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
	S0277	A. BUILDING: _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CEDAR RAPIDS	2903 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 impairment: 36 Number of tenants with cognitive impairment: 0 Total census: 36 The following regulatory insufficiencies were cited during the investigation of Complaints #105632-C and #109460-C and the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program:	A 000	Cheri Schultz 3/24/2023	
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 multiple policy and procedures including insulin administration, medications, incident report completion and the Drug and Alcohol policy for 2 of 3 tenants observed on the medication pass (Tenant #1 and Tenant #2), and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. When observed on 1/19/23 at approximately 11:05 a.m. Staff A administered medications to Tenant #1. She took Tenant #1's blood glucose reading which was 84. She then prepared the insulin pen which included dialing up the scheduled units (5 units). Staff A handed the	A 150	The Plan of Correction is attached.	

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insulin pen to Tenant #1 who injected the insulin into her abdomen. Staff A did not prompt Tenant #1 to wipe her abdomen with an alcohol wipe prior to the injection of the insulin.
- The Nurse Delegation procedure for insulin pens (either staff or tenant injected) indicated if the tenant was able to inject their own insulin they were to complete hand hygiene and be provided the insulin pen and alcohol wipe. The area was to be wiped with an alcohol wipe prior to injection.

During this observation Staff A said Tenant #1 did not have parameters related to her blood glucose readings (84). Review of Tenant #1's January 2023 medication administration records (MARs) reflected an order for a Wavesense Presto Meter (blood glucose monitoring) one time per day every Tuesday and Thursday at 11:00 a.m. The MAR reflected on 1/19/23 at 11:00 a.m. Tenant #1's blood glucose was 84 and it was signed off by Staff A. The MAR also reflected 5 units of insulin was to be injected subcutaneously via flexpen three times per day at 8:00 a.m., 11:00 a.m. and 4:00 p.m. The directions stated to call if blood glucose was less than 100 or greater than 300. Staff A signed off the insulin administered at 11:00 a.m. Tenant #1's insulin was given despite the directive on the MAR to call if Tenant #1's blood glucose was less than 100 or greater than 300.
- The Program's policy and procedure regarding medication management indicated staff would follow the six "Rights" which indicated right tenant, right dose, right time, right route, right medication and right documentation.

Continued observation on 1/19/23 at approximately 12:30 p.m. revealed Staff A administered an oral medication to Tenant #2 and then applied bacitracin ointment (topical ointment)

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to his fingernail. The bacitracin topical medication was not stored in a secured location in Tenant #2's apartment; despite being administered by Staff A.
- The Program's policy and procedure regarding medication management indicated medications (administered) would be kept in a secured location, which was not available to other people, except staff responsible for administering medications.

2. Review of an Internal Investigation document dated 12/4/22 revealed the Director received a text message from Staff E stating she had heard a "rumor" that Staff D sold marijuana to Tenant C1. Staff D was asked by Tenant C1 to get her a "cannabidiol cartridge because she was on hospice and dying." Tenant C1 told Staff D she had too many appointments that day and was not able to get to a dispensary to obtain it. Tenant C1 said she was in pain, nauseous and vomiting. Staff D said Tenant C1 told her she had a "medical card provided by the Linn Country Public Health department." It was noted Staff D had a medical card. Staff D "thought it would be okay since they both had a medical card. The resident paid for the cartridge herself." It was noted Staff D was in the dietary department. Statements were received from Staff A, D and E. The investigative conclusion indicated Tenant C1 asked for help She said she was on hospice and dying and asked her to get a "cannabidiol cartridge" to help her. It was noted both Tenant C1 and Staff D had a medical card. "No malicious intent was found."

