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
	S0209	A. BUILDING: _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF AMES	1315 COCONINO DRIVE AMES, IA 50014

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 32 Number of tenants with cognitive impairment: 1 Total census: 33 The following regulatory insufficiencies were cited during the investigation of Complaint #118147-C, Complaint #118081-C, Complaint #118079-C and Complaint #117958-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program.	A 000	The Plan of Correction is attached.	
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure 4 of 4 current tenants interviewed were treated with dignity and respect (Tenant #5, Tenant #6, Tenant #7 and Tenant #8). Findings include: 1) On 7/9/24 at 11:05 AM, Tenant #6 reported feeling she was spoken to in a demeaning manner by the Clinical Manager. Tenant #6 fell	A 155		

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

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A 155	Continued From page 1	A 155		

twice in the fall of 2023. Tenant #6 was told she was not improving quickly enough by the Clinical Manager. One staff member told Tenant #6 if she fell three times she would have to move out. Tenant #6 said she learned from these experiences not to push her pendant for assistance unless she really needed it.

Once, following a fall, Tenant #6 was unable to after attending an activity and asked staff to get her a wheelchair. The Clinical Manager later approached her and asked her about needing the wheelchair in what she perceived as an uncaring manner. Tenant #6 felt as if the Clinical Manager was affronted because she asked for assistance. The Clinical Manager did not assess Tenant #6 following the incident. Tenant #6 believed the staff needed to show more sympathy and understanding for tenants.

2) On 7/9/24 at 1:50 PM, Tenant #5 reported she was treated in a manner which left her feeling humiliated and insignificant. Tenant #5 had a stroke which left her without the use of her left side. There were times when she needed assistance straightening out her undergarments because they were twisted and causing her pain. Some staff would help her and others would not do so at the direction of the Clinical Manager. Once when another tenant was helping Tenant #5 with her clothing, the Clinical Manager reportedly yelled down the hall asking Tenant #5 why she couldn't manage her clothing on her own. The Clinical Manager then allegedly asked Tenant #5 how she would feel if the other tenant fell while helping her. Tenant #5 said she went around on pins and needles. She was afraid of getting kicked out of the building.

3) On 7/9/24 at 12:30 PM, Tenant #7 stated she

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A 155	Continued From page 2 met with the Administrator and Clinical Manager and was told she could no longer administer her own insulin in the dining room. Tenant #7 stated she took her insulin in the dining room because she did not know if she would be served first or last in the dining room, which could throw off times of the insulin self-administration and subsequent meal needed. She stated the Clinical Manager told her administering insulin in the dining room was against the law, but believed the Clinical Manager lied about this. Tenant #7 stated the Clinical Manager did not have a good bed-side manner, was not a good communicator, and liked to be in charge. 4) On 7/9/24 at 3:30 PM, Tenant #8 recalled when she moved in her interactions with the Clinical Manager wasn't pleasant. One day she woke up to find the Clinical Manager standing at the end of her bed telling Tenant #8 the aides had complained the tenant launders too many pads. Tenant #8 said it scared her to find the Clinical Manager standing at the end of her bed. Tenant #8 no longer had problems with the Clinical Manager, although she saw the Clinical Manager speaking unkindly to other tenants. 5) On 7/9/24 at 3:00 PM the Administrator confirmed she had heard concerns from a few tenants about the Clinical Manager speaking to them in an unkind manner. She was not aware of all the issues raised by tenants. On 7/15/24 at 11:25 AM, the Clinical Administrator confirmed it was not acceptable for tenants to be spoken to in an unkind manner.	A 155		
A 365	481-67.9(4)g Staffing	A 365		

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A 365	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to retain the communication log for 3 years. Findings follow: Review of a communication log on 7/9/24 revealed one undated sheet of paper listing updates for tenants. The program did not have any other records from the communication log. On 7/9/24 at 9:46 AM the Clinical Manager reported they did not retain the communication log for 3 years. The log was shredded after staff had the opportunity to review it.	A 365		

