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
	S0222	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTEIN SENIOR LIVING	1500 SOUTH KIEL HOLSTEIN, IA 51025

(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 type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 14 Number of tenants with cognitive impairment: 12 Total census: 26 No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia. The following regulatory insufficiencies were cited during the investigation of Complaint 119928-C.	A 000	See Attached POC 4/11/24	
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 consistently ensure tenants received services which were adequate and appropriate. This pertained to 1 of 1 tenant (Tenant #1) with identified skin issues. Finding	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0222	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTEIN SENIOR LIVING	1500 SOUTH KIEL HOLSTEIN, IA 51025

(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 160	Continued From page 1 follows: Record review on 4/8/24 revealed an Incident Report (IR) for Tenant #1 dated 3/27/24. Tenant #1 complained of her "bottom" hurting. The nurse completed an assessment/evaluation and noted pink/red/moist inner gluteal fold. Order received for Calmoseptine cream on 3/27/24. Further record review revealed Tenant #1's March medication administration record (MAR) indicated staff administered Calmoseptine on 3/28/24 at 8:00 p.m., 3/29/24 at 8:00 a.m. and p.m. and 3/30/24 at 8:00 a.m. Record review on 4/8/24 revealed Tenant #1's service plan directed staff to provide extensive assistance during toileting and bathing twice a week. Record review on 4/8/24 revealed Tenant #1's monthly task log for bathing/showering. On 3/18/24 staff noted Tenant #1 refused her shower many times. On 3/25/24 staff noted she did not get to Tenant #1's room until 7:00 a.m. and planned to assist after breakfast but didn't get the bath completed. Staff failed to complete Tenant #1's shower on 3/18/24 and 3/25/24 as directed. During interviews on 4/8/24 and 4/9/24 staff stated on 3/30/24 they reported concerns Tenant #1 had become weaker than normal and had darker urine. The nurse contacted Tenant #1's family who transported her to the emergency room (ER). The hospital admitted Tenant #1 where she had surgery for a stage 4 sacrum ulcer. When interviewed on 4/8/24 at 3:25 p.m. Staff A confirmed he assisted Tenant #1 to the toilet and noticed redness after the nurse brought it his attention and informed staff about the	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0222	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTEIN SENIOR LIVING	1500 SOUTH KIEL HOLSTEIN, IA 51025

(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 160	Continued From page 2 Calmoseptine order on 3/27/24. When interviewed on 4/8/24 at 3:25 p.m. Staff B confirmed she assisted Tenant #1 to the toilet and shower and noticed redness once it was brought to staffs' attention on 3/27/24. She said she applied calmoseptine as ordered after she assisted with toileting. She described placing the ointment on a glove and wiping up ward in Tenant #1's buttocks crack (intergluteal cleft). When interviewed on 4/9/24 at 9:36 a.m. Staff C said she observed Tenant #1's coccyx area on 3/30/24 after staff asked her to assist with Tenant #1 who seemed weaker than normal and had darker urine. She noted a wound the size of a quarter and appeared black. She said she assumed the staff who contacted nurse informed her of the suspect wound. She did not speak to the Program nurse directly. Review of notes on 4/8/24 revealed a notation by the nurse of the hospital inquiring about treatment for the open area on sacral/coccyx area. The nurse explained the area the Program had treated was not an open area. Further review revealed the following medical care provided; debridement of the stage 4 ulcer of the necrotic sacrum ulcer and intravenous antibiotics. The medical report noted the wound care nurse felt the ulcer was getting close to the rectum. The physician felt further debridement was needed and this was a terminal event. Due to rapid decline hospice was initiated for comfort care. When interviewed on 6/12/24 at 2:00 p.m. the wound care nurse felt the ulcer was caused by pressure. She stated the physician at the time of evaluation had ruled out a Kennedy ulcer.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0222	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTEIN SENIOR LIVING	1500 SOUTH KIEL HOLSTEIN, IA 51025

