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
	S0243	A. BUILDING: _____ B. WING _____	C 05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

(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: 29 Number of tenants with cognitive disorder: 6 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 11 Total Census: 46 The following regulatory insufficiencies were cited during the investigation into Complaints #104609-C and #103783-C.	A 000	The Plan of Correction is attached.	
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 observation, interview and record review the program failed to ensure appropriate care and services were provided regarding belongings of tenants. Findings follow:	A 160		

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A 160	Continued From page 1 A tour of the memory care unit on 5/17/22 at 10:15 AM revealed a drawer in the common area with 10 pairs of eye glasses. A tour of the program's two laundry areas, revealed there were no unclaimed tenant items in the 500 hall laundry area. There were 2 baskets of unclaimed sheets and tenant clothing in the main laundry room. An interview with Staff B on 5/11/22 at 10:10 AM revealed she was able to get tenants' laundry completed on her shift. However she reported at times there were entire piles of laundry on the unit and no one knew to whom they belonged. When staff started using the washer and dryer in the 500 hallway, tenants lost additional belongings. There had been a number of tenants' sheets in the 500 hallway laundry room and no one knew who they belonged to. One tenant lost a $400 cushion. Tenant #2 lost her glasses and dentures. Two other tenants lost one lens out of their glasses. On 5/9/22 at 1:35 PM, Staff C reported there were significant issues with tenants' laundry. Tenants' clothing and sheets often got lost and were not returned to them. Tenants' glasses and dentures got lost all of the time and were not returned to them. On 5/11/22 at 3:20 PM, Staff D stated multiple tenants complained of losing clothing, sheets and blankets. Staff D believed these items ended up in others tenants' apartments. She said tenants' glasses were always getting lost. On 5/10/22 at 10:55 AM, Staff E thought laundry was generally misplaced, not lost. She said there	A 160		

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A 160	Continued From page 2 was a closet full of items they did not know who they belonged to. Staff E also said there was a drawer with about 20 pairs of tenants' glasses. On 5/11/22 at 1:55 PM, Staff F commented when laundry went missing, it generally found it's way back to the owner. She had not heard of sheets going missing. Staff F said tenants' glasses went missing all of the time. The Portfolio Leader confirmed these findings on 5/18/22 at 3:00 PM.	A 160		
A 325	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the program failed to have a sufficient number of trained staff available to fully meet tenants' identified needs, potentially affecting all tenants (census of 46). Findings follow: 1) Observation on the memory care unit on 5/11/22 from 12:30 PM - 12:39 PM revealed there were five tenants in the dining room with no staff present during this time. One tenant had his wife present and feeding him lunch. Tenant #2 was in the dining room and got out of her wheelchair unassisted at 12:36 PM, walking around the dining room table (Tenant #2 was a 1 person assist with transfer/ambulating according to her service plan). Tenant #5 also started walking around the dining room without her walker at	A 325		

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A 325	Continued From page 3	A 325		

12:36 PM (Tenant #5 had a history of falls and staff were to encourage her to use her walker according to her service plan). Throughout this time period, Tenant #6 was attempting to locate food on her plate. She continually moved her fork around her plate in a circular movement. At 12:37 PM, Tenant #6 started to make a low, moaning sound. Two staff came out of the same apartment at 12:39 PM to assist the tenants.

At 12:50 PM, the monitor entered the Health Care Coordinator's office to report what she witnessed. The Health Care Coordinator reported Tenant #6 required hand over hand assistance with eating. The Health Care Coordinator reported there probably needed to be three staff in the memory care unit due to the acuity of the tenants' needs.

The monitor returned to the memory care unit at 1:00 PM to watch staff administer medication to tenants. One staff member was in Tenant #3's room. Additional staff were not sent to the memory care unit to assist the tenants or staff.

At 1:00 PM, a staff member assisted Tenant #6 to eat her lunch. At 1:08 PM, the staff member went to administer medication to Tenant #4 in her apartment. When the staff member and monitor exited Tenant #4's apartment, Tenant #2 was out of her wheelchair, walking in the hall.

The staff member returned to Tenant #4's apartment for a few minutes with the monitor. When the staff member and monitor exited again at 1:12 PM, Tenant #2 was again out of her wheelchair with a skin tear and blood visible on her arm.