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A 145	Continued From page 4	A 145		
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 fully evaluate the cognitive, health and functional status after a change in condition for 1 of 1 discharged tenants reviewed (Tenant C1). Findings follow: Record review on 7/8/24 revealed a visit note for Tenant C1 dated 1/2/24. The Clinical Manager identified she included the tenant's behavioral status during a recertification assessment and the tenant demonstrated none of the behaviors listed on the form. On 1/8/24 the Administrator completed an incident report for Tenant C1 after receiving a call from the tenant's daughter. Tenant C1 reported on 1/2/24 she had a visit with the Clinical Manager and Staff A. Tenant C1 accused the	A 145		

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A 145	Continued From page 5	A 145		

Clinical Manager of shaking her knees and hurting her. Tenant C1 was afraid to return to the program.

An incident report dated 1/5/24 revealed the Clinical Manager went to Tenant C1's apartment after receiving a report of the tenant displaying peculiar behavior. Tenant C1 appeared to be talking to individuals in her apartment. When the Clinical Manager attempted to enter Tenant C1's apartment, the tenant walked to the doorway and slammed the door.

The program developed a managed risk agreement for Tenant C1 on 1/11/24. There was increased concern for Tenant C1's safety due to her recent increased agitation which included an accusation of staff hurting her. Tenant C1 also had increased self talk and possible hallucinations of people who were not physically in the room. If the tenant continued to have hallucinations and unfounded accusations of staff hurting her, it could result in the termination of Tenant C1's lease and discharge from the program. The program wanted the tenant to make an appointment with her primary care provider to rule out any physical or mental issues. Tenant C1 refused to sign the document.

The Clinical Manager completed a discharge visit for Tenant C1 on 2/26/24. The visit note included a cognitive assessment which noted Tenant C1 displayed impaired decision-making, verbal disruption and delusional, hallucinatory or paranoid behavior on a daily basis.

On 7/9/24 at 9:46 AM, the Clinical Manager reported in Tenant C1's last month at the program she talked to other employees about staff trying to get her. Tenant C1's self-talk continued beyond

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A 145	Continued From page 6 1/5/24. Tenant C1 frequently talked to her dolls. The Clinical Manager confirmed she did not evaluate Tenant C1's cognitive, health and functional status when she began displaying a change in her behavioral status.	A 145		
A 350	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plan for 1 of 1 discharged tenants reviewed after a change in cognitive condition (Tenant C1). Findings follow: Record review on 7/8/24 revealed a visit note for Tenant C1 dated 1/2/24. The Clinical Manager identified she included the tenant's behavioral status during the recertification assessment and the tenant demonstrated none of the behaviors listed on the form. On 1/8/24 the Administrator completed an incident report for Tenant C1 after receiving a call from the tenant's daughter. Tenant C1 reported on 1/2/24 she had a visit with the Clinical	A 350		

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A 350	Continued From page 7	A 350		

Manager. Tenant C1 accused the Clinical Manager of shaking her knees and hurting her. Tenant C1 was afraid to return to the program.

An incident report dated 1/5/24 revealed the Clinical Manager went to Tenant C1's apartment after receiving a report of the tenant displaying peculiar behavior. Tenant C1 appeared to be talking to individuals in her apartment. When the Clinical Manager attempted to enter Tenant C1's apartment, the tenant walked to the doorway and slammed the door.

The program developed a managed risk agreement for Tenant C1 on 1/11/24. There was increased concern for Tenant C1's safety due to her recent increased agitation, which included an accusation of staff hurting her. Tenant C1 also had increased self talk and possible hallucinations of people who were not physically in the room. If Tenant C1 continued to have hallucinations and unfounded accusations of staff hurting her, it could result in the termination of Tenant C1's lease and discharge from the program. The program wanted Tenant C1 to have an appointment with her primary care provider to rule out any physical or mental issues. Tenant C1 refused to sign the document.

