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 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS OF 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. Number of tenants without cognitive impairment: 30 Number of tenants with cognitive impairment: 8 Total census: 38 The following regulatory insufficiencies were cited during the investigation of Incident #119500-I and Complaint #120782-C.	A 000	The Plan of Correction is attached	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to follow established policy regarding use of wander management systems for 1 of 1 tenant reviewed who used a WanderGuard (Tenant #2). Finding follows: On 8/19/24 at 11:10 a.m. observation of the main entrance to the building revealed the exit doors opened easily without alarms sounding. Code boxes were on the walls near the entrance doors. The Executive Director (ED) explained the program used a WanderGuard system on the exit doors. She said tenants in the Memory Care unit	A 150		

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

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A 150	Continued From page 1	A 150		

or any tenant with a GDS (Global Dementia Scale) of 4 or above wore a WanderGuard device that triggered alarms at the exit doors.

Observation of Tenant #2 at 3:00 p.m. revealed she had two electronic type of devices on lanyards around her neck. One of the devices was a pendant, used to summon staff. The other device was not readily identified. Tenant #2 resided in the non-secured area of the building, not the Memory Care unit.

On 8/20/24 at 11:40 a.m. Staff A noted Tenant #2 sometimes tried to leave the building, but the WanderGuard device she wore (around her neck) alerted staff by triggering the alarm when she got close to the exit doors. Staff A said she didn't recall how long Tenant #2 had worn the WanderGuard device, but noted it was added after the tenant moved to the program.

On 8/20/24 at 3:05 p.m. Staff C said Tenant #2 sometimes tried to exit the building. Tenant #2 indicated at times she was packing up and leaving. She wore a WanderGuard device around to neck, which triggered the alarm at the exit doors and alerted staff to redirect the tenant.

Record review on 8/19/24 and 8/20/24 revealed Tenant #2's occupancy date of 5/06/24. Her diagnosis upon admission included dementia. The initial assessments dated 4/29/24, indicated Tenant #2 made safe judgements and was capable of independent decision making. According to the assessment, Tenant #2 did not wander and was not at risk for elopement. Tenant #2's initial service plan dated 4/30/24 also noted Tenant #2 made safe judgements and would receive routine safety checks once per shift. The service plan made no mention of a

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A 150	Continued From page 2	A 150		

WanderGuard. No additional assessments or services plans could be located, other than cognitive assessments competed 7/08/24, which indicated Tenant #2 had a Global Dementia Scale (GDS) score of one (no cognitive impairment).

No documentation or consent for the WanderGuard could be located in Tenant #2's record.

On 8/21/24 at 10:50 a.m. the ED verified Tenant #2 wore a WanderGuard device. The program started using the device at some point after Tenant #2's occupancy date. The ED confirmed the use of the WanderGuard was not in Tenant #2's service plan and the program had not obtained written consent. The ED said Tenant #2 appeared to have cognitive impairment.

The program Wander Management System policy indicated egress alert devices worn by residents (such as WanderGuard) must have prior written approval of the resident or responsible party and must not violate the resident's rights. According to the policy, residents who were known to be an elopement risk would be evaluated to determine the appropriateness of use of egress alert device worn by the resident or carried on their person. The resident's service plan would be updated to indicate the resident's behavior or conditions indicating the need for the egress alert device and the physician's recommendations. Prior to use of the egress alert device by a resident living in a non-secured assisted living environment, the resident's physician would be consulted to obtain physician's instructions regarding the resident's need for supervision. If the physician indicated the resident was unable to leave without supervision, access to exits would be alarmed or

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A 150	Continued From page 3 an egress alert device, such as a WanderGuard, might be advised.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure adequate care and services for 1 of 3 tenants reviewed (Tenant #2). Finding follows: On 8/19/24 and 8/20/24, record review revealed the program failed to provide adequate assessments and updated service plans for Tenant #2. (See regulatory insufficiencies cited at Iowa Administrative Code (IAC) 481 - 69.22(1), 69.22(2), 69.22(3), 69.26(1), 69.26(3), 69.26(3)(a) for additional information). The program failed to provide adequate nurse review and documentation regarding Tenant #2's health status, specifically ongoing issues with urinary tract infections (UTIs) and indwelling catheter. Tenant #2 went to the emergency room five times between 5/11/24 and 8/06/24 for UTIs and/or problems with her catheter. (See regulatory insufficiency cited at IAC 481 - 69.27(1)(c) for additional information).	A 160		

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A 160	Continued From page 4	A 160		

Progress notes written by Tenant 2's Primary Care Provider (PCP) on 6/13/24, 7/11/24 and 8/01/24 indicated Tenant #2 had chronic UTIs, complicated by an indwelling Foley catheter and patient dementia. The PCP noted concern Tenant #2 might not understand adequate Foley catheter care. The 6/13/24 note indicated awaiting services from home health care agency to manage catheter. According to the 7/11/24 note, Tenant #2 was being followed by home health care for Foley catheter care.

