking back to his residence. The former ALD told her Tenant #1 was in staff eyesight the whole time he was out of the building. A few days later it was reported to the Administrator that Staff E had brought him back to the building in her vehicle. The Administrator spoke with the former ALD who again reported staff had eyes on him the entire time. When interviewed on 2/1/23 at 11:17 a.m. and 2/2/23 at 10:39 a.m. Staff A said she recalled giving another tenant a shower in the morning (date unknown) between 7:00 a.m. and 7:30 a.m. When she shut off the water she heard the east door alarm. She got the phone and called next door to the nursing facility to assist. She began searching and determined Tenant #1 was missing. She told Staff C (maintenance assistant) who was doing some painting that the tenant had gotten outside. She shut off the door alarm but could not leave the unit as she was the only staff working at the time. Staff E (laundry aide) also went to look for the tenant. She called the former ALD to let her know what was going on. Staff E found Tenant #1 but she was not sure where. He did not have any injuries when he returned. Staff A said she did not witness Tenant #1 leave the	A 160		

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A 160	Continued From page 4	A 160		

building and to her knowledge no one knew his whereabouts when he was out of the building. She stated she had filled out an incident report. (This incident report was not located.)

On 2/1/23 at 11:50 a.m. Staff C said he was told Tenant #1 had left the building so he started to search for him. He walked the grounds, went to the pond and around the whole building. Five or six staff were looking for him. Tenant #1 was found and returned to the building but he did not know by who. Staff C said Tenant #1 made it across the street and was found southeast from the building. The door alarm had functioned properly.

When interviewed on 2/1/23 at 1:17 p.m. and 2/2/23 at 10:51 a.m. Staff E said she was notified Tenant #1 was missing. She went out to look for him. When she got to the driveway a man in a truck stopped and asked her if they were missing anyone and she said yes. She got in the truck and rode with the man. They went to a stop sign and went straight (across the highway) then took the first left and found the tenant. He was about a 1/4 of a mile down the road. The tenant walked back to the building with Staff E. She called the nursing facility and had a nurse meet them in the parking lot. Tenant #1 did not have any injuries. The tenant had a bag with him and was wearing pants, a long sleeved shirt and shoes. It took about 20 minutes for them to walk back to the building. She said the weather was nice out and it occurred a short time after Tenant #1 moved in. Staff E said no one knew where he was when staff was looking for him. She believed she had written a staff statement about the incident. (This statement was not located).

Review of Tenant #1's file revealed he was

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admitted on 7/5/22 with a diagnosis of dementia without behavioral disturbance. He was staged at a six the Global Deterioration Scale (GDS), which indicated severe cognitive decline.

As there was no documentation as to where the tenant was located, the following is based on staff interviews. When observed on 2/2/23 the possible terrain Tenant #1 traveled during his elopement in July 2022 included the Program's parking lot, city streets, gravel and paved roads and a county road. The Program was located on 13th Street, which was a west/east city street, with one lane each direction. There was not a sidewalk on either side of the street from the Program's delivery driveway to the stop sign and intersection with county road W38. The posted speed limit on 13th Street was 25 miles per hour (mph). Traveling east on 13th Street, there was a stop sign and intersection with county road W38. The west and east bound traffic on 13th Street had stop signs at the intersection of W38. The posted limit on W38 near the intersection of 13th Street was 35 mph. County road W38 (at that location) was a north/south road, with one lane in each direction and it had a small shoulder. Going east on 13th Street, across county road W38, the posted speed limit was 25 mph. There was no shoulder on the road and there were no sidewalks. The first left was at Madison Avenue, which had a church and residential area. There was no posted speed limit observed on that section of Madison Avenue. There was no shoulder on the road and there were no sidewalks. The approximate distance from the Program to possible location Tenant #1 was found was 0.4 of mile. The approximate area where Tenant #1 was located was not visible from the Program.

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A 160	Continued From page 6 No documentation of this elopement could be located including when it happened or when he had been last seen by staff. No assessment of the tenant following his return to the program could be located. No health, functional or cognitive evaluations following this significant change of elopement could be located. No updated service plan for the tenant following this elopement could be located. When interviewed on 2/2/23 at 2:40 p.m. the Assisted Living Director confirmed these findings.	A 160		
A 220	481-67.4(4) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(4) When a tenant elopes from a program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to report an elopement for 1 of 1 tenants reviewed who eloped (Tenant #1). Findings follow: Review of an undated statement completed by the Administrator in July of 2022 revealed the Assisted Living Director (ALD) at that time told her Tenant #1 left the building with the intention of walking back to his residence. The former ALD told her Tenant #1 was in staff eyesight the whole time he was out of the building. A few days later it was reported to the Administrator that Staff E had brought him back to the building in her vehicle.	A 220		

