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
	S0245	A. BUILDING: _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIME ASSISTED LIVING	725 PEARL STREET SIOUX CITY, IA 51103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 30 Number of tenants with cognitive disorder: 16 Total Population of Program at time of on-site: 46 No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program. No regulatory insufficiences were cited during the investigation of Complaint #97534-C. The following regulatory insufficiences were cited during the investigation of Complaint #93456-C and Complaint #94003-C as well as the onsite infection control survey.	A 000		
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 interview and record review the Program failed to follow its policy and procedures regarding Covid-19. This potentially affected all tenants residing and all staff working at the Program. Findings follow: Observations on 7-26-21 of the visitor log in book revealed several visitor's temperature failed to be documented.. Record review on 7-27-21 of the Program's Covid	A 150	Plan of Correction is attached DD	

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 19 Visitor Screening policy revealed all visitors must have their temperature taken and it must be logged prior to entering facility. The Director confirmed these findings on 7-28-21 at 1:06 p.m.	A 150		
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 failed to initiate a discharge or submit a request for a waiver as soon as a tenant required routine two person assistance with standing, transfer, or evacuation for 1 of 2 former tenants reviewed (Tenant #2). Findings follow: Record review on 7-27-21 of Tenant #2's file revealed the following: 1. Charting Notes dated 7-21-2020 revealed Tenant #2 returned from the hospital with the expectation to receive palliative care upon return. Continued review of notes dated 7-23-2020 revealed she required end of life care from the Program for All Inclusive Care for the Elderly (PACE) and to contact them as needed. Further review of notes dated 8-10-2020 revealed she passed away 8-7-2020.	A 155		

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A 155	Continued From page 2 2. Change in Condition/Quarterly Assessment dated 7-29-2020 revealed Tenant #2 was recently diagnosed with atrial fibrillation (A-Fib) and declined in overall health. She received end of life care and all medications were discontinued except for comfort measure medications. She required assistance with all activities of daily living, spent the majority of time in bed, and required 2 staff for transfers. No request for a waiver of criteria for retention could be located. The Wellness Director confirmed these findings on 7-28-21 at 1:06 p.m.	A 155		
A 340	481-69.25(2) Tenant Documents 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to retain records for a minimum of three years after the transfer or death of the tenant for 1 of 2 former tenants reviewed (Tenant #3). Findings follow: On 7-27-21 no file for discharged Tenant #3 could be located. On 7-27-21 at 9:00 a.m. the Director confirmed the Owner discarded Tenant #3's records with the exception of nursing notes that were maintained on the computer.	A 340		

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A 350	Continued From page 3	A 350		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were updated as needed for 2 of 7 current and former tenants reviewed (Tenant #1, Tenant #2). Findings follow: Record review on 7-27-21 of Tenant #1's file revealed the following: - A Quarterly Assessment dated 8-18-2020 revealed she required a wheelchair for ambulation. - Tenant #1's Service Plan dated 8-17-2020 failed to be updated to reflect the need for a wheelchair for ambulation. Record review on 7-27-21 of Tenant #2's file revealed the following: - Charting Notes dated 7-21-2020 revealed Tenant #2 returned from the hospital with the expectation to receive palliative care upon return. Continued review of notes dated 7-23-2020 revealed she required end of life care from the Program for All Inclusive Care for the Elderly (PACE) and to contact them as needed. Further review of notes dated 8-10-2020 revealed she passed away 8-7-2020. - A Change in Condition/Quarterly Assessment	A 350		

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A 350	Continued From page 4 dated 7-29-2020 revealed Tenant #2 was recently diagnosed with atrial fibrillation (A-Fib) and declined in overall health. She received end of life care and all medications were discontinued except for comfort measure medications. She required assistance with all activities of daily living, spent the majority of time in bed, and required 2 staff for transfers. - Tenant #2's Service Plan dated 7-29-2020 failed to be updated based on the evaluation conducted, changes in overall health, and increased need for assistance for her ADL's. The Wellness Director confirmed these findings on 7-28-21 at 1:06 p.m.	A 350		

A150 481-67.2 (3) Program Policies and Procedures

During COVID restriction timeframe, Prime did not capture and log all temperatures of all visitors to the community.

A150 Plan of Correction

1. As Covid regulations and safety guidelines are ever changing, Prime will continue to monitor guidelines and suggestions for resident and staff safety. Policies and procedures will be updated and changed with the need to do so. As of 08/01/21 Prime visitors and staff are required to wear masks. Visitors are required to log in upon arrival. This is monitored by staff, and office personnel.
2. When it becomes necessary for additional measures to be taken Prime will post and educate on additional measures. If temperature logs need to be started again, Prime will assign a specific staff member to complete that task to ensure compliance.
3. Admin will monitor any future temperature logs daily.
4. This is ongoing to ensure the safety of Prime residents and staff.

9/28/21

9/28/21

A155 481-69.23(1) b Criteria for Admission / Retention of Tenants

Prime Assisted Living did not notify nor submit a request for a waiver when a resident became bed ridden and end of life care was initiated.

A155 Plan of Correction

1. This Administrator had a complete misunderstanding of the rule. Prime Admin, Wellness Director and Administrative Assistant have been educated by DIA staff on date of visit.
2. When a resident exceeds Level of Care as determined by rules, the Administrator will call DIA and notify them. At that point in time, DIA and Admin will determine if a waiver is appropriate and necessary. This is effective 09/10/21.

09/10/21

A340 481-69.25(2) Tenant Documents

Prime Assisted Living owner destroyed documents/records that should have been kept.

A340 Plan of Correction:

1. Prime staff that deal with record keeping of resident information will follow appropriate policies and procedures regarding record retention. Policy and procedure will be posted in records room.
2. Policy and Procedure has been updated and all employees who deal with records and record retention have been educated on the policy and procedures regarding this matter.
3. Prior to destruction of records, 2 employees will ensure that any records being labeled for destruction are verified okay to destroy prior to doing so.
4. Policy and education completed on 08/01/21 with regard to record retention.

A350 481-69.25 (1) Service Plans

Prime Assisted Living did not appropriately update the Service Plan following a decline/change of condition. Chart notes addressed changes, however Service Plan did not on Tenant #1 & Tenant #2.

A350 Plan of Correction:

1. Tenant #1 & Tenant #2 are deceased.

1. A change of condition/decline also triggers a change in the care a resident will receive. This includes changing and updating care logs. This also includes a change in the amount a resident pays for the increase in services. For this reason, both Admin and Nursing are involved.
2. When a change/decline in condition occurs and information comes to Admin for updating, Admin will discuss with nursing the changes that are necessary for the Service Plan. At this time, Admin will review Service Plan with Wellness Director to ensure that appropriate changes have been made. Since Service Plan requires additional signatures following a change, Admin will be able to review and sign at that time.
3. Admin will monitor compliance by pulling 2 charts monthly to ensure Service Plans are being updated appropriately.
4. Wellness Director was been educated on updating service plans on 07/28/21. Plan for pulling charts for compliance will start 10/2021.