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
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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. General Population Number of tenants without cognitive disorder: 23 Number of tenants with cognitive disorder: 3 Memory Care Unit Number of tenants without cognitive disorder: 6 Number of tenants with cognitive disorder: 14 Total Census of Assisted Living Program for People with Dementia: 46 There were no regulatory insufficiencies cited during the onsite infection control survey. A comment was made to the Program regarding the recommendations for eye protection for staff. The investigation of Incidents #96903-I, #100435-I and #100436-I, the investigation of Complaint #100396-C and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program were completed. The following regulatory insufficiencies were identified:	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.	A 155		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 1 of 5 tenants reviewed were treated with consideration and respect (Tenant #1). Findings follow: Review of an incident report dated 3-7-21 indicated it was reported a staff told Tenant #1 to "shut the (expletive) up" and "sit the (expletive) down." Review of the Program's investigation documents indicated the following: - The Portfolio Leader (corporate representative who was the Program Director at the time of the incident) received a statement from Staff F at approximately 10:00 a.m. that indicated tenants had informed her that Staff D had yelled at tenants to "sit the (expletive) down and "shut the (expletive) up." - A handwritten statement signed by Staff F dated 3-8-21 indicated tenants informed her that Staff D yelled at tenants to to "sit the (expletive) down and "shut the (expletive) up." - On 3-8-21 at 12:15 p.m. the Portfolio Leader interviewed Tenant #7 and she confirmed that Staff D said it to Tenant #1 on 3-7-21 around the time of the evening meal. Tenant #7 said she and Tenant #2 were in their apartment and Tenant #1 tried to follow Staff D into their apartment. Tenant #1 was in the hallway, asking questions and following staff around. Staff D was in their apartment and Tenant #1 was in the hallway outside of the apartment. Staff D opened the apartment door and "yelled into the hallway to shut the (expletive) up and sit the (expletive)	A 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 155	Continued From page 2	A 155		

down." Tenant #7 said she was "shocked" and Tenant #2 heard it too and was "really upset." Staff D made a rude comments to Tenant #2.
- On 3-8-21 at 12:30 p.m. the Portfolio Leader interviewed Tenant #2 and she said Staff D was "always swearing." She said around the time of the evening meal the night prior, there were "people outside our door having problems" and it was clarified it was one of the tenants outside of the apartment that was following Staff D. Tenant #2 reported Staff D had the apartment door open and yelled "Shut the (expletive) up and sit the (expletive) down." Tenant #2 said the tenant in the hallway probably did not remember. Tenant #2 said Staff D need to watch her language and she had previously come into her apartment, used profanity regarding being tired and "plopped down" in the chair.
- Interview notes from the Portfolio Leader's interview with Staff D indicated Staff D denied using profanity towards a tenant, said there were no tenants who irritated her and she enjoyed her job. When asked if she used profanity around a tenant, Staff D said yes and said a word might slip while she was talking to another employee.
- Continued record review revealed a Counseling Documentation Form dated 3-8-21 indicating Staff D was suspended due to a pending investigation.

When interviewed on 10-27-21 at 11:28 a.m. Staff F stated Tenant's 2 and #7 told her the previous night was terrible as Staff D had yelled at another tenant and used profanity. Staff F immediately reported it to the Portfolio Leader. She had her write something out about it. Staff F said Tenant #2 and Tenant #7 were upset about it.

When interviewed on 10-28-21 at 10:25 a.m. the Portfolio Leader confirmed she had received a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 155	Continued From page 3	A 155		

note from Staff F about the incident. She visited with Staff F to clarify what was on the note was factual. The Portfolio Leader said she was not aware any issues or conflict between Staff D and Staff F. She interviewed Tenant #2 and Tenant #7, who lived together, separately. Tenant #2 told her Staff D was coming into their apartment and Tenant #1 followed Staff D. Staff D was in the doorway of the apartment and Tenant #1 was in the hallway. Tenant #2 heard Staff D tell Tenant #1 to "shut the (expletive) ... up" and she shut the door. Tenant #2 was upset and said it was not Tenant #1's fault. The Portfolio Director spoke with Tenant #7 who said Staff D was in the room at the apartment door and yelled out in the hallway to "shut the (expletive) up." She looked out and saw Tenant #1. Tenant #7 said she was shocked and Tenant #2 was upset. The Portfolio Leader interviewed all of the resident assistants working that night but no one heard anything unusual. When she interviewed Staff D she denied the incident took place.