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A 325	Continued From page 4 2) Review of a service plan for Tenant #1 dated 12/30/21 revealed safety checks were to be performed 8 times per shift by staff. A review of Documentation Survey Reports for 1/2022 - 2/2022 revealed safety checks were not provided according to Tenant #1's service plan on the following dates: 1/2, 1/3, 1/4, 1/6, 1/7, 1/10, 1/12, 1/17, 1/19, 1/20, 1/22, 1/23, 1/24, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/2, 2/4, 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/14, 2/15, 2/16, 2/17,2/19, 2/22, 2/25 and 2/27. Tenant #1's service plan identified he needed assistance to use the toilet and maintain bladder continence. He was incontinent of bladder and needed reminders to use the toilet. Staff were to either assist Tenant #1 with using and emptying his urinal or dispose of used incontinent products. The continence team was to assist Tenant #1 to the toilet and provide incontinence care four times per shift when he was awake. Tenant #1 preferred to wake up at 11:00 AM and go to bed at midnight. A review of the Documentation Survey Reports for 1/2022 - 2/2022 revealed the continence team did not provide care four times per shift on the following dates: 1/7, 1/17, 1/20, 1/22, 1/23, 1/24, 1/26, 1/30, 1/31, 2/4, 2/5, 2/6, 2/10, 2/14 and 2/22. 3) Tenant #2 had a Service Plan dated 10/22/21. According to her service plan, Tenant #2 was supposed to receive safety checks for falls 16 times per shift. She had a history of falls. Tenant #2 was a one-person assist with transfers and ambulating. A review of Tenant #2's Documentation Survey Reports were reviewed for the months of 12/2021 - 2/2022, Tenant #2 did	A 325		

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not receive safety checks according to her service plan on 12/2, 12/3, 12/5, 12/10, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/21, 12/23, 12/29, 12/30, 1/3, 1/4, 1/6, 1/13, 1/17, 1/19, 1/20, 1/22, 1/23, 1/24, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/1, 2/4, 2/6, 2/9, 2/10, 2/11, 2/14, 2/15, 2/16, 2/17, 2/22, 2/19 and 2/25.

Tenant #2's service plan noted she was incontinent of bladder infrequently. Four times a shift when Tenant #2 was awake, staff were to remind her to use the toilet. Staff needed to provide hands on assistance. There was no notation on the December, 2021 Documentation Survey Report on the frequency of assistance Tenant #2 received with continence cares. For 1/2022 - 2/2022, the Documentation Survey Reports identified Tenant #2 did not receive staff assistance four times every shift on 1/22, 1/31, 2/4, 2/6, 2/9, 2/10, 2/11, 2/14, 2/19 and 2/23.

4) Tenant #3 had a service plan dated 9/23/21. Her service plan indicated she had a history of falls and was on safety checks every hour. Safety checks were not documented on Tenant #3's Documentation Survey Reports for December 2021 or January 2022. In February 2022, safety checks were not conducted per Tenant #3's service plan on 2/1, 2/2, 2/3, 2/4, 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/14, 2/15, 2/16, 2/17, 2/19, 2/22 and 2/25.

Tenant #3's service plan noted she was to receive showers twice weekly and as needed. Staff were to assist Tenant #3 by cueing her and washing and drying hard to reach areas. A review of the Documentation Survey Report for December 2021 revealed Tenant #1 received no showers. She did refuse one shower. The

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A 325	Continued From page 6 Documentation Survey Report for January 2022 revealed Tenant #3 refused four showers. Skin assessment sheets revealed she received two showers in January 2022 - on 1/6 and 1/13. Documentation Survey Reports for February 2022 revealed Tenant #3 received two showers that month. 5) Tenant #4 had a service plan dated 11/23/21. She was to receive 24-hour supervision and visual checks as she lived in the memory care unit. Tenant #4 was at risk for falls due to a seizure disorder and her age. According to the 12/2021 - 2/2022 Documentation Survey Reports, Tenant #4 was to receive safety checks eight times per shift. Safety checks were not carried out as scheduled on 12/2, 12/3, 12/5, 12/10, 12/12, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/21, 12/23, 12/29, 12/30, 1/3, 1/4, 1/6, 1/10, 1/12, 1/14, 1/17, 1/19, 1/20, 1/22, 1/23, 1/24, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/2, 2/4, 2/5, 2/6, 2/9, 2/10, 2/11, 2/12, 2/14, 2/15, 2/16, 2/17, 2/19, 2/22, 2/25 and 2/27. 6) Former Tenant C2 had a service plan dated 3/11/21. According to her service plan, Tenant C2 was at risk for falls due to weakness and cognition. Tenant C2 was on safety checks for falls eight times a shift. A review of the Documentation Survey Reports for 1/2022 - 3/2022 revealed Tenant C2 did not receive safety checks according to her service plan on 1/3, 1/4, 1/5, 1/7, 1/6, 1/10, 1/12, 1/14, 1/17, 1/19, 1/20, 1/22, 1/23, 1/24, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/4, 2/5, 2/6, 2/10, 2/11, 2/14, 2/15, 2/16, 2/17, 2/19, 2/22, 2/25, 3/5, 3/16, 3/17, 3/20, 3/22, 3/28, 3/29, 3/30 and 3/31. Tenant C2's service plan noted she needed	A 325		

