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 |
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| | S0261 | A. BUILDING: _____ B. WING _____ | C 01/09/2024 |

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| COURTYARD ESTATES AT HAWTHORNE CROSSING | 601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035 |

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| A 000 | Initial Comments<br><br>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.<br><br>Number of tenants without cognitive disorder: 22<br>Number of tenants with cognitive disorder: 16<br><br>TOTAL census of Assisted Living Program for People with Dementia: 38<br><br>The following regulatory insufficiencies were cited during the investigation of complaints #117505-C, #117668-C, and #116778-C. | A 000 | | |
| A 285 | 481-67.5(2)f(4) Medications<br><br>67.5(2) Each program shall follow its own written medication policy, which shall include the following:<br><br>f. When medications are administered traditionally by the program:<br><br>(4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to obtain medications as ordered. This pertained to 1 of 3 discharged tenants reviewed (Tenant C1). Finding follows:<br><br>Record review on 12/28/23 of Tenant C1's file revealed the following: | A 285 | | |

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

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| A 285 | Continued From page 1<br><br>Progress Notes included the following entries:<br>a. 12/11/23 at 1:53 p.m. (late entry) the hospice provider expressed concerns related to level of care, lack of pain management due to delayed delivery, and the condition of Tenant #1 during their visit.<br>b. 12/8/23 at 5:03 p.m. a change of condition assessment completed for re-admission to hospice and return from a hospital stay for hip surgery. New orders for 5 milligrams (mg) of oxycodone to be given every 4 hours as needed (PRN) for pain entered at 5:42 p.m. by a Registered Nurse (RN) and .25 mgs of lorazepam to be given every 2 hours PRN for restlessness was entered at 7:44 p.m. by the Licensed Practical Nurse (LPN).<br>c. 12/11/23 at 1:09 p.m. clarification needed from hospice provider regarding the orders for PRN morphine and PRN Ativan (lorazepam). At 2:14 p.m. updated to include clarification of orders for morphine to be given every 2 hours and lorazepam every 2 hours. The pharmacy noted the medications would be delivered by mail.<br>d. 12/11/23 at 10:30 p.m. (late entry) guardian wanted to speak to nurse regarding cares from this afternoon and attempted to contact them two times and left a voicemail.<br><br>Record review of Tenant C1's hospice notes revealed the following:<br>a. 12/8/23 he was admitted to hospice care after 5 p.m. and noted overall decline in health after hip surgery and returned with a foley catheter and bowel incontinence. Medication orders that included oxycodone for pain were sent to pharmacy, reviewed hospice plan of care with the staff and to notify of any changes with level of care.<br>b. 12/9/23 nurse completed follow up visit with Tenant C1 and he denied any pain and noted | A 285 | | |

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maroon tint to his urine in the drainage bag. Staff confirmed he pulled on the bag and the nurse requested they change to a leg bag when the catheter was changed.
c. 12/10/23 nurse completed another visit with Tenant C1 and continued to have red tinted urine in drainage bag due to him pulling on it.
d. 12/11/23 staff called the hospice on call around 1:00 a.m. and reported increased pain and blood in his urine. They were instructed to administer PRN Tylenol or oxycodone and staff stated they would try Tylenol first.
e. 12/11/23 upon arrival the nurse noted Tenant C1 in bed and hollered out when touched or moved. The nurse and the aid cut off his pants to minimize moving him to provide a bed bath due to strong odor. They observed dried feces on his pubic hair and brief and required scissors to cut the hair to remove his brief. She asked for pain medications and staff reported none were available and they continued to clean him up without medications to ease his pain. The nurse contacted the Advanced Registered Nurse Practitioner (ARNP) to have orders sent to the pharmacy for immediate delivery.

The Medication Administration Record (MAR) dated December 2023 revealed a start date of 12/8/23 for the following medications:
a. 2 tablets of 325 mg acetaminophen to be given every 6 hours as needed for pain. Staff administered 2 tablets at 2:01 a.m. on 12/11/23.
b. .25 mg/ml of lorazepam oral concentrate to be given every 2 hours as needed for restlessness. Staff administered the first dose on 12/12/23.
c. .25 mg/ml of morphine oral solution to be given every 2 hours as needed for pain. Staff administered the first dose on 12/12/23.
d. 5 mg of oxycodone to be given every 4 hours as needed for pain. Tenant C1 received no

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oxycodone for pain.