When interviewed on 10-28-21 at 3:33 p.m. Staff D stated she was hired in January of 2021 and worked the second shift. Staff D denied using profanity towards a tenant, denied telling a tenant to sit down or be quiet, denied mistreating or being disrespectful to tenants and denied being verbally aggressive to a tenant. She recalled the night before being suspended she was a little late administering medications. She asked a tenant to sit down in the hall but did not use any profanity.

Review of Tenant #1's file revealed a diagnosis of Alzheimer's disease with late onset. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. The service plan indicated Tenant #1 had mild to moderate disorientation and difficulty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 155	Continued From page 4 recalling and retaining information. Tenant #1 was independent with ambulation and resided in the memory care unit. In summary, Tenant #2 and Tenant #7 reported they observed Staff D tell Tenant #1 to sit down and shut up with profanities on 3-7-21. Tenant #2 and Tenant #7 reported it to Staff F when Staff F asked about the previous night. Staff F reported the allegation to the Portfolio Leader. When interviewed separately by the Director, Tenant #2 and Tenant #7 confirmed the allegation. Tenant #1 was not treated with consideration, respect and dignity.	A 155		
A 270	481-67.5(2)f(1) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).	A 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 270	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure a medication manager course was completed prior to administering medications for 1 of 4 staff reviewed who administered meds (Staff B). Findings follow: Record review on 10-26-21 of Staff B's training documents revealed a hire date of 5-5-21. Staff B had nurse delegations completed related to medication management dated 5-21-21 and 10-8-21. A Certificate of Completion document indicated Staff B had successfully complete the Medication Management Course dated 10-26-21. Continued record review revealed a document provided by the Program indicated Staff B first administered medications on 10-11-21. When interviewed on 11-4-21 the Portfolio Leader confirmed the above finding.	A 270		
A 275	481-67.5(2)f(2) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. This REQUIREMENT is not met as evidenced by:	A 275		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 275	Continued From page 6 Based on observation, interview and record review the Program failed to ensure medications were stored and inaccessible to others for 1 of 2 tenants observed receiving medications from staff (Tenant #5). Findings follow: When observed on 10-26-21 at approximately 11:30 a.m. Staff E administered Systane Eye drops to Tenant #5 in her apartment. The eye drops were kept in an unlocked cabinet in the apartment. In the cabinet there was also a medication planner. When interviewed on 10-26-21 at approximately 11:30 a.m. Staff E confirmed the medication was not locked and staff administered the medications from the medication planner. Review of Tenant #5's file on 10-27-21 revealed the service plan reflected the nurse set up the medications in a pill planner. Staff ordered and administered medications. Review of the October Medication Administration Record (MAR) confirmed staff administered oral medications to the tenant at 8:00 a.m. and 5:00 p.m. as well as eye drops three times a day. The Program's Medication Policy indicated medications would be kept in a locked location that was not accessible to people other than staff who were responsible to administer the medications. When interviewed on 11-4-21 the Portfolio Leader confirmed the above finding.	A 275		
A 325	481-67.9(1) Staffing	A 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 325	Continued From page 7 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide sufficient staff to meet the needs of the tenants. This potentially affected all tenants (census of 46). Findings follow: A community meeting with 9 tenants and 1 visitor was held on 10-26-21 at 12:45 p.m. A separate interview was held with a tenant at 1:05 p.m. Comments regarding staff response to pendants included that it took awhile to get help, especially on the weekends. One tenant said at times it took 30 to 45 minutes. Review of pendant history documentation from 10-22-21 to 10-24-21 (Friday, Saturday and Sunday) revealed there were 24 times the reset time for the tenants pendants was greater than 15 minutes in the three day time period requested. - Of those 24 times noted above, there were 19 times the reset time for the pendants was greater than 20 minutes (79% of the 24 entries). - Of those 24 times noted above, there