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assistance with bathing or showering twice a week and as needed. Staff were to provide assistance with set up, transfers and steadying in and out of the shower. Staff were also to help Tenant C2 to wash, dry, and shampoo/rinse/dry her hair. Program documentation revealed Tenant C2 received showers in January 2022 on 1/6, 1/11, 1/13 and 1/28. The Documentation Survey Reported identified Tenant C2 received one shower in February 2022. The Documentation Survey Report revealed Tenant C2 received four showers in March 2022.

7) Former Tenant C3 had a service plan dated 8/9/21. Tenant C3 received 24 hour supervision and visual checks because she lived in the memory care unit. She received safety checks 8 times per shift. A review of the Documentation Survey Reports for 1/2022 - 3/2022 revealed Tenant C3 did not receive safety checks according to her service plan on 1/3, 1/4, 1/6, 1/7, 1/17, 1/19, 1/20, 1/22, 1/23, 1/24, 1/26, 1/28, 1/29, 1/30, 1/31, 2/1, 2/4, 2/5, 2/6, 2/9, 2/10, 2/11, 2/14, 2/15, 2/16, 2/17, 2/19, 2/22, 3/5, 3/16, 3/17, 3/20 and 3/22.

8) On 5/12/22 at 1:50 PM, Staff A reported she generally was assigned to work on the memory care unit by herself on the weekends. She did not find these to be safe working conditions.

On 5/11/22 at 10:10 AM, Staff B reported she was never assigned to work on the memory care unit by herself, but on the weekends there was usually just one person working. She reported there needed to be three people to safely provide toileting assistance for one of the tenants.

On 5/9/22 at 1:35 PM, Staff C stated it was

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unsafe to have only two staff members assigned to the memory care unit due to some tenants' combative behaviors and need for two-person assists.

On 5/11/22 at 3:20 PM, Staff D stated there needed to be two people assigned to the memory care unit, but three would be better, especially to meet the needs of Tenant #1.

On 5/10/22 at 1:55 PM, Staff F reported they are able to get by with two staff members but there some days when they need three staff to complete tasks such as showers.

On 5/10/22 at 2:25 PM, Staff G said when the memory care unit was fully staffed, she was able to provide continence care to tenants according to their plan. About once per week, she would come in to work and find tenants with their incontinence undergarments soaked.

9) On 5/18/22, three tenants expressed concern about the length of time it took staff to respond to their needs when they pushed their pendants for assistance. Tenant #8 reported at 10:15 AM the prior Monday she experienced an episode of hypoglecemia and pressed her pendant to ask staff for orange juice. When staff arrived after 15-20 minutes, they told her they did not immediately receive her page because there were dead zones in the building where pages were not transmitted to the staff's IPads. At 2:10 PM, Tenant #9 said the longest she had to wait for assistance was about 50 minutes. Tenant #9 sat in on a tenant meeting with the Portfolio Leader, who informed her the longest she would have to wait for staff to answer a page was 7 minutes. Tenant #9 utilized a motorized scooter.

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She said there were times she contacted staff 30 minutes before leaving the building for assistance getting her walker to the front door on her scooter, but no one showed up, so she had to try and carry the walker on her scooter to the front door. When staff did not show up, no one turned off the "page" on her pendant. At 2:25 PM, Tenant #10 reported she has had to wait over an hour for staff to come to provide assistance on 5/8/22. She produced a magnet to show the monitor. Tenant #10 now turns off her own pendant when she is tired of waiting for staff to assist her. Tenant #10 wore bulky braces on her legs. She stated at times she would put them back on, get out of bed and get the ice pack or needed item and return to bed rather than wait long periods of time for staff to come to her apartment.