The Clinical Manager completed a discharge visit for Tenant C1 on 2/26/24. The visit note included a cognitive assessment which noted Tenant C1 displayed impaired decision-making, verbal disruption and delusional, hallucinatory or paranoid behavior on a daily basis.

Tenant C1 had a service plan dated 7/19/23. The plan was not updated after 1/5/24 to identify any behavioral issues for Tenant C1.

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A 350	Continued From page 8 On 7/9/24 at 9:46 AM, the Clinical Manager reported in Tenant C1's last month at the program she talked to other employees about staff trying to get her. Tenant C1's self-talk continued beyond 1/5/24. Tenant C1 frequently talked to her dolls. The Clinical Director confirmed she did not update Tenant C1's service plan to address the change in her cognitive status.	A 350		
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: Based on interview and record review, the program failed to ensure preferences were included in the service plan for 1 of 5 tenants reviewed (Tenant #5). Findings follow: Record review on 7/9/24 revealed a Patient Information Report for Tenant #5 dated 1/30/24 listing diagnoses of hemiplegia affecting the left nondominant side and unspecified sequelae of cerebral infarction. Tenant #5 had a Nurse Visit Note Report dated 6/19/24. According to the note, the nurse completed a musculoskeletal system assessment on that date. The nurse identified Tenant #5 experienced decreased strength, atrophy and limited range of motion in her upper and lower left extremities. She was experiencing chronic arthritic stiffness to her low back and left hip. The nurse also noted Tenant #5 displayed	A 395		

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A 395	Continued From page 9	A 395		

impaired-decision making as she failed to perform the usual activities of daily living.

Tenant #5 had a service plan dated 10/18/23. The service plan identified Tenant #5 was independent with dressing.

On 7/9/24 at 8:15 AM, Staff B reported Tenant #5 had approached her with her bra twisted and shirt up on her back and asked for assistance in arranging these items of clothing.

On 7/9/24 at 1:50 PM, Tenant #5 stated she had a stroke which left her unable to use her left side. Tenant #5 reported she had asked staff and other tenants for assistance with straightening her clothing as well as untwisting her undergarments when she was unable to do this herself. There were times staff had helped with this and other times they had not. The Clinical Manager reportedly told staff they shouldn't help her and doing it herself would improve Tenant #5's self esteem.

On 7/9/24 at 9:46 AM, the Clinical Manager reported Tenant #5 liked help with dressing, putting on her coat and going outside to smoke. One of Tenant's #5's sides did not work well. The Clinical Manager stated Tenant #5 could put on a bra with assistance. She reported Tenant #5 could not live at the program if she required assistance with dressing as it was a service they did not provide. The Clinical Manager would not attempt to get approval for Tenant #5 to have dressing assistance.

On 7/15/24 at 11:25 AM, the Corporate Administrator reported program staff were able to assist tenants with dressing. This was a service offered to Tenant #5 in the past, but she did not

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A 395	Continued From page 10 want to pay for it. Tenant #5 now had a funding option for dressing assistance but no one added it to her service plan as a preferred service.	A 395		
A 420	481-69.27(1)a 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: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete a nurse review to assess health status following a change in condition for 1 of 1 discharged tenants reviewed (Tenant C1). Findings follow: Record review on 7/8/24 revealed a visit note for Tenant C1 dated 1/2/24. The Clinical Manager identified she included the tenant's behavioral status during the recertification assessment and the tenant demonstrated none of the behaviors listed on the form. On 1/8/24 the Administrator completed an	A 420		

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A 420	Continued From page 11	A 420		

incident report for Tenant C1 after receiving a call from the tenant's daughter. Tenant C1 reported on 1/2/24 she had a visit with the Clinical Manager and Staff A. Tenant C1 accused the Clinical Manager of shaking her knees and hurting her. Tenant C1 was afraid to return to the program.