On 8/20/24 at 11:15 a.m. the Visiting Nurse Association Registered Nurse (VNA RN) said her agency received a referral to change Tenant #2's catheter once per month, but she said VNA had visited more often due to issues with the catheter. The RN noted Tenant #2 was at high risk for UTI. She said her office contacted the Executive Director (ED) and/or nurse at the program for VNA to provide training to the program staff for catheter care, but got no response.

On 8/22/24 at 11:00 a.m. the VNA RN reviewed the indwelling catheter care instruction sheet from University of Iowa Health Care, which indicated the catheter bags should be cleaned daily with soap and water and weekly with a vinegar and water solution. The vinegar water solution should soak in the bag for 30 minutes. The VNA RN stated the VNA provided new catheter bags once per month.

On 8/20/24 at 2:00 p.m. Staff B explained staff changed Tenant #2's catheter bag twice per day. Tenant #2 used one bag at night when in bed and another bag on her leg during the day. Staff rinsed out the used bag with water and left it out to dry until they switched the bags. Staff B said she used only water to rinse out the bags; she

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A 160	Continued From page 5 was not trained to use soap or vinegar. On 8/20/24 at 3:05 p.m. Staff C said staff changed Tenant #2's catheter bags twice per day. Staff C cleaned the bags with a vinegar and water solution, as she had been trained by Staff A. On 8/20/24 at 3:30 p.m. Staff D said staff switched out Tenant 2's catheter bags twice per day. Staff D said she used only water to rinse out the bags for later use. No one told her to use soap or vinegar. On 8/21/24 at 8:50 a.m. Staff A explained staff should clean the used catheter bag each time when they switched the bags twice per day. She said was trained by a prior program nurse to use vinegar when cleaning catheter bags. Staff A stated she trained the staff to use a mixture of half vinegar and half water to pour into the bag, swish it around, drain the bag and rinse with water. Staff A said the program nurse working at the time Tenant #2 moved to the program said she didn't know about cleaning catheter bags and asked Staff A to train the staff. On 8/21/24 at 10:50 a.m. the ED confirmed staff should be trained on the appropriate techniques to properly clean used catheter bags.	A 160		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are	A 135		

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A 135	Continued From page 6 available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete an adequate cognitive evaluation prior to occupancy for 1 of 3 tenants reviewed (Tenant #2). Finding follows: Record review on 8/19/24 revealed Tenant #2's occupancy date of 5/06/24. Further review revealed an initial evaluation dated 4/29/24, which included health and functional assessment. The evaluation indicated Tenant #2 was oriented and capable of independent decision making, but did not contain a scored, objective cognitive assessment. According to the evaluation, Tenant #2's diagnosis included unspecified dementia with unspecified severity. Additional record review revealed Primary Care Provider (PCP) contact notes dated 6/13/24 indicated a physical exam of Tenant #2 and review of medical history. The PCP documented Tenant #2 had moderate dementia with mood disturbance, recurrent UTI (urinary tract infection) and an indwelling Foley catheter. The contact notes indicated concern Tenant #2 might not understand adequate Foley care, due to her dementia. The PCP noted Tenant #2 had limited insight into her health and poor short-term memory.	A 135		

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A 135	Continued From page 7 On 8/21/24 at 10:50 a.m. the Executive Director verified no cognitive assessment for Tenant #2 completed prior to occupancy.	A 135		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete evaluations for functional, cognitive and health status within 30 days of occupancy for 1 of 3 tenants reviewed (Tenant #2). Finding follows: On 8/19/24 record review revealed Tenant #2's Resident Information form indicated an occupancy date of 5/06/24. No evaluations completed within 30 days of occupancy could be located. On 8/21/24 at 10:50 a.m. the Executive Director confirmed the program failed to complete evaluations within 30 days of Tenant #2's occupancy.	A 140		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant	A 145		