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A 220	Continued From page 7 The Administrator spoke with the former ALD who again reported staff had eyes on him the entire time. Review of Tenant #1's file revealed he was admitted on 7/5/22 with a diagnosis of dementia without behavioral disturbance. He was staged at a six the Global Deterioration Scale (GDS), which indicated severe cognitive decline. When interviewed on 2/2/23 at 3:09 p.m. the Administrator confirmed the former ALD told her staff had eyes on the tenant the entire tine he was out of the building. Later on the former ALD told her Tenant #1 had been off the property and was by the park. Staff had eyes on him and Staff E drove him back to the building. The Administrator was not sure of the date of Tenant #1's elopement. She said there were no staff statements and it was not reported to the Department, per guidance from the corporate office. According to the Program's Incident Reporting policy and procedure a missing tenant would be an example of a State Reportable Incident	A 220		
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.	A 140		

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A 140	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days of taking occupancy for 1 of 1 tenants reviewed admitted in 2022 (Tenant #1). Findings follow: Review of Tenant #1's file on 2/1/23 revealed he was admitted on 7/5/22. Evaluations were completed prior to taking occupancy on 6/29/22. No evaluations were completed within 30 days of taking occupancy. When interviewed on 2/2/23 at 2:40 p.m. the Assisted Living Director confirmed the above finding.	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:	A 145		

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A 145	Continued From page 9	A 145		

Based on interview and record review the Program failed to complete evaluations as needed with significant change and annually for 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow:

1. Review of Tenant #1's file on 2/1/23 he was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline.

Review of an undated statement completed by the Administrator indicated in July of 2022 the former Assisted Living Director (ALD) told her Tenant #1 left the building with the intention of walking back to his residence.
- When interviewed on 2/1/23 at 1:17 p.m. and 2/2/23 at 10:51 a.m. Staff E said she was notified Tenant #1 was missing. She went to look for him. When she got to the driveway a man in a truck stopped and asked her if they were missing anyone and she said yes. She got in the truck and rode with the man. They went to a stop sign and went straight (across the highway) then took the first left and found the tenant. He was about a 1/4 of a mile down the road. The tenant walked back to the building with Staff E.
- Evaluations were not completed as needed with significant change after Tenant #1's elopement in July 2022.

Record revealed Tenant #1 was admitted to hospice on 10/14/22. Evaluations were not completed as needed.

Staff Communication Reports included the following:
- On 11/19/22 there was a change in Tenant #1's bladder continence and appetite (decreased).
- On 12/23/22 Tenant #1 was incontinent and did not eat.

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- On 12/25/22 Tenant #1 was incontinent of urine for the second time that day.
- On 12/27/22 Tenant #1 urinated in the hallway.
- On 1/12/23 Tenant #1 had a change in his ability to walk and stand.
- On 1/27/23 Tenant #1 had been sleeping all day and had a decreased appetite.

Incident reports indicated Tenant #1 fell on 11/12/22, 12/8/22 (twice), 12/20/22, 12/22/22 and 1/19/23. On 11/12/22 Tenant #1 sustained a skin tear with the fall and on 12/8/22 he fell and hit his head. An incident report dated 12/15/22 indicated on 12/8/22, 12/10/22, 12/11/22 and 12/12/22 Tenant #1 urinated in inappropriate places including the hallway and the back of the recliner.

Evaluations located in the file were dated 6/29/22 pre-admission), and on 10/5/22 (90 day). Evaluations were not completed within 30 days of taking occupancy, following the elopement in July 2022, admission to hospice on 10/14/22 or as needed with falls, changes in his ability to walk, decreased appetite, increased incontinence and urination in places other than the toilet.

2. Review of Tenant #2's file on 2/1/23 revealed she was staged at seven on the GDS, which indicated very severe cognitive decline.

When interviewed on 2/1/23 at 11:17 a.m. Staff A indicated Tenant #2 was dependent on staff for eating. She required the assistance of one staff to get out of bed and for dressing and grooming. Staff A said Tenant #2 was sad.

A Physician's Orders document dated 1/4/23 indicated a referral was made to hospice for evaluation related to a decline in function. A hospice document indicated new orders (hospice)

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were received dated 1/6/23.

Staff Communication Reports indicated the following:
- On 11/21/22 Tenant #2 refused breakfast and lunch meals. She seemed agitated, twitchy and weak. Staff attempted to help her up and she reached out into the air.
- On 12/21/22 Tenant #2 was incontinent and staff had to feed her breakfast and lunch.
- On 12/21/22 Tenant #2 came out of her apartment, pulled down her pants and was about to urinate on a kitchen chair.
- On 12/22/22 Tenant #2 had changes noted in her bowel and bladder incontinence and staff had to feed her for each meal.
- On 12/25/22 Tenant #2 was incontinent and had to be fed for meals.
- On 12/27/22 Tenant #2 pulled down her pants and urinated on the couch.
- On 1/30/23 a change of behavior was noted with Tenant #2 crying. Staff noted she would not stay in bed and was found in Tenant #1's apartment. She was "very clingy and cried a lot tonight."