On 5/18/22 at 10:45 AM, Staff I confirmed there were parts of the building which were dead zones. She said there were areas in the dining room, memory care unit and the dining room in which staff IPads did not receive pages.

The Clinical Care Coordinator reported on 5/18/22 at 1:50 PM staff should respond to pages within 5 minutes, but regulation allowed up to 15 minutes.

The Program provided a 79 page Device Activity Report which listed each time a pendant was pushed from 5/1/2022 to 5/17/2022. There appeared to be some duplicates (many entries had pendants being pushed at the same time and date for the exact same period of time) and there were pendants entries for discharged tenants. However, there were 61 pages of pendants answered in under 15 minutes (17

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A 325	Continued From page 10 entries per page), leaving a large number of pages answered outside an acceptable time frame. Time frames varied from 15 minutes, 7 seconds to 939 minutes. It seemed probable the 23 entries over 100 minutes occurred when a tenant left the building and the page was not cleared. 10) On 5/18/22 at 3:00 PM, the Portfolio Leader confirmed these findings related to staffing. She reported the Chief Operating Officer directed her to get an expedited bid to fix the pager system.	A 325		
A 155	481-69.23(1)b Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 1 of 4 current tenants reviewed who required two staff to assist with transfers (Tenant #1). Findings follow: Record review on 5/11/22 revealed Tenant #1 was diagnosed with Alzheimer's disease, hemiplegia (unspecified, affecting his left nondominant side), osteoarthritis and a history of falling. Tenant #1 was at risk for falls due to his unsteady gait and history of dementia. Tenant #1's service plan, dated 5/3/22, indicated he was ambulatory with staff assistance. He had a	A 155		

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A 155	Continued From page 11 history of falls and staff were to monitor Tenant #1 for changes in his mobility. He needed escorts to and from activities and the dining room due to his cognitive functioning level. On 5/12/22 at 10:25 AM, Staff A reported Tenant #1 was definitely a 2-person assist with transfers. He had especially poor balance in the morning, which made it hard to get him from his chair to a standing position. She also commented Tenant #1 punched and hit at staff which added to the difficulty with helping him from a sitting to standing position. On 5/11/22 at 10:10 AM, Staff B reported Tenant #1 was a 2-person assist with transfers. On 5/9/22 at 1:35 PM, Staff C said she would not transfer Tenant #1 by herself as it was unsafe. She added Tenant #1 would punch her if she tried to transfer him by herself. On 5/10/22 at 3:20 PM, Staff D stated she thought there needed to be three staff to assist with helping Tenant #1 to the toilet. He required two staff to help him stand and another staff to help pull his incontinence undergarment and pants down. On 5/12/22 at 12:35 PM, the Clinical Coordinator reported she accompanied two staff members to see if they could assist Tenant #1 with transferring alone. She confirmed Tenant #1 could not transfer from a sitting to a standing position with only one staff member. The Clinical Care Coordinator confirmed Tenant #1 exceeded the program's level of care.	A 155		

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(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 12	A 160		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the program retained 1 of 4 residents reviewed who, despite intervention, displayed unmanageable physical aggression (Tenant #4). Findings follow: Record review on 5/11/22 revealed Tenant #4 had a service plan dated 2/21/22. The service plan directed staff to approach Tenant #4 carefully and slowly if she was upset. They were to attempt to distract her with activities or ask about her family. They could call her family or the on-call nurse to speak with Tenant #4. Tenant #4 was noted to have mild to moderate disorientation and required cueing at times. Staff were to use a calm voice when speaking with her. She had demonstrated deficits in judgement related to her safety. She had a history of paranoia and previously used a cane and walker as a weapon.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0243	A. BUILDING: _____ B. WING _____	C 05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

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A 160	Continued From page 13 It was noted Tenant #4 could be resistive to cares. She had become physically aggressive with staff. Tenant #4 had medication she could take for breakthrough behaviors. Staff were to make three attempts at redirection before using these medications. On 5/12/22 at 10:25 AM, Staff A reported Tenant #4 was aggressive toward staff on a daily basis. On 5/11/22 at 10:10 AM, Staff B stated Tenant #4 wouldn't allow staff to assist her with showering and she took her clothing off all the time. If staff tried and assist her with dressing, Tenant #4 ripped her clothing off and grabbed your hands hard. Staff B reported Tenant #4 hit staff daily. On 5/10/22 at 10:55 AM, Staff E said Tenant #4 walked around the unit unclothed. Tenant #4 also hit, kicked and spit daily. She swore at staff and tenants several times daily. The Portfolio Leader confirmed these findings on 5/18/22 at 3:00 PM.	A 160		
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 observation, interview and record	A 350		