An incident report dated 1/5/24 revealed the Clinical Manager went to Tenant C1's apartment after receiving a report of the tenant displaying peculiar behavior. Tenant C1 appeared to be talking to individuals in her apartment. When the Clinical Manager attempted to enter Tenant C1's apartment, the tenant walked to the doorway and slammed the door.

The program developed a managed risk agreement for Tenant C1 on 1/11/24. There was increased concern for Tenant C1's safety due to her recent increased agitation which included an accusation of staff hurting her. Tenant C1 also had increased self talk and possible hallucinations of people who were not physically in the room. If the tenant continued to have hallucinations and unfounded accusations of staff hurting her, it could result in the termination of Tenant C1's lease and discharge from the program. The program wanted the tenant to make an appointment with her primary care provider to rule out any physical or mental issues. Tenant C1 refused to sign the document.

The Clinical Manager completed a discharge visit for Tenant C1 on 2/26/24. The visit note included a cognitive assessment which noted Tenant C1 displayed impaired decision-making, verbal disruption and delusional, hallucinatory or paranoid behavior on a daily basis.

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A 420	Continued From page 12 Following a change in Tenant C1's behavioral status, the Clinical Manager did not thoroughly assess the tenant's health status, review all orders and make any needed recommendations. On 7/9/24 at 9:46 AM, the Clinical Manager reported in Tenant C1's last month at the program she talked to other employees about staff trying to get her. Tenant C1's self-talk continued beyond 1/5/24. Tenant C1 frequently talked to her dolls. The Clinical Director confirmed she did not complete a nurse review.	A 420		

PLAN OF CORRECTION FOR STATEMENT OF DEFICIENCIES FACILITY RECERTIFICATION INSPECTION AND COMPLAINTS 118147-C, 118081-C,1180799-C AND 117958-C SURVEY COMPLETED JULY 10, 2024

September 27, 2024

Facility Name: The Rose of Ames, L.P.
Street Address, City, ZIP: 1315 Coconino Road, Ames, Iowa 50014
Facility Cert Number: S0209
Exit Date: 07/15/2024

481 IAC 67.3(1) Tenant Rights Tenants to be treated with consideration, respect, and full recognition of personal dignity and autonomy. Clinical manager has been counseled on her clinical demeanor and manner of speaking with residents. A performance improvement plan (PIP) was formulated, which among other things, identified such interpersonal deficiencies and committed the clinical manager to avoidance of past behaviors and engagement with residents to better identify and serve their needs.
Completion Date: 08/16/2024
Narrative: Following the exit interview, Open Arms formulated a performance improvement plan (PIP) and presented it to the clinical manager on July 18, 2024. The PIP addressed the operational deficiencies mentioned in the exit interview and identified in the statement of deficiencies. Compliance with the stated goals of the PIP have been monitored by the agency Administrator and corporate Administrator and both are satisfied with the behavioral changes that have been observed.

Recurrence will be avoided by continued monitoring of the operational environment and solicitation of input from staff and residents to assure proper consideration, respect and recognition of personal dignity and autonomy are extended to residents. Compliance threshold is 100%.

481 IAC 67.9(4)g Staffing Communication in writing by service provider staff of significant occurrences, which written communication record shall be retained for three years. The practice of retaining the communication log by Open Arms staff has been reestablished at the Rose facility. The failure to retain the log was an administrative oversight.
Completion Date: 07/16/2024
Narrative: Maintenance and retention of a written shift communication log is an expectation for the agency and this practice was erroneously abandoned. The situation has been corrected.

Recurrence will be avoided by a periodic supervisory audit of the maintenance and retention of the shift communication log. Compliance threshold is 100%.