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A 145	Continued From page 8 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 assessments due to significant change for 1 of 3 tenants reviewed (Tenant #2). Finding follows: Record review on 8/19/24 revealed Tenant #2's Resident Information form indicated an occupancy date of 5/06/24. No evaluations completed after Tenant #2 moved to the program on 5/6/24 could be located, other than cognitive assessments completed 7/08/24. Initial assessments dated 4/29/24 and service plan dated 4/30/24 did not indicate frequent urinary tract infections (UTIs), outside service for catheter care or wandering/use of a WanderGuard system. Tenant #2 had emergency room visits for UTIs and/or problems with her indwelling catheter on 5/11/24, 6/08/24, 7/08/24, 7/16/24 and 8/06/24. According to a note by her Primary Care	A 145		

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A 145	Continued From page 9 Physician (PCP) dated 6/13/24, a referral was made to home health care to manage the catheter. The note also listed a diagnosis of recurrent UTI. A PCP note documented 7/11/24 indicated Tenant #2 was being followed by home health care for Foley catheter care. Observation on 8/19/24 at 3:00 p.m. observation revealed Tenant #2 had two electronic type devices around her neck on two lanyards. On of the items was a pendant to be used to summon staff. The other device was not readily identified. On 8/20/24 at 11:40 a.m. Staff A said Tenant #2 wore a WanderGuard device around her neck. The device triggered the WanderGuard alarm system at the building exit doors. Staff A said Tenant #2 sometimes talked of leaving and tried to exit the building, but staff were alerted by the WanderGuard alarm. Staff A indicated the program had added the WanderGuard for Tenant #2 since she moved to the program. On 8/21/24 at 10:50 a.m. the Executive Director confirmed the program did not conduct additional assessments for Tenant #2 regarding significant changes of frequent UTIs/ER visits, addition of home health care services for catheter care or use of WanderGuard system due to attempted elopement/wandering.	A 145		
A 315	481-69.25(1)n Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal	A 315		

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A 315	Continued From page 10 representative This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to obtain documentation of legal representative(s) for 1 of 3 tenants reviewed (Tenant #2). Finding follows: Record review on 8/19/24 revealed no documents pertaining to guardianship, conservatorship or power of attorney (POA) could be located in Tenant #2's record. Tenant #2's Resident Information form listed Daughter #1 as the only emergency contact, but did not list anyone as a legal representative. Tenant #2 moved to the program on 5/06/24. Tenant #2's initial Service Plan and Occupancy Agreement dated 4/30/24 was signed by Daughter #1 as the legal representative. On 8/21/24 at 10:50 a.m. the Executive Director (ED) stated the program did not have any documentation of a legal representative for Tenant #2 until Daughter #2 emailed POA documents on 8/20/24, indicating she was POA for health care. Daughter #2 also emailed a written statement from a physician dated November 2023, which indicated Tenant #2 was not competent to make complex health care or financial decisions. The ED said Daughter #1 presented herself as the financial and health care POA, but did not provide the documents.	A 315		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for	A 350		

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A 350	Continued From page 11 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 complete adequate evaluations prior development of a service plan for 1 of 3 tenants reviewed (Tenant #2). Finding follows: Record review on 8/19/24 revealed Tenant #2's occupancy date of 5/06/24, with initial evaluation dated 4/29/24, which included health and functional assessment. The evaluation indicated Tenant #2 was oriented and capable of independent decision making, but did not contain a scored, objective cognitive assessment tool. According to the evaluation, Tenant #2's diagnosis included unspecified dementia with unspecified severity. Tenant #2's service plan, dated 4/30/24, indicated she made safe judgements and was able to recall or retain information. According to the service plan, Tenant #2 could make appropriate decisions about her care. Primary Care Provider (PCP) contact notes dated 6/13/24 indicated a physical exam of Tenant #2 and review of medical history. The PCP documented Tenant #2 had moderate dementia	A 350		

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A 350	Continued From page 12 with mood disturbance, recurrent UTI (urinary tract infection) and an indwelling Foley catheter. The contact notes indicated concern Tenant #2 might not understand adequate Foley care, due to her dementia. The PCP noted Tenant #2 had limited insight into her health and poor short-term memory. On 8/21/24 at 10:50 a.m. the Executive Director verified no cognitive evaluation for Tenant #2 completed prior to the development of the service plan.	A 350		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to update the initial service plan within 30 days of occupancy for 1 of 3 tenants reviewed (Tenant #2). Finding follows: On 8/19/24 record review revealed Tenant #2's Resident Information form indicated an occupancy date of 5/06/24. Initial service plan was dated 4/30/24 and included personal/health related care. No updated service plan could be located in Tenant #2's record.	A 360		