were 14 times the reset time for the pendants was greater than 30 minutes (58% of the 24 entries). - Of those 24 times noted above, there were 6 times the reset time for the pendants was greater than 40 minutes (25% of the 24 entries). - Of those 24 times noted above, there were 3 times the reset time for pendants was greater than 50 minutes (12.5% of the 24 entries). The longest time period to reset a pendant in the three day time period requested was 51 minutes	A 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 325	Continued From page 8 and 44 seconds on 10-23-21 at 1:38 a.m. Review of the Program's Emergency Pendant policy revealed each tenant would be offered a 24 personal emergency response pendant. If the pendant alarm sounded staff was to check the apartment number and go the the apartment. When interviewed on 11-4-21 the Portfolio Leader said the expectation was that pendants were answered in five minutes or less. She confirmed the above finding.	A 325		
A 345	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). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide training on activities of daily living (ADLs) within 30 days of hire for 2 of 5 staff reviewed employed greater than 30 days (Staff C and Staff D). Finding follow: Record review on 10-26-21 of Staff C's file revealed a hire date of 2-1-21. Staff C did not have any completed nurse delegations for ADLs within 30 days of hire or at the time reviewed. Record review on 10-26-21 of Staff D's file	A 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 345	Continued From page 9 revealed a hire date of 1-28-21. Staff D did not have any completed nurse delegations for ADLs within 30 days of hire or at the time reviewed. When interviewed on 11-4-21 the Portfolio Leader confirmed the above finding.	A 345		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a background check prior to employment for 1 of 2 staff reviewed hired in the past six months (Staff A). Findings include: Record review on 10-26-21 of Staff A's training documents revealed a hire date of 8-16-21. A Single Contact License & Background Check document indicated an abuse registries and criminal history background check were completed on 8-17-21 at 5:04 p.m. No concerns were noted. Continued record review revealed a Certificate of Completion for Safe Food Handling/Food Safety was dated 8-16-21. Staff A's background check was completed and the end of the business day on 8-17-21; however,	A 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 400	Continued From page 10 Staff A's date of hire provided by the Program was 8-16-21 and training records indicated Staff A worked on 8-16-21. Review of a statement provided by the Portfolio Leader revealed she was in a different Program and unaware Staff A was to start on 8-16-21. She had scheduled Staff A for new hire orientation on 8-18-21. When the Portfolio Leader returned to the building she completed the background check on 8-17-21. When interviewed on 11-4-21 the Portfolio Manager confirmed the above the finding.	A 400		
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 complete evaluations as needed with significant change for 2 of 5 tenants reviewed (Tenant #3 and #4). Findings follow:	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 145	Continued From page 11 1. Review of an incident report dated 9-28-21 revealed Tenant #2 was getting ice and noticed another tenant picking up a gallon of milk. Tenant #2 asked the other tenant to put down the milk because she did not want her to drop it. Tenant #3 came up to Tenant #2 and said the other tenant could have the milk. Tenant #3 then pushed Tenant #2, which caused Tenant #2 to fall backwards. Tenant #2 heard a "pop" when she fell. Staff responded and noticed bleeding and swelling from the right elbow. An ambulance was called and Tenant #2 was transported to the hospital due to a possible fracture in the arm. Tenant #2's Progress Notes dated 9-28-21 indicated she returned from the hospital with a soft cast on her wrist/forearm. Tenant #2 sustained a right radial fracture from her fall. The cast was to be in place for two to three weeks. On 10-27-21 review of Tenant #3's file revealed a diagnosis of Alzheimer's disease. She was staged at a six on the GDS (Global Deterioration Scale), which indicated severe cognitive decline. Evaluations were not completed as needed with significant change after the incident when Tenant #3 shoved Tenant #2, which resulted in fall with a fracture. The most recent evaluations provided for Tenant #3 were the 30 day evaluations completed in August 2021. 