A Counseling Documentation Form indicated Staff D received a final warning and the issue was related to "Conduct/Behavior" and "Policy or Safety Violation." The report indicated on 12/4/22

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it was reported to the Director that Staff D bought a "THC pen" for a tenant. Staff D said she and Tenant C1 had a "Medical Cannibodal (sic) card." Tenant C1 asked Staff D to buy her one as she did not have time to get to a dispensary. Tenant C1 paid for her own cartridge. Tenant C1 told Staff D she had a cancer diagnosis, was dying, was in pain and vomiting. Staff D said she "wanted to help the resident and thought it would okay to help her since they both had a medical card and she stated she was dying." The report indicated Staff D would not "purchase, give, or participate in any activity regarding medications going forward. If the employee does she will be terminated effective immediately." It also indicated education regarding dependent adult abuse was provided. The form was signed by Staff D and the Director on 12/9/22.

When interviewed on 1/24/23 at 4:03 p.m. and 1/25/23 at 11:53 a.m. the Director said Tenant C1 told Staff D she had nausea and pain. Staff D had her medical card and Tenant C1 told Staff D she had one too. Tenant C1 asked Staff D to picked up a THC cartridge. Staff D thought it was okay because Tenant C1 paid for it and they both had a card. The Director said it possibly happened one to two times but she was not sure.

The Program's policy regarding Drugs and Alcohol indicated employees were prohibited from certain activities when they were working, conducting company business, or when on company premises (whether working or not). Those activities included "the possession, sale, purchase, transfer, or transit of any illegal or unauthorized drug, including prescription medication that is not prescribed to the individual, or drug-related paraphernalia." The policy indicated marijuana was an illegal drug under

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A 150	Continued From page 4 federal law. 3 When interviewed on 1/24/23 3:43 p.m. and 1/25/23 at 11:53 a.m. at the Director revealed Tenant C2's family had said at a family meeting that the tenant was possibly missing a ring. The timeframe provided was during the past two to three years. It was either a ring from work or a class ring. Family also reported a 20 dollar bill was possibly missing. The Director did not recall the timeframe of the missing money. She said Tenant C2's family did not get back to her about the ring. There had been no other reports of missing items. The possible missing items were reported at a family meeting including herself, the former Healthcare Coordinator and Tenant C2's family. She confirmed there was no written documentation or incident report completed related to the possible missing items. The Program's policy and procedure regarding incident reporting indicated staff would notify the nurse (or designee) when a tenant had fallen or any unusual event occurred. The incident report would be completed by the nurse (or designee). The incident report would be factual, dated and timed. The incident report would be submitted to the nurse "as soon as possible." The nurse was responsible to follow up with "a review of reportable incidents" and enter them into the electronic records system. 4. When interviewed on 1/25/23 at 11:53 a.m. the Director confirmed these findings.	A 150		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the	A 285		

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A 285	Continued From page 5 following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications as prescribed for 2 of 3 current (Tenant #1 and Tenant #3) and 1 of 1 discharged (Tenant C2) tenants who received medications administered by staff. Findings follow: 1. Review of Tenant #1's file on 1/24/23 and 1/25/23 revealed an incident report dated 1/15/23 indicating a medication error had occurred with Tenant #1. She received a dose pf Insulin Aspa Flexpen, 5 units, at supper. Staff administered the insulin and got called away before she signed it off as being given. Another staff gave her insulin again at 7:30 p.m. A fax to the tenant's primary care provider (PCP) dated 1/15/23 reflected staff administered 5 units of insulin before supper. Staff did not sign off the medication as they were "called away" to assist another tenant. Another staff saw that it was not signed off and administered another dose at 7:30 p.m. Tenant #1's blood glucose reading before supper was 190. At 8:00 p.m. Tenant #1's blood glucose reading was 203. Tenant #1's January 2023 medication administration records (MARs) reflected 5 units of	A 285		

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insulin was to be injected subcutaneously via flexpen three times per day at 8:00 a.m., 11:00 a.m. and 4:00 p.m. Tenant #1 did not receive the insulin as ordered on 1/15/23 when she received two doses, including one dose not at the prescribed time.

2. Review of Tenant #3's file on 1/25/23 revealed an incident report dated 12/28/22 indicating Tenant #3 had returned to the building the day prior after completion of a skilled nursing facility (SNF) stay. Tenant #3 had previously been prescribed scheduled hydrocodone. Staff administered hydrocodone to her before bedtime; however, there was no order to administer hydrocodone. Staff did not sign out the medication (due to the medication being discontinued) and did not sign it out in the narcotic book.