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A 360	Continued From page 13 On 8/21/24 at 10:50 a.m. the Executive Director confirmed the program failed to update Tenant #2's service plan within 30 days occupancy.	A 360		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to update service plans due to significant change for 1 of 3 tenants reviewed (Tenant #2). Finding follows: Record review on 8/19/24 revealed Tenant #2's Resident Information form indicated an occupancy date of 5/06/24. Initial service plan dated 4/30/24 did not indicate frequent urinary tract infections (UTIs), outside service for catheter care or wandering/use of a WanderGuard system. No updated service plans could be located in Tenant #2's record. Tenant #2 had emergency room visits for UTIs and/or problems with her indwelling catheter on 5/11/24, 6/08/24, 7/08/24, 7/16/24 and 8/06/24. According to a note by her Primary Care Physician (PCP) dated 6/13/24, a referral was made to home health care to manage the	A 370		

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 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS OF 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 370	Continued From page 14 catheter. The note also listed a diagnosis of recurrent UTI. A PCP note documented 7/11/24 indicated Tenant #2 was being followed by home health care for Foley catheter care. On 8/19/24 at 3:00 p.m. observation revealed Tenant #2 had two electronic type devices around her neck on two lanyards. On of the items was a pendant to be used to summon staff. The other device was not readily identified. On 8/20/24 at 11:40 a.m. Staff A said Tenant #2 wore a WanderGuard device around her neck. The device triggered the WanderGuard alarm system at the building exit doors. Staff A said Tenant #2 sometimes talked of leaving and tried to exit the building, but staff were alerted by the WanderGuard alarm. Staff A indicated the program had added the WanderGuard for Tenant #2 since she moved to the program. On 8/21/24 at 10:50 a.m. the Executive Director confirmed the program did not Tenant #2's service plan regarding significant changes of frequent UTIs/ER visits, addition of home health care services for catheter care or use of WanderGuard system due to attempted elopement/wandering.	A 370		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of	A 430		

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 08/22/2024

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

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A 430	Continued From page 15	A 430		

each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status;

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the program failed to complete nurse reviews every 90 days and as needed for change of condition for 1 of 3 tenants reviewed (Tenant #2). Finding follows:

Record review on 8/19/24 revealed Tenant #2's Resident Information form indicated she moved to the program on 5/06/24. No nurse review of overall health could be located in Tenant #2's record, other than an initial health assessment completed on 4/29/24. Progress notes contained a brief entry on 5/06/24 by the nurse, indicating Tenant #2's vital signs. The next progress note regarding health status was 6/08/24, which indicated Tenant #2 pulled out her catheter, had no urine output and went to the emergency room (ER). Tenant #2 returned to the program the same day, with a new catheter and a diagnosed UTI, with antibiotic prescribed. A progress note on 6/19/24 documented a fall, with a facial laceration. Tenant #2 went to ER. Progress note the next day indicated Tenant #2 had facial bruising, with no additional information regarding treatment or diagnosis at the ER. The last progress note in Tenant #2's record, dated 7/08/24, indicated the tenant complained of pain in lower abdomen and exhibited more confusion than usual. The entry also noted an occluded catheter earlier in the day. The progress note indicated Tenant #2 went to the ER, with no further information or entries. In summary, the

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	S0213	A. BUILDING: _____ B. WING _____	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS OF 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 430	Continued From page 16 progress notes documented three emergency room visits between 5/06/24 and 7/08/24, with notation of one UTI. The progress noted provided little to no information regarding assessment and recommendations/referrals. Tenant #2's record revealed several emergency room records, indicating emergency room visits for UTIs and/or problems with her indwelling catheter on 5/11/24, 6/08/24, 7/08/24, 7/16/24 and 8/06/24. According to a note by her Primary Care Physician (PCP) dated 6/13/24, a referral was made to home health care to manage the catheter. The note also listed a diagnosis of recurrent UTI. A PCP note documented 7/11/24 indicated Tenant #2 was being followed by home health care for Foley catheter care. On 8/20/24 at 11:40 a.m. Staff A said Tenant #2 wore a WanderGuard device around her neck. The device triggered the WanderGuard alarm system at the building exit doors. Staff A said Tenant #2 sometimes talked of leaving and tried to exit the building, but staff were alerted by the WanderGuard alarm. Staff A indicated the program had added the WanderGuard for Tenant #2 since she moved to the program. On 8/21/24 at 10:50 a.m. the Executive Director confirmed the program failed to complete a 90 day nurse review or nurse reviews as needed for change in condition, such as frequent UTIs/ER visits, addition of home health care services for catheter care or use of WanderGuard system due to attempted elopement/wandering.	A 430		
A 515	481-69.29(1) Staffing 69.29(1) Each tenant shall have access to a	A 515		