(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 160	Continued From page 3 When interviewed on 6/13/24 at 11:50 a.m. Physician A said the result of the wound could not be determined definitively. He said he could not "rule out" a Kennedy ulcer. He added the team made the decision to make the tenant comfortable and initiate hospice instead of aggressively treating the ulcer. He acknowledged an assisted living may not have been aware of deterioration of the area if they were not observing closely. Record review on 6/19/24 revealed a description of a Kennedy ulcer from National Institutes of Health (NIH). The document provided the following information; "The Kennedy Terminal Ulcer (KTU) is an unavoidable skin breakdown which occurs in some patients as part of the dying process. It often appears on the sacrum or coccyx, but can appear elsewhere." The article said the "KTU appears to be a part of multiorgan system failure and end-stage disease." When interviewed on 6/18/24 at 7:55 a.m. Physician B said she could not provide any additional information to determine the source of the ulcer. She said she did not know what a Kennedy ulcer was. Review of Tenant #1's record on 4/9/24 revealed an occupancy date of 11/15/21. Tenant #1's Global Deterioration Scale score was four (moderate cognitive decline). When interviewed on 4/9/24 at 12:30 p.m. the administrative staff acknowledged the Program failed to provide and/or document the provision of services identified in the service plan. This included administration of ordered medication in a timely manner.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0222	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTEIN SENIOR LIVING	1500 SOUTH KIEL HOLSTEIN, IA 51025

(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	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently complete nurse review of health status and efficacy of physician ordered treatment. This pertained to 1 of 1 tenant with a sacral ulcer (Tenant #1). Findings follow: Record review on 4/8/24 revealed an Incident Report (IR) for Tenant #1 dated 3/27/24. Tenant #1 complained of her "bottom" hurting. The nurse completed an assessment/evaluation and noted reddened, moist area inner gluteal fold at sacral area. She reported this to the Advanced Registered Nurse Practitioner (ARNP) who was on site at the Program to see another tenant. The ARNP did not observe the reddened area. On 3/27/24 the Program received an order for Calmoseptine two times a day. Further record review revealed Tenant #1's March medication administration record (MAR). Staff administered Calmoseptine on 3/28/24 at 8:00 p.m., 3/29/24 at	A 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0222	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTEIN SENIOR LIVING	1500 SOUTH KIEL HOLSTEIN, IA 51025

(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 5 8:00 a.m. and p.m. and 3/30/24 at 8:00 a.m. When interviewed on 4/8/24 the Program's nurse confirmed the nurse practicioner ordered Calmoseptine but did not observe the area while in the building seeing another tenant. She also confirmed she failed to complete additional evaluation of the area. She stated she observed the area on 3/27/24 and appeared as documented in Tenant #1's notes. The Program failed to provide an explanation of delay in obtaining Calmoseptine as ordered. During interviews on 4/8/24 and 4/9/24 staff said on 3/30/24 they reported concerns Tenant #1 had become weaker than normal and had darker urine. The nurse contacted Tenant #1's family who transported her to the emergency room (ER). Record review on 6/13/24 revealed the Program nurse noted on 3/30/24 staff reported Tenant #1 very tired and wouldn't sit up. Staff assist to transfer and darker than usual urine. Nurse encouraged fluids. Reported info to the POA and recommended Tenant #1 be taken to emergency room (ER) for assessment. POA in agreement. Further review revealed the Program Nurse noted on 4/1/24 a report obtained from hospital nurse - debridement procedure performed 3/30/24 on gluteal fold, intravenous antibiotics and plan to be seen by wound care nurse 4/1/24. An additional notation documented hospital staff questioned treatment orders for area on sacral/coccyx area. Hospital staff questioned the order for Calmoseptine for an open area. The Program nurse documented the observations did not revealed an open area. When interviewed on 6/13/24 at 11:50 a.m.	A 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0222	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTEIN SENIOR LIVING	1500 SOUTH KIEL HOLSTEIN, IA 51025