Incident Reports indicated the following:
- On 11/26/22 Tenant #2 walked into the kitchen at 4:30 p.m., pulled down her pants and urinated on the floor.
- On 12/3/22, 12/5/22, 12/22/22 12/26/22, 12/30/22 and 1/7/23 it was noted Tenant #2 had falls.

Further record review revealed a Subsequent Health/Functional Assessment dated 10/1/21. The next Subsequent Health/Functional Assessment was dated 2/1/23. Tenant #2 had nurse reviews completed in March, June and September 2022; however, evaluations were not

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A 145	Continued From page 12 completed at least annually or as needed with significant change for falls, changes in her ability to feed herself, incontinence, urination in places other than the toilet, tearfulness and her admission to hospice. 3. When interviewed on 2/2/23 at 2:40 p.m. the Assisted Living Director confirmed the above finding.	A 145		
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 service plans within 30 days of taking occupancy, as needed with significant change, and annually for 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow: 1. Review of Tenant #1's file on 2/1/23 revealed he was admitted on 7/5/22. An undated service plan was provided with the preliminary evaluations completed on 6/29/22. A service plan was not developed within 30 days of taking occupancy. Review of an undated statement completed by the Administrator indicated in July of 2022 the former Assisted Living Director (ALD) told her	A 360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS ASSISTED LIVING	512 13TH STREET WELLMAN, IA 52356

(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 360	Continued From page 13	A 360		

Tenant #1 left the building with the intention of walking back to his residence.
- When interviewed on 2/1/23 at 1:17 p.m. and 2/2/23 at 10:51 a.m. Staff E said she was notified Tenant #1 was missing. She went to look for him. When she got to the driveway a man in a truck stopped and asked her if they were missing anyone and she said yes. She got in the truck and rode with the man. They went to a stop sign and went straight (across the highway) then took the first left and found the tenant. He was about a 1/4 of a mile down the road. The tenant walked back to the building with Staff E.
- The service plan was not updated as needed with significant change after Tenant #1's elopement in July 2022.

Record review revealed Tenant #1 was admitted to hospice on 10/14/22 but the service plan was not updated as needed.

Staff Communication Reports included the following:
- On 11/19/22 there was a change in Tenant #1's bladder continence and appetite (decreased).
- On 12/23/22 Tenant #1 was incontinent and did not eat.
- On 12/25/22 Tenant #1 was incontinent of urine for the second time that day.
- On 12/27/22 Tenant #1 urinated in the hallway.
- On 1/12/23 Tenant #1 had a change in his ability to walk and stand.
- On 1/27/23 Tenant #1 had been sleeping all day and had a decreased appetite.
- On 1/30/23 it was noted Tenant #1 was in more pain.

Incident reports indicated Tenant #1 fell on 11/12/22, 12/8/22 (twice), 12/20/22, 12/22/22 and 1/19/23. On 11/12/22 Tenant #1 sustained a skin

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A 360	Continued From page 14	A 360		

tear with the fall and on 12/8/22 he fell and hit his head. An incident report dated 12/15/22 indicated on 12/8/22, 12/10/22, 12/11/22 and 12/12/22 Tenant #1 urinated in inappropriate places including the hallway and the back of the recliner

Tenant #1 had a signed service plan that was not dated; however, it was provided with the evaluations completed on 6/29/22, prior to taking occupancy. A service plan was provided (not dated or signed) with an initiation date of 10/5/22. The next service plan provided was completed on 2/1/23 (the date Tenant #1's file was requested). The service plan was not updated within 30 days of taking occupancy for Tenant #1 or after the elopement in July 2022 or after his admission to hospice on 10/14/22. The service plan was also not updated as needed with falls, including some falls with injuries, changes in his ability to walk, decreased appetite, increased incontinence and urination in places other than the toilet.

2. Review of Tenant #2's file on 2/1/23 revealed she was staged at seven on the GDS, which indicated very severe cognitive decline.

When interviewed on 2/1/23 at 11:17 a.m. Staff A indicated Tenant #2 was dependent on staff for eating. She required the assistance of one staff to get out of bed and for dressing and grooming. Staff A said Tenant #2 was sad.

A Physician's Orders document dated 1/4/23 indicated a referral was made to hospice for evaluation related to a decline in function. A hospice document indicated new orders (hospice) were received dated 1/6/23.