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 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS OF 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 515	Continued From page 17 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. This REQUIREMENT is not met as evidenced by: Based on interviews, the program failed to ensure a functional personal emergency response system. This potentially affected all 38 tenants residing at the Program. Finding follows: On 8/20/24 at 2:00 p.m. Staff B discussed an incident in late January 2024 when Tenant #1 used his personal pendant to summon staff, but the emergency response system did not work correctly at that time. The pendant alert was supposed to notify staff on their electronic tablets, but the application on the tablets did not work. The pendant alerts went only to a computer in the office area at the front of the building, which repeated a loud noise to alert staff. The noise from the computer could not be heard all over the building, especially when in tenant apartments. Staff B said by the time she heard the alert noise coming from the computer in the office area and checked it, she thought the screen showed at least ten minutes had passed since Tenant #1 had pressed the pendant. Staff B noted the emergency system continued to not work correctly and still did not alert staff on their tablets. On 8/21/24 at 8:50 a.m., Staff A confirmed the pendant alerts sent by the tenants did not notify staff on their electronic tablets. The alerts went only to a computer in the office area at the front of the building, which made a noise to notify staff. The computer noise could not be heard when staff were in tenant apartments. Staff A didn't	A 515		

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 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS OF 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 515	Continued From page 18	A 515		

recall how long the system had not worked correctly, but indicated it had been months.

On 8/21/24 at 11:30 a.m. Staff D and Staff E were interviewed together. Staff D said she thought the emergency response system last alerted staff on their tablets in December, 2023. Staff E said the emergency response system had not alerted staff tablets since she started working at the program in early May, 2024. Both staff said the pendant alerts when to the computer in the office area, which then issued a noise to notify the staff. They said staff could not hear the alert if away from the front of the building or in a tenant apartment.

On 8/21/24 at 10:50 a.m. the Executive Director (ED) verified ongoing problems with the tenant emergency response system. She said the issue of the tenant pendants not alerting staff electronic tablets first arose in December, 2023 when another company took over management of the program. She said the problem continued through at least January, but it was fixed for a period of time after January, until the program switched Internet providers in April or May of this year. Since the Internet switch, only the computer in the front office area received the alert sent when tenants pushed their pendants. The computer made a noise to alert the staff. The ED confirmed the noise issued from the computer could not be heard in tenant apartments or far hallways. She indicated she had been in contact with her corporation and information technology (IT) department to fix the problem, but it was not resolved. The ED indicated the expectation was for staff to respond to the pendant pages in five to seven minutes, but she was unable to track the response time since the system did not function correctly.

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 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS OF 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 515	Continued From page 19 On 8/21/24 at approximately 2:15 p.m. the ED was informed the program needed to develop and implement an immediate plan to ensure a functional tenant emergency response system. The ED submitted a plan to have a staff person remain in the front area of the building at all times to monitor the computer alerts. At approximately 3:15 p.m. the ER reported the corporation/IT department had fixed the electronic system and the staff tablets were receiving pendant alerts. This was verified by the on-site surveyor.	A 515		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: Prairie Hills Tipton	DATE SURVEY COMPLETED: 8/22/24

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1 A150	**Regulation and Reg Number** 481-67.2(3) Program Policies and Procedures A 150 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to follow established policy regarding use of wander management systems for 1 of 1 tenant reviewed who used a WanderGuard (Tenant #2).	**Tag #** A150	**What initial correction was made?** DHW and/or designee was educated on 9/26/24 and will be educated with all staff again on 10/26/24 Policy GP-16: Use of Wander Management System by 10/26/24 conducted by the Divisional Director of Resident Care. If an egress alert device, such as WanderGuard® or other egress alert device is to be worn, the resident's Service Plan will be updated to include the resident's behavior or conditions indicating the need for an egress alert device, the resident's physician recommendations, and resident notification of the egress alert device recommendation RN completed Tennent #2 evaluations to include functional, cognitive and health status and updated resident care plan to include the use of the Wander Guard System.	**How will we ensure and maintain compliance going forward?** Education was provided to all team members regarding the Wander Guard system on 09/26/2024 and will be completed again by the divisional nurse by 10/26/24. The DHW and/or designee will review and audit the residents' charts who use a wander guard system monthly to ensure evaluations and service plans include the use of the Wander Guard System along with resident's behavior or conditions indicating the need for an egress alert device, the resident's physician recommendations, and resident notification of the egress alert device recommendation. The audits will be ongoing while residents are utilizing the Wander Guard System.	**Implementation Date** 9/26/24 **Completion Date:** Ongoing **Responsible Party:** DHW or Designee