(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 6 Physician A said the origin of the wound could not be determined definitively. He said he could not "rule out" a Kennedy ulcer. He added the team made the decision to make the tenant comfortable and initiate hospice instead of aggressively treating the ulcer. He acknowledged an assisted living may not have been aware of deterioration of the area if they were not observing closely. Record review on 6/19/24 revealed a description of a Kennedy ulcer from National Institutes of Health (NIH). The document provided the following information: "The Kennedy Terminal Ulcer (KTU) is an unavoidable skin breakdown which occurs in some patients as part of the dying process. It often appears on the sacrum or coccyx, but can appear elsewhere." The article said the "KTU appears to be a part of multiorgan system failure and end-stage disease." When interviewed on 6/18/24 at 7:55 a.m. Physician B said she could not provide any additional information to determine the source of the ulcer. She said she did not know what a Kennedy ulcer was. When interviewed on 6/18/24 the Director acknowledged the Program failed to complete a nurse review to determine efficacy of the prescribed treatment (Calmoseptine).	A 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0222	DATE SURVEY COMPLETED: 4/09/2024

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Regulation and Reg Number** **481-67.3(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 consistently ensure tenants received services which were adequate and appropriate. This pertained to 1 of 1 tenant, (Tenant #1) with identified skin issues.	**Tag #** A160	**What initial correction was made?** Staff training completed on 4/11/24 on: Tenant Rights, Service Plans, Task Completion and documentation, Showers/Baths (schedule and refusals), skin care, Incontinence Care, Medication Management, and Nurse Communication. Skin assessments will be completed for all residents residing in the community by 7/24/2024. The Nurse, at the time of this survey is no longer employed by the community as of: 4/5/2024 The new Community Nurse as of 4/1/2024, received training on 4/11/2024 on Tenant Rights, Service Plans, Task Completion and documentation, Showers/Baths (schedule and refusals), skin care, Incontinence Care, Medication Management, Nurse Review, Change of Condition assessments, and Nurse Communication.	**How will we ensure and maintain compliance going forward?** Upon hire all care staff will be trained in: Tenant Rights, Service Plans, Tasks documentation, and Communicating resident condition/changes with the nurse. Upon admission and as needed, skin assessments will be completed by the nurse, with change of condition assessments completed as needed. Education completed with the new Community Nurse related to skin changes, Bathing, Nurse Review, Skin assessments, and change of condition assessments upon hire. Director, Nurse or Designee will ensure Bathing schedule and Task completion are appropriate, weekly, monthly, as needed, as determined by the Director, Nurse, of Designee.	**Implementation Date: 4/11/2024** **Completion Date:** Ongoing **Responsible Party:** Director or Designee
Tag# 2	**481-69.27(1)c Nurse Review**	**Tag#** **A 430**	**What initial correction was made?** Staff training completed on 4/11/24 on: Tenant Rights, Service Plans, Task	**How will we ensure and maintain compliance going forward?**	**Implementation Date: 4/11/2024**

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.

	69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently complete nurse review of health status and efficacy of physician ordered treatment. This pertained to 1 of 1 tenant with a sacral ulcer (Tenant #1).		Completion and documentation, Showers/Baths (schedule and refusals), skin care, Incontinence Care, Medication Management, and Nurse Communication. Skin assessments will be completed for all residents residing in the community by 7/24/2024. The Nurse, at the time of this survey is no longer employed by the community as of: 4/5/2024 The new Community Nurse as of 4/1/2024, received training on 4/11/2024 on Tenant Rights, Service Plans, Task Completion and documentation, Showers/Baths (schedule and refusals), skin care, Incontinence Care, Medication Management, Nurse Review, Change of Condition assessments, and Nurse Communication.	Upon hire all care staff will be trained in: Tenant Rights, Service Plans, Tasks documentation, and Communicating resident condition/changes with the nurse. Upon admission and as needed, skin assessments will be completed by the nurse, with change of condition assessments completed as needed. Education completed with the new Community Nurse related to skin changes, Bathing, Nurse Review, Skin assessments, and change of condition assessments upon hire. Director, Nurse or Designee will ensure Bathing schedule and Task completion are appropriate, weekly, monthly, as needed, as determined by the Director, Nurse, of Designee. .	**Completion Date:** Ongoing **Responsible Party:** Director or Designee

Compliance Date: 8/1/2024

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.