Tenant #3's current medication orders provided by the SNF did not reflect an order for hydrocodone. The SNF MARs reflected Norco (hydrocodone-acetaminophen) 5/325 milligram (mg), one tablet three times per day was discontinued on 12/3/22. The MARs also reflected hydrocodone-acetaminophen 5/325 mg, one tablet twice per day as needed for pain was discontinued on 12/11/22.

Further record review revealed Tenant #3 returned to the Program on 12/27/22 with a current medication list which did not include orders for hydrocodone-acetaminophen. On 12/28/22, staff administered a dose of hydrocodone to Tenant #3 before bed; despite not having an order to administer the narcotic medication.

3. Review of Tenant C2's file on 1/23/23 and

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1/24/23 revealed an incident reported dated 5/24/22 indicating the tenant had received the wrong medications on 5/20/22, 5/21/22, 5/22/22, 5/23/22 and morning and noon doses on 5/24/22. Staff had taken the wrong medication planner to Tenant C2's apartment. Staff administered the medications to Tenant C2 out of the wrong medication planner.

Tenant C2's file service plan reflected family set up medications in a planner and staff provided reminders to take the medications. Staff assisted with ordering the medications and the medication planner was stored in a locked drawer/cabinet.

Progress Notes indicated the following:
- On 5/21/22 a "Fall Note" indicated Tenant C2's family arrived to assess him. Tenant C2 did not want to go to the emergency department (ED).
- On 5/22/22 a "Fall Note" indicated Tenant C2 said he was feeling better, but he felt "terrible last night."
- On 5/23/22 a "Fall Note" indicated Tenant C2 was found on the floor in his bedroom by staff that morning. When staff turned Tenant C2 over, he complained of left shoulder pain. Family was notified.
- On 5/24/22 a "Fall Note" indicated Tenant C2 was found on the floor that morning beside his bed. He was assisted back to bed.
- On 5/24/22 the nurse was made aware that another tenant's medication planner was not available to change over. The nurse looked and saw Tenant C2's medication planners on the counter. The nurse went to Tenant C2's apartment and observed the other tenant's medication planners in Tenant C2's apartment with medications gone since 5/20/22. Tenant C2 had been administered the incorrect medications since 5/20/22. The nurse called Tenant C2's

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family and notified the PCP on-call. A verbal order was received for a basic metabolic panel (BMP) and complete blood count (CBC) to be completed. It was also directed to monitor him, push fluids and to check vital signs. Tenant C2's family asked that he not be told of the error.
- On 5/2/5/22 a signed verbal order was received for the BMP and CBC.
- On 5/25/22 vitals were taken at 12:30 a.m., 4:30 a.m. and 8:00 a.m. The note indicated Tenant C2 was resting and doing well.

Further review revealed the following incident reports:
- On 5/21/22 at 11:05 a.m. staff went to give Tenant C2 his medications and found him on the bathroom floor. He was laying on his left side with his head on the scale in the bathroom. There was a "large reddened area noted on his left temple. Bruise noted on the top of his left ear, left cheek." Vital signs were taken and family was notified.
- On 5/23/22 at 8:05 a.m. staff went to get Tenant C2 for breakfast and found him on laying on the floor on his left side in front of the closet. Tenant C2 complained of pain to the left shoulder when staff rolled him over.
- On 5/24/22 at 8:00 a.m. staff found Tenant C2 on the floor on the side of this bed. No injuries were noted. Vital signs were taken.

Tenant C2's May 2022 MARs indicated staff were to remind him to take his meds from the from the pill planner three times per day at 9:00 a.m., 12:00 p.m. and 8:00 p.m. Staff initialed for the completion of the medication reminder including from 5/20/22 to 5/24/22. On 5/21/22 at 8:00 p.m. the medication reminder was charted as "drug refused." The medication reminders were charted by four different staff in that time period.