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Tag #2 A160	**Regulation and Reg Number** 481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure adequate care and services for 1 of 3 tenants reviewed (Tenant #2). Finding follows: On 8/19/24 and 8/20/24, record review revealed the program failed to provide adequate assessments and updated service plans for Tenant #2. (See regulatory insufficiencies cited at Iowa Administrative Code (IAC) 481 - 69.22(1), 69.22(2), 69.22(3), 69.26(1), 69.26(3), 69.26(3)(a) for additional information). The program failed to provide adequate nurse review and documentation regarding Tenant #2's health status, specifically ongoing issues with urinary tract infections (UTIs) and indwelling catheter. Tenant #2 went to the emergency room five times between 5/11/24 and 8/06/24 for UTIs and/or problems with her catheter. (See regulatory insufficiency cited at IA	**Tag #** A160	**What initial correction was made?** DHW will be educated on Policy AS01-Asessments by 10/26/24 conducted by the Divisional Director of Resident Care The resident Assessment are completed/updated: a. Prior to move-in. b. 30-days after move-in. c. Every six (6) months. d. Whenever there is significant change in resident status. Tenant #2 assessments and service plans were updated 09/22/24 by the DHW. Assessment system was updated to trigger assessments and service plans prior to move in, 30 days after moving in and every 6 months.	**How will we ensure and maintain compliance going forward?** DHW and/or designee will audit four resident's charts once per week for eight weeks to ensure all residents residing in the community have functional, cognitive and health status evaluations documented accurately along with the resident service plan. Once the initial audit is completed, resident charts will be audited on a quarterly basis.	**Implementation Date:** 10/04/24 **Completion Date:** Ongoing **Responsible Party:** DHW or Designee
Tag #3 **A135**	**Regulation and Reg Number** 481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior	**Tag #** **A135**	**What initial correction was made?** Tenant #2's cognitive evaluation was completed on 09/22/24 by the Director of Health and Wellness.	**How will we ensure and maintain compliance going forward?** DHW or designee will audit four resident's charts once per week for eight weeks to ensure all residents residing in	**Implementation Date:** 10/4/24

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	to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are A 160 A 135 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0213 (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING (X3) DATE SURVEY COMPLETED C 08/22/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRAIRIE HILLS OF 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		Assessment system was updated to trigger assessments and service plans prior to move in, 30 days after moving in and every 6 months. DHW will be educated on Policy AS01-Asessments by 10/26/24 conducted by Divisional Director of Resident Care The resident Assessment are completed/updated: a. Prior to move-in. b. 30-days after move-in. c. Every six (6) months. d. Whenever there is significant change in resident status.	the community have functional, cognitive and health status evaluations documented accurately. Once the initial audit is completed, resident charts will be audited on a quarterly basis.	**Completion Date:** ongoing **Responsible Party:** DHW or Designee

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	SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE A 135 Continued From page 6 available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete an adequate cognitive evaluation prior to occupancy for 1 of 3 tenants reviewed (Tenant #2)				
Tag #4 **A140**	**Regulation and Reg Number** 481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant	**Tag #** A140	**What initial correction was made?** DHW will be educated on Policy AS01-Asessments by 10/26/24 conducted by the Divisional Director of Resident Care. The resident Assessment are completed/updated: a. Prior to move-in. b. 30-days after move-in. c. Every six (6) months. d. Whenever there is significant change in resident status.	**How will we ensure and maintain compliance going forward?** DHW or designee will audit new move in charts within 30 days of move in to ensure all new residents residing in the community have functional, cognitive and health status evaluations documented within 30 days of move in. Once the initial audit is completed, resident charts will be audited a quarterly basis.	**Implementation Date:** 10/4/24 **Completion Date:** Ongoing