2. Review of an incident report dated 1-14-21 reflected staff was completing hourly checks and found Tenant #4 on her back in front of her recliner in her apartment. Tenant #4 did not let staff get close to do vitals and it looked like her arm was hanging. The on-call nurse was notified and she called the primary care provider (PCP). Both came into the building to assess Tenant #4. She was sent to the hospital via ambulance.	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 145	Continued From page 12 Review of Tenant #4's file revealed a diagnosis of Alzheimer's disease and a GDS score if six, which indicated severe cognitive decline. Progress Notes indicated the following: - On 1-14-21 Tenant #4 returned from the emergency room (ER) with a diagnosis of broken left clavicle. - On 1-15-21 Tenant #4 returned from appointment with an immobilizer on the left arm. She was to wear the immobilizer at all times and had a follow up appointment on 1-29-21. - On 1-27-21 it was noted Tenant #4 had an area on the left buttock that was bleeding. The area measured 4 x 2 and the skin looked like it was sheared. An order was received to use a heart shaped sacral patch to her coccyx every three days and as needed. - On 1-28-21 Tenant #4 had a fever of 99.7, and the top of the left shoulder to her ear was red, warm and swollen. The PCP was contacted and came to assess her. An order was received for cephalexin 500 milligram (mg), twice daily for 10 days. - On 2-2-21 the PCP came to assess Tenant #4's cellulitis and a new order was received for amoxcillion clavulanate 600-42.9 liquid. Cephalexin was discontinued. - On 2-15-21 Tenant #4 had a follow up appointment and orders were received to continue with the immobilizer for two more weeks and for physical therapy (PT). Tenant #4 was on hospice and was not eligible for PT. Continued record review revealed the most current evaluations for Tenant #4 were dated 1-15-21. Evaluations were not completed as needed with the discontinuation of the immobilizer, cellulitis and treatment and the	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 145	Continued From page 13 coccyx wound and treatment. 3. When interviewed on 11-4-21 the Portfolio Leader confirmed the above finding.	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 service plans as needed for 3 of 5 tenants reviewed (Tenants #2, #3 and #4). Findings follow: 1. Review of an incident report dated 9-28-21 reflected Tenant #2 was getting ice and noticed another tenant picking up a gallon of milk. Tenant #2 asked the other tenant to put down the milk because she did not want her to drop it. Tenant #3 came up to Tenant #2 and said the other tenant could have the milk. Tenant #3 then pushed Tenant #2, which caused Tenant #2 to fall backwards. Tenant #2 heard a "pop" when she fell. Staff responded and noticed bleeding and swelling from the right elbow. An ambulance was called and Tenant #2 was transported to the hospital due to a possible fracture in the arm. On 10-27-21 a review of Tenant #2's Progress Notes indicated the following:	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 14 - On 9-28-21 (late entry) Tenant #2 returned from the hospital with a soft cast on her wrist/forearm. Tenant #2 sustained a right radial fracture from her fall. The cast was to be in place for two to three weeks. - On 10-3-21 (late entry) it was noted Tenant #2 complained of pain and bruising on her right arm by the cast. She also complained of numbness and cool fingers. The nurse suggested the tenant be sent out to the emergency room (ER) to have the cast adjusted. - On 10-3-21 (late entry) Tenant #2 returned from the ER the previous night and had the cast adjusted. She received instructions on stretching and range of motion for the fractured right radius. The ER doctor said she needed to elevate her right arm more frequently. - On 10-4-21 (late entry) it was noted Tenant #2 had a moisture excoriation and "yeast like build up" in her left groin area. Tenant #2 said it was painful. Staff were to apply Nystatin powder to her left groin twice daily. - On 10-12-21 it was noted Tenant #2 had a skin tear on the right elbow just above the cast. A new order was received to apply antibiotic ointment, cover with a non-adherent dressing and wrap with cling daily until healed. - On 10-21-21 it was noted Tenant #2's skin tear on the right elbow above the cast was healed. Further record review revealed a Staff Documentation/Communication document to the RN dated 10-2-21 indicating Tenant #2 had a possible yeast infection in her folds along her groin area. The area was "completely raw." It was mostly on the left side, where the bleeding was located. The nurse's response to the concern was to apply Tenant #2's Nystatin powder to the area twice daily.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 15	A 350		