Tenant C1 was an 83 year old male with diagnoses including dementia, glaucoma, high blood pressure, hypoparathyroidism and hip replacement.

On 12/8/23 at 2:36 p.m. the LPN texted the hospice provider and requested orders for liquid morphine and liquid Ativan to be given every 2 hours. Continued review of the text chain revealed the hospice provider asked the LPN to have the Veterans Administration (VA) hospital order his medications since he was not admitted to hospice yet.

When interviewed on 12/28/23 and 1/2/24 at various times the Licensed Practical Nurse (LPN) said she contacted the Registered Nurse (RN #1) that worked 12/8/23 and discussed Tenant C1 returning to the community from the hospital at the request of his Power of Attorney (POA). She reported she attempted to communicate with the hospital physician and attending nurse and was told they would not without the consent from his POA. She asked for the tentative discharge summary and was provided the information to her sometime in the mid-afternoon on 12/8/23. She confirmed she communicated with the hospice care transition coordinator for his re-admission to hospice and discussed his medication needs via text message. The LPN stated she contacted the VA case manager and they would not order his meds due to upcoming admission to hospice care as they would be responsible for his medications after admission. She said they transported Tenant C1 back to the community and hospice admitted him after 5 p.m. She confirmed she assumed hospice would be responsible for ordering and following up on his medications and failed to

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communicate they had not been ordered prior to admission to their services as previously requested by the hospice care transition coordinator. She provided the discharge information to RN #1 to be entered into the system and left for the day. The LPN stated she was contacted on 12/9/23 by the Program's on-call nurse regarding Tenant C1's pain medications at the request of the hospice nurse visiting him that day. She confirmed a lack of clear communication regarding the medication situation and assumed the hospice nurse would order them at that time.

On 12/28/23 at 3:16 p.m. RN #1 stated she completed her functional, cognitive, and health assessments via facetime when the LPN visited Tenant C1 in the hospital for discharge back to the community. She confirmed the LPN reported he required the assistance of one staff and failed to have the LPN demonstrate his ability to do so. She said she was at the Program this day filling in due to there not being a full-time nurse hired yet. RN #1 reported she entered the orders for the oxycodone into the system from the information off of the discharge orders from the hospital. She assumed the LPN or the hospice provider would be responsible for ensuring medications were ordered.

On 1/3/24 at 10:21 a.m. RN #2 reported she completed the re-admission for Tenant C1 on 12/8/23 in the evening after he returned from the hospital. She reported the Program would have been responsible for ensuring any medication orders were taken care of upon his discharge from the hospital and prior to the admission to hospice care. She completed a follow-up visit on 12/9/23 and discovered the Program failed to have any comfort medications on hand and

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proceeded to contact the pharmacy to have them delivered by mail. She said if Tenant C1 required them before they were delivered she could get a new order and go to the pharmacy directly to pick them up. She reported on 12/10/23 Tenant C1 continued to deny any pain. RN #2 noted she observed blood in his urine due to him messing around with the catheter bag and reported no concerns when she looked in his brief.

On 1/2/24 at 10:37 a.m. Staff A reported at the start of her morning shift on 12/11/23 she completed rounds with the overnight shift and no concerns were reported on Tenant C1. She said later she checked him and he needed to be changed and went to get the Clinical Educator to assist with his catheter as he appeared to be in pain when touched and she did not want to make him uncomfortable. Staff A stated the Clinical Educator instructed her to leave him alone until he could get some pain medication and none were available by the time she left at 2:00 p.m.