Staff Communication Reports indicated the following:

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A 360	Continued From page 15	A 360		

- On 11/21/22 Tenant #2 refused breakfast and lunch meals. She seemed agitated, twitchy and weak. Staff attempted to help her up and she reached out into the air.
- On 12/21/22 Tenant #2 was incontinent and staff had to feed her breakfast and lunch.
- On 12/21/22 Tenant #2 came out of her apartment, pulled down her pants and was about to urinate on a kitchen chair.
- On 12/22/22 Tenant #2 had changes noted in her bowel and bladder incontinence and staff had to feed her for each meal.
- On 12/25/22 Tenant #2 was incontinent and had to be fed for meals.
- On 12/27/22 Tenant #2 pulled down her pants and urinated on the couch.
- On 1/30/23 a change of behavior was noted with Tenant #2 crying. Staff noted she would not stay in bed and was found in Tenant #1's apartment. She was "very clingy and cried a lot tonight."

Incident Reports indicated the following:
- On 11/26/22 Tenant #2 walked into the kitchen at 4:30 p.m., pulled down her pants and urinated on the floor.
- On 12/3/22, 12/5/22, 12/22/22 12/26/22, 12/30/22 and 1/7/23 it was noted Tenant #2 had falls.

Tenant #2 had a service plan with an initiation date of 2/10/21. The service plan was not dated or signed. Another service plan was provided with a revision date of 9/21/22. The service plan was also not dated or signed. The next service plan was completed on 2/1/23 (the date Tenant #2's file was requested). Tenant #2's service plan was not updated annually (with signatures) and was not updated with significant change including falls, changes in her ability to feed herself,

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A 360	Continued From page 16 incontinence, urination in places other than the toilet, tearfulness and her admission to hospice. 3. When interviewed on 2/2/23 at 2:40 p.m. the Assisted Living Director confirmed the above finding.	A 360		
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected planned and spontaneous activities for 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow: Review of Tenant #1's file on 2/1/23 revealed he was staged at six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The service plan dated 2/1/23 (date tenant files were reviewed) and the service plan prior (undated) did not reflect planned and spontaneous activities for Tenant #1. Review of Tenant #2's file on 2/1/23 she was staged at a seven on the GDS, which indicated very severe cognitive decline. The service plan dated 2/1/23 (date tenant files were reviewed)	A 410		

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A 410	Continued From page 17 and the service plan prior (undated) did not reflect planned and spontaneous activities for Tenant #2. On 2/1/23 at 10:52 a.m. Staff B said there were "zero" activities that took place at the Program per day. She said the tenants could go to the nursing facility for activities. On 2/2/23 at 3:09 p.m. the Administrator said there were not enough activities provided day at the Program. She said tenants could go to the nursing facility for activities. On 2/2/23 at 2:40 p.m. the Assisted Living Director confirmed the service plans in the time period requested for tenants listed above were provided.	A 410		
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 every 90 days for 2 of 2 tenants reviewed (Tenants #1	A 430		

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A 430	Continued From page 18 and #2). Findings follow: Review of Tenant #1's file on 2/1/23 revealed he received personal cares. A 90 day review was completed dated 10/5/22. A subsequent 90 day review was not completed within 90 days. Revew of Tenant #2's file on 2/1/23 revealed she received personal cares. A 90 day review was completed dated 9/20/22. A subsequent 90 day review was not completed within 90 days. When interviewed on 2/2/23 at 2:40 p.m. the Assisted Living Director confirmed the above finding.	A 430		
A 637	481-69.32(4)a Life Safety - Emergency Policies / Structure 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: a. Written procedures regarding alarm systems, if an alarm system is in place. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to have written procedures in place regarding an alarm system. This potentially affected all tenants (census of 6). Findings follow: Review of the ALP Monitoring Entrance Form on 2/1/23 indicated the Program had six tenants, including four tenants with a Global Deterioration Scale (GDS) of four or greater. The Program's Assisted Living Program Certificate indicated the Program was a Dedicated Dementia Specific Assisted Living Program.	A 637		

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A 637	Continued From page 19 When observed on 1/31/23 to 2/2/23 the Program had an alarm system for exit doors. When interviewed on 2/2/23 at approximately 9:00 a.m. the Assisted Living Director said the door alarm policy and procedure was within their Missing Tenant/Elopement policy and procedure. Review of the Missing Resident/Elopement policy and procedure revelaed no information related to the door alarms or door alarm system. The Door Code policy and procedure was reviewed, but it was a policy related to the determination of which tenants would receive the door alarm code. When interviewed on 2/2/23 at 3:39 p.m. the Assisted Living Director and Administrator confirmed there was not a policy and procedure related to the door alarms and the policy and procedures for door alarm response was not located in the Missing Resident/Elopement policy and procedure.	A 637		