Tenant #2's service plan updated on 10-15-21 did not reflect the skin tear on the right elbow and dressing change. The service plan did not reflect the excoriated area in Tenant #2's groin and the treatment of the area.

2. An incident report dated 9-28-21 reflected Tenant #3 pushed Tenant #2, which caused Tenant #2 to fall backwards. Tenant #2 sustained a right radial fracture from her fall.

On 10-27-21 review of Tenant #3's file revealed a diagnosis of Alzheimer's disease. She was staged at a six on the GDS (Global Deterioration Scale), which indicated severe cognitive decline.

Review of Tenant #3's Documentation Survey Report for September 2021 revealed she received bathing assistance. There were seven entries documented as "NA" for bathing. One bath was documented as given on 9-14-21. The Documentation Survey Report for October 2021 (1st-27th) revealed there were seven entries documented "NA" for bathing. One bath was documented as given on 10-15-21.

When interviewed on 11-4-21 the Portfolio Leader said "NA" indicated not applicable. She was not sure why it would be charted for bathing for Tenant #3; however, if staff had given a shower the day before they might chart NA as the bathing service was provided the day prior.

Tenant #3's most recent service plan was dated 8-10-21. The service plan was not updated after the incident where Tenant #3 shoved Tenant #2 to reflect the behavior or interventions. In addition, although the plan reflected staff assisted Tenant #3 with bathing; it did not include information as to what to do if the tenant refused bathing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 16 services. 3. Review of an incident report dated 1-14-21 reflected staff was completing hourly checks and found Tenant #4 on her back in front of her recliner in her apartment. Tenant #4 did not let staff get close to do vitals and it looked like her arm was hanging. The on-call nurse was notified and she called the primary care provider (PCP). Both came into the building to assess Tenant #4. She was sent to the hospital via ambulance. Review of Tenant #4's file revealed a diagnosis of Alzheimer's disease and a GDS score if six, which indicated severe cognitive decline. Progress Notes indicated the following: - On 1-14-21 Tenant #4 returned from the emergency room (ER) with a diagnosis of broken left clavicle. - On 1-15-21 Tenant #4 returned from appointment with an immobilizer on the left arm. She was to wear the immobilizer at all times and had a follow up appointment on 1-29-21. - On 1-27-21 it was noted Tenant #4 had an area on the left buttock that was bleeding. The area measured 4 x 2 and the skin looked like it was sheared. An order was received to use a heart shaped sacral patch to her coccyx every three days and as needed. - On 1-28-21 Tenant #4 had a fever of 99.7, and the top of the left shoulder to her ear was red, warm and swollen. The PCP was contacted and came to assess her. An order was received for cephalexin 500 milligram (mg), twice daily for 10 days. - On 2-2-21 the PCP came to assess Tenant #4's cellulitis and a new order was received for amoxcillion clavulanate 600-42.9 liquid. Cephalexin was discontinued.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 17 - On 2-15-21 Tenant #4 had a follow up appointment and orders were received to continue with the immobilizer for two more weeks and for physical therapy (PT). Tenant #4 was on hospice and was not eligible for PT. Tenant #4's September 2021 MAR reflected the order for a heart shaped sacral patch to coccyx area every three days and as needed. It was charted as refused eight times and completed twice. The October 2021 MARs (1st-26th) reflected the tenant refused the treatment six times. There were no entries regarding the completion of the task. The most current service plan for Tenant #4 was dated 1-15-21. The service plan was not updated after the immobilizer was discontinued, the diagnosis of cellulitis and treatment, the coccyx wound and treatment or refusals of the treatment. 4. When interviewed on 11-4-21 the Portfolio Leader confirmed the above findings.	A 350		