On 12/28/23 at 11:08 a.m. the Clinical Educator confirmed she worked as the RN on 12/11/23. She said around mid-morning staff asked her to check on Tenant C1 and the Advanced Registered Nurse Practitioner (ARNP) requested his catheter be removed due to discolored urine and not leaving it alone. During the exam, she observed dried blood that may have been mixed with feces and asked staff to clean him up. Staff reported Tenant C1 displayed increased agitation above his baseline and she instructed staff to leave him alone until he received comfort medications for relief. She assumed the medications were available because they were listed on the MAR. The Clinical Educator said the first time she saw the brief was with the ARNP and was a quick glance but did see what may

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have been dried blood and/or feces. She confirmed he was not cleaned up until mid-afternoon and sent a communication report to the Director, LPN, and the Regional Nurse Specialist.

Communication report completed by the Clinical Educator to the Director and LPN on 12/11/23 revealed she reported the hospice ARNP couldn't remove Tenant C1's catheter because a syringe could not be located. His peri area needed cleaned up due to his brief stuck to him and wanted pain medications administered but none were available. No one knew if he could bear weight to get into the shower. At 1:00 p.m. RN #2 had not arrived and staff attempted to clean Tenant C1 but could not due to yelling out in pain. After the hospice staff arrived it took three staff to clean him up with the Clinical Educator holding his hands while the hospice staff used scissors to remove his brief as it was stuck to him. She wrote there were lots of feces to clean up. The Clinical Educator apologized for his condition and would report the situation to the Director. RN #2 clarified comfort medications, notified the pharmacy and they would be delivered by mail.

The Client Coordination Note Report noted a late entry for a visit to Tenant C1 on 12/11/23 from the ARNP. She noted observations of him laying in bed and asked an aide to assist her to assess his groin area and catheter. She reported he exhibited pain upon moving him and asked for comfort medications to be given and none were available. During the assessment she documented possible dried blood and feces and instructed the aide to give him a bed bath once he was comfortable with comfort medications. She noted the visit lasted 40 minutes and RN #2 was to follow up later.

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| A 285 | Continued From page 7<br><br>On 12/28/23 at 10:21 a.m. RN #2 reported the ARNP visited Tenant C1 around 10:00 a.m. and she visited around 2:00 p.m. She said the ARNP reported he was soiled and needed to be changed and when they arrived he was still in the same condition from the morning visit. Tenant C1 moved restlessly in bed and hollered out when touched. She retrieved the Program's RN to observe the condition of Tenant C1 with the brief stuck to his pubic hairs with dried blood and feces. She noted the brief was fully soiled and observed some blood when she removed the catheter. She asked why no comfort medications were available and no one knew what was going on so she called in orders and they would be delivered later.<br><br>On 1/8/24 at 3:00 p.m. RN #1 confirmed she failed to review the discharge instructions with the LPN during the facetime assessment on 12/8/23 to ensure he continued to meet the criteria to return and they could meet his needs for pain control.<br><br>On 1/8/24 at 3:00 p.m. the Director confirmed these findings. | A 285 | | |
| A 145 | 481-69.22(3) Evaluation of Tenant<br><br>69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed | A 145 | | |

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| A 145 | Continued From page 8<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to evaluate the functional, cognitive, and health status as warranted for 1 of 1 tenants reviewed with a significant change in health status (Tenant #1). Finding follows:<br><br>Record review on 12/28/23 of Tenant C1's file revealed the following:<br><br>Progress Notes included the following entries:<br>a. 12/11/23 at 1:53 p.m. (late entry) the hospice provider expressed concerns related to level of care, lack of pain management due to delayed delivery, and the condition of Tenant #1 during their visit.<br>b. 12/8/23 at 5:03 p.m. a change of condition assessment completed for re-admission to hospice and return from a hospital stay for hip surgery. New orders for 5 milligrams (mg) of oxycodone to be given every 4 hours as needed (PRN) for pain entered at 5:42 p.m. by a Registered Nurse (RN) and .25 mgs of lorazepam to be given every 2 hours PRN for restlessness was entered at 7:44 p.m. by the Licensed Practical Nurse (LPN).<br>c. 12/11/23 at 1:09 p.m. clarification needed from hospice provider regarding the orders for PRN morphine and PRN Ativan (lorazepam). At 2:14 p.m. updated to include clarification of orders for | A 145 | | |

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morphine to be given every 2 hours and lorazepam every 2 hours. The pharmacy noted the medications would be delivered by mail.