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	change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete evaluations for functional, cognitive and health status within 30 days of occupancy for 1 of 3 tenants reviewed (Tenant #2).		Tenant #2 30-day evaluation of the functional, cognitive and health status was completed on 09/22/24. Assessment system was updated to trigger assessments and service plans prior to move in, within 30 days of move in and every 6 months.		**Responsible Party:** DHW or designee
Tag #5 A145	**Regulation and Reg Number** 481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant A 135 A 140 A 145 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0213 (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING (X3) DATE SURVEY COMPLETED C 08/22/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRAIRIE HILLS OF TIPTON 219 SOUTH CEDAR STREET TIPTON, IA 52772 (X4) ID	**Tag #** A145	**What initial correction was made?** DHW will be educated on Policy AS01-Asessments by 10/26/24 conducted by the Division Director of Resident Care. The resident Assessment are completed/updated: a. Prior to move-in. b. 30-days after move-in. c. Every six (6) months. d. Whenever there is significant change in resident status. Tenant #2 evaluation was completed on 09/22/24 to reflect resident's change in condition.	**How will we ensure and maintain compliance going forward?** DHW and/or designee will audit four resident's chart once per week for eight weeks for changes to ensure all residents residing in the community have functional, cognitive and health status evaluations and service plans documented accurately. Once the initial audit is completed, resident charts will be audited on a quarterly basis.	**Implementation Date:** 10/4/24 **Completion Date:** 11/25/24 **Responsible Party:** DHW or Designee

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	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 8 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 assessments due to significant change for 1 of 3 tenants reviewed (Tenant #2)				

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Tag #6 A315	**Regulation and Reg Number** 481-69.25(1)n Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal A 145 A 315 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0213 (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING (X3) DATE SURVEY COMPLETED C 08/22/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRAIRIE HILLS OF 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	Tag #	**What initial correction was made?** Executive Director and Director of Health and Wellness will be educated on Policy DP-02 by 10/26/24. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative POA paperwork was for Tennant #1 and Tennant #2, obtained by the Executive Director on 09/20/2024.	**How will we ensure and maintain compliance going forward?** If a resident has a DPOA, POA, Guardianship, Legal Representative, or Attorney of healthcare. The paperwork will be obtained for a new move in at admission and maintained in the resident chart. DHW and/or designee will audit four resident's chart once per week for eight weeks to ensure all residents residing in the community have A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative. Once the initial audit is completed, resident charts will be audited on a quarterly basis.	**Implementatin Date:** 9/20/2024 **Completion Date:** Ongoing **Responsible Party:**

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	INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE A 315 A 350 Continued From page 10 representative This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to obtain documentation of legal representati				
Tag #7 **A350**	**Regulation and Reg Number** 481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for A 315 A 350 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0213 (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING (X3) DATE SURVEY COMPLETED C 08/22/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	**Tag #**	**What initial correction was made?** DHW will be educated on Policy AS05-Service Plans by 10/26/24 by the Division Director of Resident Care. Service Plans are created/updated: (1) a. Prior to or at the time of move-in. b. 30 days after move-in. c. Every six (6) months. d. Whenever there is significant change in resident status. Tenant #2 Service Plan was updated on 09/22/24. Assessment system was updated to trigger assessments and service plans prior to	**How will we ensure and maintain compliance going forward?** DHW or designee will audit four resident's charts once per week for eight weeks to ensure all residents residing in the community have functional, cognitive and health status evaluations and service plans documented accurately. Once the initial audit is completed, resident charts will be audited on an ongoing basis quarterly.	**Implementation Date:** 09/22/24 **Completion Date:** Ongoing **Responsible Party:** **DHW or Designee**

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	PRAIRIE HILLS OF 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 11 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 complete adequate evaluations prior development of a service plan for 1 of 3 tenants reviewed (Tenant #2)		move in, 30 days after moving in and every 6 months.		

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Tag #8 **A360**	**Regulation and Reg Number** 481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to update the initial service plan within 30 days of occupancy for 1 of 3 tenants reviewed (Tenant #2).	**Tag #**	**What initial correction was made?** DHW will be educated on Policy AS05-Service Plans by 10/26/24 by the Division Director of Resident Care**.** Service Plans are created/updated: (1) a. Prior to or at the time of move-in. b. 30 days after move-in. c. Every six (6) months. d. Whenever there is significant change in resident status. Tenant #2 Service Plan was updated on 09/22/24 by the DHW. Assessment system was updated to trigger assessments and service plans prior to move in, 30 days after moving in and every 6 months.	**How will we ensure and maintain compliance going forward?** DHW or designee will audit four resident's chart once per week for eight weeks to ensure all residents residing in the community have service plan that is individualized based on the resident's needs and preferences. Once the initial audit is completed, resident charts will be audited on an ongoing basis quarterly.	**Implementation Date:** 10/4/24 **Completion Date:** 11/25/24 **Responsible Party:** **DHW or Designee**
Tag #9 A370	**Regulation and Reg Number** 481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by	**Tag #**	**What initial correction was made?** DHW will be educated on Policy AS05-Asessments by 10/26/24 by the Division Director of Resident Care. Service Plans are created/updated: (1) a. Prior to or at the time of move-in. b. 30 days after move-in. c. Every six (6) months.	**How will we ensure and maintain compliance going forward?** DHW or designee will audit four resident's chart once per week for eight weeks to ensure all residents residing in the community have service plan that is individualized based on the resident's needs and preferences. Once the initial audit is completed, resident charts will be audited on an ongoing basis quarterly.	**Implementation Date:** 10/4/24 **Completion Date:** Ongoing