Prairie Hills At Tipton
219 South Cedar Street
Tipton, Iowa 52772

Date: 1/12/2022

Complaint Intake #: Complaint #'s 100396-C, Incidents # 100435-I and #100436-I, and On site Infection Control Survey

Plan of Correction (POC) Submitted For:

- Investigation Date: 10/25/2021 to 11/4/2021

A. Regulatory Insufficiency: 481-67.3 Tenant Rights (1): All tenants have the following rights: **481-67.3 (1)** To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

1. **Elements Detailing the programs correction of the insufficiencies:**
    a. Staff member D was suspended on 3/8/2021
    b. Staff member D was terminated on 01/10/2022
2. **Actions program taking to protect tenants in similar situations:**
    a. All Community employees will receive education on dependent adult abuse and tenant rights by 1/31/2022
3. **Measures taken to ensure problem does not reoccur:**
    a. Director and/or designee will ensure all current employees receive training on tenant rights and dependent adult abuse annually
    b. Director and/or designee will ensure all new employees receive training on tenant rights and dependent adult abuse upon hire
4. **Program plans to monitor performance to ensure solutions are permanent:**
    a. Director and/or designee will monitor that solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

B. Regulatory Insufficiency: 481-67.5(2)f(1) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).

1. Elements Detailing the programs correction of the insufficiencies:

a. Staff B has completed an approved Medication Manager course 10/26/2021

2. **Actions program taking to protect tenants in similar situations:**
    a. Staff members will pass only administer medications if they have completed an approved medication manager course.
3. **Measures taken to ensure problem does not reoccur:**
    a. Director and or Designee will perform audits of EMAR and Employee files to ensure that only Medication Managers are passing medications in the community weekly, monthly, as needed, as determined by the Director and/or Designee.
4. **Program plans to monitor performance to ensure solutions are permanent:**
    a. Director and or designee will ensure that all staff members who pass medications have completed an approved Medication Manager course prior to passing medications within the community.

C. Regulatory Insufficiency: 481-67.5(2)f(2) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.

1. **Elements Detailing the programs correction of the insufficiencies:**
    a. Tenant 5's eye drops were secured in a locked cupboard/drawer.
    b. All Tenants that the Community provides Medication Management for will have their medications secured in a locked cupboard/drawer.
2. **Actions program taking to protect tenants in similar situations:**
    a. Medication Managed Tenants medications will be secured in a locked cupboard/drawer.
3. **Measures taken to ensure problem does not reoccur:**
    a. Director and or Designee will perform audits of Medication Managed Tenants medications to assure they are secured properly in the community weekly, monthly, as needed, as determined by the Director and/or Designee.
4. **Program plans to monitor performance to ensure solutions are permanent:**
    a. Director and or Designee will perform audits of Medication Managed Tenants medications to assure they are secured properly in the community weekly, monthly, as needed, as determined by the Director and/or Designee.

D. Regulatory Insufficiency: 481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

1. Elements Detailing the programs correction of the insufficiencies:

a. All community staff will receive education on responding to pendants in an appropriate amount of time.

2. Actions program taking to protect tenants in similar situations:

a. All community staff will receive education on responding to pendants in an appropriate amount of time.

3. Measures taken to ensure problem does not reoccur:

a. Director and or Designee will perform audits on Pendant response times weekly, monthly, as needed, as determined by the Director and/or Designee.