Record review of Tenant C1's hospice notes dated 12/8/23, documented he was admitted to hospice care after 5:00 p.m. and noted overall decline in health after hip surgery and returned with a foley catheter and bowel incontinence. Medication orders included oxycodone for pain were sent to pharmacy, reviewed hospice plan of care with the staff and to notify of any changes with level of care.

On 12/8/23 at 2:36 p.m. the Licensed Practical Nurse (LPN) texted the hospice provider and requested orders for liquid morphine and liquid Ativan to be given every 2 hours. Continued review of the text chain revealed the hospice asked the LPN to have the Veterans Administration (VA) hospital order his medications since he was not admitted to hospice yet.

On 12/28/23 and 1/2/24 at various times the Licensed Practical Nurse (LPN) said she visited Tenant C1 in the hospital on 12/8/23. He layed in bed and said he was too tired to get up and walk. She stated the hospital staff reported he walked about 25 feet with a walker previously so assumed he could get around ok. She contacted the Registered Nurse (RN #1) and discussed Tenant C1 returning to the community from the hospital at the request of his Power of Attorney (POA). She reported she attempted to communicate with the hospital physician and attending nurse and was told they would not without the consent from his POA. She asked for the tentative discharge summary and was provided the information to her sometime in the mid-afternoon on 12/8/23.

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| A 145 | Continued From page 10<br><br>She and the Lifestyle Enrichment Coordinator (LEC) used a gait belt to transfer him from the bed to a wheelchair. They both held the gait belt to steady him and assist with moving to the wheelchair. She confirmed she failed to ensure he could transfer with only one person.<br><br>On 12/28/23 at 1:57 p.m. the LEC reported she and the LPN used a gait belt, put their arms under Tenant C1's arms, and completed a pivot transfer from the bed to a wheelchair to transport him back to the community.<br><br>On 12/28/23 at 3:16 p.m. RN #1 stated she completed her functional, cognitive, and health assessments via facetime when the LPN visited Tenant C1 in the hospital for discharge back to the community. She confirmed the LPN reported he required the assistance of one staff and failed to have the LPN demonstrate his ability to do so. She said she was at the Program this day filling in due to a full-time nurse had not been hired yet. RN #1 reported she entered the orders for the oxycodone into the system from the information off of the discharge orders from the hospital. She assumed the LPN or the hospice provider would be responsible for ensuring medications were ordered.<br><br>On 12/28/23 Staff A stated Tenant C1 required the assistance of two staff for transfers and cares and no pain medications were available for his restlessness.<br><br>On 12/28/23 at 4:27 p.m. Staff B reported after Tenant C1 returned from the hospital he required two staff for transfers and repositioning during his shift. | A 145 | | |