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	all parties. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to update service plans due to significant change for 1 of 3 tenants reviewed (Tenant #2)		d. Whenever there is significant change in resident status. Tenant #2 Service Plan was updated on 09/22/24 by the DHW. Assessment system was updated to trigger assessments and service plans prior to move in, 30 days within move in and every 6 months.		**Responsible Party:** DHW or Designee
Tag #10 A430	**Regulation and Reg Number** 481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of A 370 A 430 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0213 (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING (X3) DATE SURVEY COMPLETED C 08/22/2024	**Tag #**	**What initial correction was made?** DHW will educate on Policy AS05-Service Plans and Nurse Review by 10/26/24 conducted by Divisional Director of Resident Care Nurse Reviews: (3) a. Nurse reviews will be conducted by a registered nurse (RN). b. Any resident experiencing a significant change in condition will have a nurse review. i. Residents not receiving personal or health-related services who are observed having a significant change in condition will be assessed by a registered nurse. ii. Residents receiving personal or health-related services will be: 1. Monitored quarterly or after the change in condition for any adverse	**How will we ensure and maintain compliance going forward?** DHW or designee will audit four resident's charts once per week for eight weeks to ensure all residents residing in the community have a nurse review every 90 days. Once the initial audit is completed, resident charts will be audited on a quarterly basis.	**Implementation Date:** 10/4/24 **Completion Date:** Ongoing **Responsible Party:** DHW or Designee

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	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRAIRIE HILLS OF 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 430 Continued From page 15 each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete nurse reviews every 90 days and		reactions to medications and to make appropriate interventions. Assessment system was updated to trigger assessments and service plans prior to move in, 30 days after moving in and every 6 months. 2. Assessed for their health status and have recommendations and referrals made as needed. a. Implemented recommendations and referrals will be monitored for at least ninety (90) days for progress related to previous change in condition. Tenant #2 nurse review was completed on 09/22/24.		

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	as needed for change of condition for 1 of 3 tenants reviewed (Tenant #2				
Tag #11 A515	**Regulation and Reg Number** 481-69.29(1) Staffing 69.29(1) Each tenant shall have access to a A 430 A 515 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0213 (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING (X3) DATE SURVEY COMPLETED C 08/22/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRAIRIE HILLS OF TIPTON 219 SOUTH CEDAR STREET TIPTON, IA 52772 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY	**Tag #** A515	**What initial correction was made?** Executive Director and DHW will education on Policy DP17 by 10/26/24 provided by Divisional Director of Resident Care. All resident call systems are periodically inspected to ensure they are operating correctly in the event of an emergency. a. Pendants and wall alarms/resident alter call systems will be checked at least quarterly to ensure an alert is triggered when pressed/activated. i. If a resident's call system is not working properly, the Executive Director and Facilities Director are to be notified immediately. ii. Care Managers are to immediately notify their supervisor when communication devices are not working properly. The nurse call system was repaired on 09/21/24 and proper functioning verified.	**How will we ensure and maintain compliance going forward?** ED and/or designee with conduct weekly checks of the nurse call system to ensure proper function for the next 8 weeks and then periodically. In an instance of the nurse call system non-functioning, a staff member will be assigned to monitor the nurse call system and provide communication to other staff to respond to resident calls through the nurse call system.	**Implementation Date:** 9/21/2024 **Completion Date:** Ongoing **Responsible Party:** Executive Director or Designee

	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 515 Continued From page 17 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. This REQUIREMENT is not met as evidenced by: Based on interviews, the program failed to ensure a functional personal emergency response system. This potentially affected all 38 tenants residing at the Program.				

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