481-69.22(3) Evaluation of Tenant Tenants shall be evaluated at least annually or upon significant change in condition. Staff need to be attentive to the need to update all aspects of a resident's cognitive, health and functional status upon observed behaviors, with specific reference to cognitive function.
481-69.26(1) Service Plan Service plan shall be developed and updated annually or when needed upon specific change in resident circumstances, with specific reference to cognitive function.
481.69.27(1) a. Nurse Review A nurse review shall occur upon significant change in condition or every 90 days for person receiving health related care, with specific reference to medications relative to cognitive function or behavioral change.
Completion date: 08/16/2024
Narrative: Following the exit interview, Open Arms formulated a performance improvement plan (PIP) and presented it to the clinical manager on July 18, 2024. The PIP addressed the operational deficiencies mentioned in the exit interview and identified in the statement of deficiencies. Compliance

with the stated goals of the PIP have been monitored by the agency Administrator and corporate Administrator and both are satisfied with the increased attention to operational and clinical requirements that were noted as deficient in the investigation. Specific emphasis was placed on RN patient review and service plan updates.

Recurrence will be avoided by continued monitoring of adherence by clinical manager and RN staff to clinical and operational expectations.

481.69.26(4) a. Service Plans A service plan shall be developed and updated annually or when needed upon significant change in condition, with specific reference to altering patient services as appropriate for changes in patient condition and as consistent with the scope of program service parameters.
Completion date: 08/16/2024
Narrative: Following the exit interview, Open Arms formulated a performance improvement plan (PIP) and presented it to the clinical manager on July 18, 2024. The PIP addressed the operational deficiencies mentioned in the exit interview and identified in the statement of deficiencies. Compliance with the stated goals of the PIP have been monitored by the agency Administrator and corporate Administrator and both are satisfied with the increased attention to operational and clinical requirements that were noted as deficient in the investigation. Any declinations of patient services will be reviewed by supervisors before the proposed service plans are processed and implemented.

Recurrence will be avoided by continued monitoring of adherence by clinical manager and RN staff to clinical and operational expectations.

Gregory A. McClenahan, Chief Manager

09-27-2024

Dated

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
	S0209	A. BUILDING: _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF AMES	1315 COCONINO DRIVE AMES, IA 50014

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 32 Number of tenants with cognitive impairment: 1 Total census: 33 The following regulatory insufficiencies were cited during the investigation of Complaint #118147-C, Complaint #118081-C, Complaint #118079-C and Complaint #117958-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program.	A 000		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure 4 of 4 current tenants interviewed were treated with dignity and respect (Tenant #5, Tenant #6, Tenant #7 and Tenant #8). Findings include: 1) On 7/9/24 at 11:05 AM, Tenant #6 reported feeling she was spoken to in a demeaning manner by the Clinical Manager. Tenant #6 fell	A 155	See attached response and Plan of Correction	

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A 155	Continued From page 1 twice in the fall of 2023. Tenant #6 was told she was not improving quickly enough by the Clinical Manager. One staff member told Tenant #6 if she fell three times she would have to move out. Tenant #6 said she learned from these experiences not to push her pendant for assistance unless she really needed it. Once, following a fall, Tenant #6 was unable to after attending an activity and asked staff to get her a wheelchair. The Clinical Manager later approached her and asked her about needing the wheelchair in what she perceived as an uncaring manner. Tenant #6 felt as if the Clinical Manager was affronted because she asked for assistance. The Clinical Manager did not assess Tenant #6 following the incident. Tenant #6 believed the staff needed to show more sympathy and understanding for tenants. 2) On 7/9/24 at 1:50 PM, Tenant #5 reported she was treated in a manner which left her feeling humiliated and insignificant. Tenant #5 had a stroke which left her without the use of her left side. There were times when she needed assistance straightening out her undergarments because they were twisted and causing her pain. Some staff would help her and others would not do so at the direction of the Clinical Manager. Once when another tenant was helping Tenant #5 with her clothing, the Clinical Manager reportedly yelled down the hall asking Tenant #5 why she couldn't manage her clothing on her own. The Clinical Manager then allegedly asked Tenant #5 how she would feel if the other tenant fell while helping her. Tenant #5 said she went around on pins and needles. She was afraid of getting kicked out of the building. 3) On 7/9/24 at 12:30 PM, Tenant #7 stated she	A 155		