4. Program plans to monitor performance to ensure solutions are permanent:

a. Director and or Designee will perform audits on pendant response times weekly, monthly, as needed, as determined by the Director and/or Designee.

E. Regulatory Insufficiency: 481-67.9(1) Staffing 67.9(1) 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: Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

1. Elements Detailing the programs correction of the insufficiencies:

a. Staff D terminated was terminated on 01/10/2022.

b. Staff C was delegated on 01/13/2022.

2. Actions program taking to protect tenants in similar situations:

a. All staff will be delegated within 30 days after their hire date going forward.

3. Measures taken to ensure problem does not reoccur:

a. Director and or Designee will perform Employee file audits weekly, monthly, as needed, as determined by the Director and/or Designee to assure compliance.

4. Program plans to monitor performance to ensure solutions are permanent:

a. Director and or Designee will perform Employee file audits weekly, monthly, as needed, as determined by the Director and/or Designee to assure compliance.

F. Regulatory Insufficiency: 481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.

1. Elements Detailing the programs correction of the insufficiencies:

a. Staff A's background check was completed 8/17/2021, all record checks were negative.

2. Actions program taking to protect tenants in similar situations:

a. Required Background checks will be completed on all new hires prior to the beginning of their training.

3. Measures taken to ensure problem does not reoccur:

a. Director and or Designee will perform Employee file audits weekly, monthly, as needed, as determined by the Director and/or Designee to assure compliance.

4. Program plans to monitor performance to ensure solutions are permanent:

a. Director and or Designee will perform Employee file audits weekly, monthly, as needed, as determined by the Director and/or Designee to assure compliance.

G. Regulatory Insufficiency 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 insufficiency was corrected:

a. Registered Nurse for the community at the time of this Regulatory Insufficiency is no longer employed by the community.

b. Education and training with Registered nurse completed, reviewed qualifications for change in condition assessments and evaluation of tenant's functional, cognitive, and health status.

c. Tenant's 3 and 4 had Change of Condition assessments completed for their fractures. Tenant 3 had a Change of Condition on 09/29/2021 and Tenant 4 had a Change of Condition on 01/15/2021. These assessments were not given to the surveyor at the time of the survey exit.

2. Actions program taking to protect tenants in similar situations:

a. Registered Nurse will monitor residents' conditions and ensure change of condition assessments are completed timely.

3. Measures taken to ensure the problem does not recur:

a. Registered Nurse will monitor tenants for any changes in their conditions and complete assessments if indicated.

4. Program plans to monitor performance to ensure solutions are permanent:

a. Registered Nurse will monitor residents' conditions and ensure change of condition assessments are completed timely.

H. Regulatory Insufficiency: 481-69.26(1) **Service Plans.** 481-69.26(231C) 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 tenants specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

1. **Elements Detailing the programs correction of the insufficiencies:**
   a. Registered Nurse for the community at the time of this Regulatory Insufficiency is no longer employed by the community.
   b. Education and training with Registered nurse completed, reviewed qualifications for change in condition assessments, service plan updates and evaluation of tenant's functional, cognitive, and health status.
   c. Tenant 2's ISP was update on 01/13/2022, Tenant 3's ISP was updated on 09/29/2021 and Tenant 4's ISP was updated on 01/15/2021.
2. **Actions program taking to protect tenants in similar situations:**
   a. Random audits will be completed weekly, and/or monthly as needed as determined by the Director/RN or designee to ensure compliance.
3. **Measures taken to ensure problem does not reoccur:**
   a. Director, RN, and or Designee will ensure that evaluations are completed on residents as needed: if a change of condition is noted a comprehensive assessment and updates to the plan of care will be completed to assure the needs of residents are being met.
4. **Program plans to monitor performance to ensure solutions are permanent:**
   a. Director, RN and/or designee will monitor that solutions implemented are in place weekly, monthly, as needed, as determined by the Director/RN or designee to ensure compliance.

All corrections will be in place by 01/31/2022.

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.

ok 2/9/22