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| A 145 | Continued From page 11<br>On 1/8/24 at 3:00 p.m. RN #1 confirmed she failed to thoroughly review the discharge instructions with the LPN during the facetime assessment on 12/8/23 to ensure he continued to meet the criteria to return and they could meet his needs for pain control.<br><br>Review of the Program's Assessment policy noted the RN would be responsible for the comprehensive assessment and included a health, cognitive, and functional evaluation to ensure the individual's needs would be met. The tenant should be interviewed because families may unintentionally give incorrect information at times.<br><br>On 1/8/24 at 3:00 p.m. the Director confirmed these findings. | A 145 | | |
| A 155 | 481-69.23(1)b Criteria for Admission / Retention of Tenants<br><br>69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who:<br><br>b. Requires routine, two-person assistance with standing, transfer or evacuation<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to evaluate the transfer ability for 1 of 1 tenants reviewed with a significant change in health status (Tenant #1). Findings follow:<br><br>Record review on 12/28/23 of Tenant C1's file revealed the following: | A 155 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0261 | A. BUILDING: _____ B. WING _____ | C 01/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COURTYARD ESTATES AT HAWTHORNE CROSSING | 601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 155 | Continued From page 12<br><br>Progress Notes included the following entries:<br>a. 12/11/23 at 1:53 p.m. (late entry) the hospice provider expressed concerns related to level of care, lack of pain management due to delayed delivery, and the condition of Tenant #1 during their visit.<br>b. 12/8/23 at 5:03 p.m. a change of condition assessment completed for re-admission to hospice and return from a hospital stay for hip surgery. New orders for 5 milligrams (mg) of oxycodone to be given every 4 hours as needed (PRN) for pain entered at 5:42 p.m. by a Registered Nurse (RN) and .25 mgs of lorazepam to be given every 2 hours PRN for restlessness was entered at 7:44 p.m. by the Licensed Practical Nurse (LPN).<br>c. 12/11/23 at 1:09 p.m. clarification needed from hospice provider regarding the orders for PRN morphine and PRN Ativan (lorazepam). At 2:14 p.m. updated to include clarification of orders for morphine to be given every 2 hours and lorazepam every 2 hours. The pharmacy noted the medications would be delivered by mail.<br><br>Record review of Tenant C1's hospice notes dated 12/8/23 indicated he was admitted to hospice care after 5:00 p.m. and noted overall decline in health after hip surgery and returned with a foley catheter and bowel incontinence. Medication orders that included oxycodone for pain were sent to pharmacy, reviewed hospice plan of care with the staff and to notify of any changes with level of care.<br><br>On 12/8/23 at 2:36 p.m. the LPN texted the hospice provided and requested orders for liquid morphine and liquid Ativan to be given every 2 hours. Continued review of the text chain revealed the hospice asked the LPN to have the | A 155 | | |

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|---|---|---|---|---|
| A 155 | Continued From page 13<br><br>Veterans Administration (VA) hospital order his medications since he was not admitted to hospice yet.<br><br>On 12/28/23 and 1/2/24 at various times the Licensed Practical Nurse (LPN) said she visited Tenant C1 in the hospital on 12/8/23. He laid in bed and said he was too tired to get up and walk. She stated the hospital staff reported he walked about 25 feet with a walker previously so assumed he could get around ok. She contacted the Registered Nurse (RN #1) and discussed Tenant C1 returning to the community from the hospital at the request of his Power of Attorney (POA). She reported she attempted to communicate with the hospital physician and attending nurse and was told they would not without the consent from his POA. She asked for the tentative discharge summary and was provided the information to her sometime in the mid-afternoon on 12/8/23.<br><br>She and the Lifestyle Enrichment Coordinator (LEC) used a gait belt to transfer him from the bed to a wheelchair. They both held the gait belt to steady him and assist with moving to the wheelchair. She confirmed she failed to ensure he could transfer with only one person.<br><br>On 12/28/23 at 1:57 p.m. the LEC reported she and the LPN used a gait belt, put their arms under Tenant C1's arms, and completed a pivot transfer from the bed to a wheelchair to transport him back to the community.<br><br>On 12/28/23 at 3:16 p.m. RN #1 stated she completed her functional, cognitive, and health assessments via facetime when the LPN visited Tenant C1 in the hospital for discharge back to the community. She confirmed the LPN reported | A 155 | | |

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|---|---|---|---|---|
| A 155 | Continued From page 14<br>he required the assistance of one staff and failed to have the LPN demonstrate his ability to do so. She said she was at the Program this day filling in due to no full-time nurse had not been hired yet. RN #1 reported she entered the orders for the oxycodone into the system from the information off of the discharge orders from the hospital. She assumed the LPN or the hospice provider would be responsible for ensuring medications were ordered.<br><br>On 12/28/23 Staff A stated Tenant C1 required the assistance of two staff for transfers and cares and no pain medications were available for his restlessness.<br><br>On 12/28/23 at 4:27 p.m. Staff B reported after Tenant C1 returned from the hospital he required two staff for transfers and repositioning during his shift.<br><br>On 1/8/24 at 3:00 p.m. RN #1 confirmed she failed to thoroughly review the discharge instructions with the LPN during the facetime assessment on 12/8/23 to ensure he continued to meet the criteria to return and they could meet his needs for pain control.<br><br>On 1/8/24 at 3:00 p.m. the Director confirmed these findings. | A 155 | | |