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A 155	Continued From page 2 met with the Administrator and Clinical Manager and was told she could no longer administer her own insulin in the dining room. Tenant #7 stated she took her insulin in the dining room because she did not know if she would be served first or last in the dining room, which could throw off times of the insulin self-administration and subsequent meal needed. She stated the Clinical Manager told her administering insulin in the dining room was against the law, but believed the Clinical Manager lied about this. Tenant #7 stated the Clinical Manager did not have a good bed-side manner, was not a good communicator, and liked to be in charge. 4) On 7/9/24 at 3:30 PM, Tenant #8 recalled when she moved in her interactions with the Clinical Manager wasn't pleasant. One day she woke up to find the Clinical Manager standing at the end of her bed telling Tenant #8 the aides had complained the tenant launders too many pads. Tenant #8 said it scared her to find the Clinical Manager standing at the end of her bed. Tenant #8 no longer had problems with the Clinical Manager, although she saw the Clinical Manager speaking unkindly to other tenants. 5) On 7/9/24 at 3:00 PM the Administrator confirmed she had heard concerns from a few tenants about the Clinical Manager speaking to them in an unkind manner. She was not aware of all the issues raised by tenants. On 7/15/24 at 11:25 AM, the Clinical Administrator confirmed it was not acceptable for tenants to be spoken to in an unkind manner.	A 155		
A 365	481-67.9(4)g Staffing	A 365	See attached response and plan of correction	

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A 365	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to retain the communication log for 3 years. Findings follow: Review of a communication log on 7/9/24 revealed one undated sheet of paper listing updates for tenants. The program did not have any other records from the communication log. On 7/9/24 at 9:46 AM the Clinical Manager reported they did not retain the communication log for 3 years. The log was shredded after staff had the opportunity to review it.	A 365		

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A 145	Continued From page 4	A 145		
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 fully evaluate the cognitive, health and functional status after a change in condition for 1 of 1 discharged tenants reviewed (Tenant C1). Findings follow: Record review on 7/8/24 revealed a visit note for Tenant C1 dated 1/2/24. The Clinical Manager identified she included the tenant's behavioral status during a recertification assessment and the tenant demonstrated none of the behaviors listed on the form. On 1/8/24 the Administrator completed an incident report for Tenant C1 after receiving a call from the tenant's daughter. Tenant C1 reported on 1/2/24 she had a visit with the Clinical Manager and Staff A. Tenant C1 accused the	A 145	See attached response and Plan of Correction	

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A 145	Continued From page 5 Clinical Manager of shaking her knees and hurting her. Tenant C1 was afraid to return to the program. An incident report dated 1/5/24 revealed the Clinical Manager went to Tenant C1's apartment after receiving a report of the tenant displaying peculiar behavior. Tenant C1 appeared to be talking to individuals in her apartment. When the Clinical Manager attempted to enter Tenant C1's apartment, the tenant walked to the doorway and slammed the door. The program developed a managed risk agreement for Tenant C1 on 1/11/24. There was increased concern for Tenant C1's safety due to her recent increased agitation which included an accusation of staff hurting her. Tenant C1 also had increased self talk and possible hallucinations of people who were not physically in the room. If the tenant continued to have hallucinations and unfounded accusations of staff hurting her, it could result in the termination of Tenant C1's lease and discharge from the program. The program wanted the tenant to make an appointment with her primary care provider to rule out any physical or mental issues. Tenant C1 refused to sign the document. The Clinical Manager completed a discharge visit for Tenant C1 on 2/26/24. The visit note included a cognitive assessment which noted Tenant C1 displayed impaired decision-making, verbal disruption and delusional, hallucinatory or paranoid behavior on a daily basis. On 7/9/24 at 9:46 AM, the Clinical Manager reported in Tenant C1's last month at the program she talked to other employees about staff trying to get her. Tenant C1's self-talk continued beyond	A 145		