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	S0243	A. BUILDING: _____ B. WING _____	C 05/18/2022

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PRAIRIE HILLS AT CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

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A 350	Continued From page 14 review the program failed to update the service plans as needed for 3 of 7 tenants reviewed (Tenants #3, #4, #7). Findings follow: 1) Record review on 5/10/22 revealed Tenant #3 had service plans dated 1/7/22 and 4/7/22. According to both service plans, Tenant #3 preferred showers twice weekly and as needed with the assistance of 1 staff member. The staff member was to provide cueing, washing and drying of hard to reach areas. Staff were to to help Tenant #3 with transferring in and out of the tub as well as shampooing, rinsing and drying her hair. A review of the Documentation Survey Report for December 2021 revealed Tenant #3 received no showers. She did refuse one shower. The Documentation Survey Report for January 2022 revealed Tenant #3 refused four showers. Skin assessment sheets revealed she received two showers in January 2022 - on 1/6 and 1/13. Documentation Survey Reports for February 2022 revealed Tenant #3 received two showers that month. On 5/11/22 at 10:10 AM, Staff B reported Tenant #3 refused her showers. On 5/10/22 at 10:55 AM, Staff E reported Tenant #3 refused cares and often went over a week without taking a shower. On 5/10/22 at 1:55 PM, Staff F stated Tenant #3 refused showers. Interventions to encourage Tenant #3 to take showers were not on her service plan although this was an ongoing issue, dating back to	A 350		

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A 350	Continued From page 15 January 2022. 2) Tenant #4 had a service plan dated 5/9/22. The service plan indicated Tenant #4 required assistance or repetitive verbal cues to complete dressing. Staff were to lay out clothes for Tenant #4 to change in to. She required minimal physical assistance with tying her shoes, obtaining clothes from her closet or putting on a coat. Staff were to assist Tenant #4 as needed with dressing and undressing. An addendum to Tenant #4's service plan dated 5/9/22 noted it would take staff 2 minutes a day, 7 days a week to assist Tenant #4 with dressing. On 5/17/22 at 10:15 AM, the monitor observed Tenant #4 in the main living room of the memory care unit without a shirt or bra on. Staff reported she had been removing her shirt throughout the morning even though they provided verbal and physical assistance to Tenant #4 to put her shirt back on. There were two other tenants in the living room who appeared to be sleeping. On 5/12/22 at 10:25 AM, Staff A reported Tenant #4 was undressed, but in her apartment. Earlier in the day she was running up and down the halls naked, which got the other tenants upset. On 5/11/22 at 10:10 AM, Staff B stated Tenant #4 removed her clothing all the time. When she attempted to help the tenant dress, she ripped the clothing away and grabbed Staff B's hands hard. On 5/9/22 at 1:35 PM, Staff C said Tenant #4 removed her clothing and ran down the halls naked often, which got everyone in an uproar.	A 350		

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A 350	Continued From page 16 On 5/10/22 at 10:55 AM, Staff E reported Tenant #4 walked around the unit unclothed several times daily. Tenant #4's service plan did not include interventions to address the removal of clothing in public areas or walking around the unit without clothing on. 3) Record review for Tenant #7 on 5/5/22 revealed a progress note dated 5/2/22 in which a staff reported to the RN there was a suspicion of adult abuse. There were concerns about the tenant's behavior and not wanting to use the restroom. A change of condition service plan was written for Tenant #7 on 5/3/22 due to concerns of potential adult abuse. Tenant #7 had severe memory loss and a diagnosis of dementia. The service plan noted Tenant #7 attempted to dress himself, but needed assistance with appropriateness. Tenant #7 required assistance and repetitive verbal cues to complete dressing. He required assistance from one staff person for all dressing, but was to do as much as he could on his own. Tenant #7 also required assistance to maintain bladder continence. He was incontinent of bladder and sometimes of bowel. Staff were to take him to the bathroom. There were times when he needed to urinate, but did not want to physically enter the bathroom to use the toilet. Staff were to apply barrier cream to Tenant #7's rectum and peri area for redness. Tenant #7 used incontinence products which were to be checked and changed four times a shift when he was awake.	A 350		