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A 145	Continued From page 6 1/5/24. Tenant C1 frequently talked to her dolls. The Clinical Manager confirmed she did not evaluate Tenant C1's cognitive, health and functional status when she began displaying a change in her behavioral status.	A 145		
A 350	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plan for 1 of 1 discharged tenants reviewed after a change in cognitive condition (Tenant C1). Findings follow: Record review on 7/8/24 revealed a visit note for Tenant C1 dated 1/2/24. The Clinical Manager identified she included the tenant's behavioral status during the recertification assessment and the tenant demonstrated none of the behaviors listed on the form. On 1/8/24 the Administrator completed an incident report for Tenant C1 after receiving a call from the tenant's daughter. Tenant C1 reported on 1/2/24 she had a visit with the Clinical	A 350	See attached response and Plan of Correction	

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A 350	Continued From page 7 Manager. Tenant C1 accused the Clinical Manager of shaking her knees and hurting her. Tenant C1 was afraid to return to the program. An incident report dated 1/5/24 revealed the Clinical Manager went to Tenant C1's apartment after receiving a report of the tenant displaying peculiar behavior. Tenant C1 appeared to be talking to individuals in her apartment. When the Clinical Manager attempted to enter Tenant C1's apartment, the tenant walked to the doorway and slammed the door. The program developed a managed risk agreement for Tenant C1 on 1/11/24. There was increased concern for Tenant C1's safety due to her recent increased agitation, which included an accusation of staff hurting her. Tenant C1 also had increased self talk and possible hallucinations of people who were not physically in the room. If Tenant C1 continued to have hallucinations and unfounded accusations of staff hurting her, it could result in the termination of Tenant C1's lease and discharge from the program. The program wanted Tenant C1 to have an appointment with her primary care provider to rule out any physical or mental issues. Tenant C1 refused to sign the document. The Clinical Manager completed a discharge visit for Tenant C1 on 2/26/24. The visit note included a cognitive assessment which noted Tenant C1 displayed impaired decision-making, verbal disruption and delusional, hallucinatory or paranoid behavior on a daily basis. Tenant C1 had a service plan dated 7/19/23. The plan was not updated after 1/5/24 to identify any behavioral issues for Tenant C1.	A 350		

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A 350	Continued From page 8 On 7/9/24 at 9:46 AM, the Clinical Manager reported in Tenant C1's last month at the program she talked to other employees about staff trying to get her. Tenant C1's self-talk continued beyond 1/5/24. Tenant C1 frequently talked to her dolls. The Clinical Director confirmed she did not update Tenant C1's service plan to address the change in her cognitive status.	A 350		
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: Based on interview and record review, the program failed to ensure preferences were included in the service plan for 1 of 5 tenants reviewed (Tenant #5). Findings follow: Record review on 7/9/24 revealed a Patient Information Report for Tenant #5 dated 1/30/24 listing diagnoses of hemiplegia affecting the left nondominant side and unspecified sequelae of cerebral infarction. Tenant #5 had a Nurse Visit Note Report dated 6/19/24. According to the note, the nurse completed a musculoskeletal system assessment on that date. The nurse identified Tenant #5 experienced decreased strength, atrophy and limited range of motion in her upper and lower left extremities. She was experiencing chronic arthritic stiffness to her low back and left hip. The nurse also noted Tenant #5 displayed	A 395	See attached response and Plan of Correction	

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A 395	Continued From page 9 impaired-decision making as she failed to perform the usual activities of daily living. Tenant #5 had a service plan dated 10/18/23. The service plan identified Tenant #5 was independent with dressing. On 7/9/24 at 8:15 AM, Staff B reported Tenant #5 had approached her with her bra twisted and shirt up on her back and asked for assistance in arranging these items of clothing. On 7/9/24 at 1:50 PM, Tenant #5 stated she had a stroke which left her unable to use her left side. Tenant #5 reported she had asked staff and other tenants for assistance with straightening her clothing as well as untwisting her undergarments when she was unable to do this herself. There were times staff had helped with this and other times they had not. The Clinical Manager reportedly told staff they shouldn't help her and doing it herself would improve Tenant #5's self esteem. On 7/9/24 at 9:46 AM, the Clinical Manager reported Tenant #5 liked help with dressing, putting on her coat and going outside to smoke. One of Tenant's #5's sides did not work well. The Clinical Manager stated Tenant #5 could put on a bra with assistance. She reported Tenant #5 could not live at the program if she required assistance with dressing as it was a service they did not provide. The Clinical Manager would not attempt to get approval for Tenant #5 to have dressing assistance. On 7/15/24 at 11:25 AM, the Corporate Administrator reported program staff were able to assist tenants with dressing. This was a service offered to Tenant #5 in the past, but she did not	A 395		

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A 395	Continued From page 10 want to pay for it. Tenant #5 now had a funding option for dressing assistance but no one added it to her service plan as a preferred service.	A 395		
A 420	481-69.27(1)a 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: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete a nurse review to assess health status following a change in condition for 1 of 1 discharged tenants reviewed (Tenant C1). Findings follow: Record review on 7/8/24 revealed a visit note for Tenant C1 dated 1/2/24. The Clinical Manager identified she included the tenant's behavioral status during the recertification assessment and the tenant demonstrated none of the behaviors listed on the form. On 1/8/24 the Administrator completed an	A 420	See attached response and Plan of Correction	

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A 420	Continued From page 11 incident report for Tenant C1 after receiving a call from the tenant's daughter. Tenant C1 reported on 1/2/24 she had a visit with the Clinical Manager and Staff A. Tenant C1 accused the Clinical Manager of shaking her knees and hurting her. Tenant C1 was afraid to return to the program. An incident report dated 1/5/24 revealed the Clinical Manager went to Tenant C1's apartment after receiving a report of the tenant displaying peculiar behavior. Tenant C1 appeared to be talking to individuals in her apartment. When the Clinical Manager attempted to enter Tenant C1's apartment, the tenant walked to the doorway and slammed the door. The program developed a managed risk agreement for Tenant C1 on 1/11/24. There was increased concern for Tenant C1's safety due to her recent increased agitation which included an accusation of staff hurting her. Tenant C1 also had increased self talk and possible hallucinations of people who were not physically in the room. If the tenant continued to have hallucinations and unfounded accusations of staff hurting her, it could result in the termination of Tenant C1's lease and discharge from the program. The program wanted the tenant to make an appointment with her primary care provider to rule out any physical or mental issues. Tenant C1 refused to sign the document. The Clinical Manager completed a discharge visit for Tenant C1 on 2/26/24. The visit note included a cognitive assessment which noted Tenant C1 displayed impaired decision-making, verbal disruption and delusional, hallucinatory or paranoid behavior on a daily basis.	A 420		

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A 420	Continued From page 12 Following a change in Tenant C1's behavioral status, the Clinical Manager did not thoroughly assess the tenant's health status, review all orders and make any needed recommendations. On 7/9/24 at 9:46 AM, the Clinical Manager reported in Tenant C1's last month at the program she talked to other employees about staff trying to get her. Tenant C1's self-talk continued beyond 1/5/24. Tenant C1 frequently talked to her dolls. The Clinical Director confirmed she did not complete a nurse review.	A 420		

The Rose of Ames, L.P.
By: EverGreen Real Estate Development Corp., Gen. Ptr.
By: _____, President
Gregory A. McClenahan
Dated: 9-27-2024