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A 350	Continued From page 17 On 5/5/22 at 12:35 PM, Staff A reported it took a great deal of convincing to get Tenant #7 dressed the morning of 5/3/22. Generally, Tenant #7 got up fine. That morning, she and a co-worker walked him to the restroom and asked him to pull down his brief. Tenant #7 took off running from the bathroom. It took several minutes to convince him to return to the bathroom and use the toilet. On 5/5/22 at 2:30 PM, Staff D reported when she began working at the program, Tenant #7 used the toilet by himself. Over the prior three weeks, Tenant #7 started jabbing at her when she tried to take down his pants to assist him to use the toilet. His guard was up. Tenant #7 also did not like her to try and help take his shirt off. These were new behaviors. On 5/5/22 at 2:05 AM, Staff H said she noticed a decline in Tenant #7's behavior over the prior 3 to 4 weeks. When she was helping Tenant #7 to bed and pulled down his pants he yelled, which he had not done before. Tenant #7's service plan did not address interventions staff should use when assisting with dressing or undressing him due to the change in his behavior. 5) The Portfolio Leader confirmed these findings on 5/18/22 at 3:00 PM.	A 350		

PRAIRIE HILLS
CLINTON
ASSISTED LIVING AND MEMORY CARE

06/03/2022

Prairie Hills at Clinton: Investigation #103783-C, #104609-C

Iowa Department of Inspections and Appeals
Health Facilities Division
Lucas State Office Building
321 East 12th St.
Des Moines, IA 50319-0083

To Whom It May Concern:

Please consider this as our plan of correction for the Statement of findings/violations cited during 05/05/2022-05/18/2022 complaint investigation completed by the Iowa Department of Inspections and Appeals in accordance with the Code 295.1090.

A. 481-67.3(2) Tenant Rights: Tenant rights. All tenants have the following rights: to receive care, treatment and services which are adequate and appropriate.

1. Elements detailing how the program will correct the statement of findings/violations.
    a. Staff education will be completed on properly completing residents' laundry including labeling during the process and returning to the appropriate resident in a timely manner.
    b. A process will be put into place for lost and found items for each resident, including reporting these items to the director or designee.

2. What measures will be taken to ensure the problem does not recur?
    a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

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

1. Elements detailing how the program will correct the statement of findings/violations.
    a. All current staff will be reeducated on pendant use and response time expectations
    b. All staff will be educated on use of pendant exception report.
    c. All new hires will be educated on pendant use and response time expectations.
    d. An IT request was created with the program's IT company on 05/18/2022 at 1552. It was determined that an access point for the WiFi was down. This was resolved on 05/19/2022.
    e. Staff education completed on 05/16/2022 for monitoring meals in memory care and following the residents' service plans for meal assistance.

2. What measures will be taken to ensure the problem does not recur?
    a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.
    b. Pendant audit reports will be run routinely/ audited by director or designee; staff education will be completed as concerns are identified.

C. 481-69.23(1)b Criteria for Admission/Retention of Tenants: Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer, or evacuation; c. is dangerous to self or other tenants or staff.

1. Elements detailing how the program will correct the statement of findings/violations.
    a. Tenant #1 was issued a 30-day discharge notice on 05/13/2022 due to resident being outside AL criteria.
    b. Tenant #4 was issued a 30-day discharge notice on 05/20/2022 due to resident being outside AL criteria.
    c. New Director will be trained/educated on Iowa Regulations related to admission/retention of tenants into Assisted Living.

2. What measures will be taken to ensure the problem does not recur?
    a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

D. 481-69.26(1) Service Plans: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(a) 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.

1. Elements detailing how the program will correct the statement of findings/violations.
    a. Residents' service plans will be reviewed, and evaluations will be completed as needed per residents' change. Service plans will reflect individual needs.
    b. Staff education will be provided on reporting any changes in ability to complete ADLs to RN or designee
    c. Staff will be educated on completing shower sheets per each scheduled shower.

2. What measures will be taken to ensure the problem does not recur?
    a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed by auditing reports as determined by the Director/RN or designee to ensure compliance.
    b. **Shower sheets will be audited routinely to ensure showers are completed as scheduled.**
    c. **Health Care coordinator and or designee will complete routine care audits to ensure toileting and other cares are being done as scheduled.**

    All corrections will be in place by 06/30/2022

    Revised Compliance date of 7/15/2022

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.

Regards,

Jessica Martinez
Director
Prairie Hills at Clinton