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Tenant C2's medications included
- furosemide (diuretic) 40 mg, one tablet daily
- Lisinopril (ACE inhibitor) 20 mg, two tablets daily
- metoprolol succinate (beta blocker) 100 mg (24 hour tablet), one tablet daily
- omeprazole (proton-pump inhibitor) 20 mg, one capsule daily
- potassium chloride (mineral supplement) 10 mill equivalents (mEq), 1 tablet daily

Further record review revealed Tenant C2 received Tenant C3's medications from 5/20/22 to 5/24/22. Tenant C3's medications were to be taken four times a day (as opposed to three times a day as Tenant C1 received). Tenant C3's medications included:

a. at 7:00 a.m.
- atenolol (beta blocker) 25 mg, 1/2 tablet
- furosemide (diuretic) 40 mg, 1/2 tablet
- gabapentin (anticonvulsant and nerve pain) 100 mg
- levothyroxine (hormone) 125 micrograms (mcg), two tablets
- rifaximin (antibiotic) 550 mg
- potassium chloride (mineral supplement) 20 mEq
- spironolactone (diuretic) 100 mg, half tablet
- famotidine (antihistamine and antacid) 20 mg
- Senna-Plus (stimulant laxative)

b. at noon
- gabapentin 100 mg
- furosemide (diuretic) 40 mg, 1/2

c. at 5:00 p.m.
- nortriptyline (antidepressant and nerve pain) 50 mg (2 capsules).

d. at 8:00 p.m.
- gabapentin 100 mg, 3 capsules
- rifaximin 550 mg
- famotidine 20 mg

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A 285	Continued From page 10 - Senna-Plus 4. When interviewed on 1/23/23 at 4:03 p.m. and 1/25/23 at 11:53 a.m. the Director said she was informed by the former Healthcare Coordinator of the medication error for Tenant C2. The former Healthcare Coordinator went to Tenant C2's apartment and found Tenant C3's med planner. She said someone had grabbed the wrong planner and took it to Tenant C2's apartment. There were no issues with Tenant C3 getting his medications related to the error. Tenant C2's PCP was notified and labs were ordered. She confirmed staff did not document the administration of Tenant #1's insulin which led to the medication error. The Director confirmed Tenant #3 received one dose of hydrocodone which had been discontinued with her hospital and SNF stay.	A 285		
A 145	481-69.22(3) Evaluation of Tenant 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 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	A 145		

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A 145	Continued From page 11 by: Based on interview and record review the Program failed to complete evaluations as needed with significant change and annually for 1 of 3 current tenants reviewed (Tenant #3). Findings follow: 1. Review of Tenant #3's file on 1/25/23 revealed a Comprehensive Assessment and Global Deterioration Scale (GDS) were dated 10/18/21. The next Comprehensive Assessment and GDS provided were dated 12/22/22. Health, functional and cognitive evaluations were not completed annually for Tenant #3. Continued record review revealed Progress Notes indicated the following: - On 1/18/23 the primary care provider (PCP) was faxed regarding Tenant #3's excoriated bilateral buttocks. An order for Calmoseptine was requested three times daily and as needed. - On 1/18/23 new orders were received including for Calmoseptine three times daily and as needed. - On 1/23/23 the PCP was notified the area on Tenant #3's buttock was bleeding, bilateral buttocks were excoriated and Calmoseptine was not staying on. A request was sent for therapies for transfers and a wound care consult. - On 1/24/23 new orders were received for physical therapy (PT) and occupational therapy (OT) and a wound clinic consultation. The tenant's most recent evaluations were completed on 12/22/22. Evaluations were not completed as needed with a change in Tenant #3's skin related to excoriated bilateral buttocks with bleeding and treatment ordered, the orders for PT and OT for transfers and the wound care consultation.	A 145		

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A 145	Continued From page 12 2. When interviewed on 1/25/23 at 11:53 a.m. the Director confirmed these findings.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception for 1 of 3 current tenants reviewed (Tenants #2). Findings follow: Review of Tenant #2's file on 1/24/23 and 1/25/23 revealed a hospital After Visit Summary indicating Tenant #2 was hospitalized from 12/12/22 to 12/19/22 for a cerebrovascular accident. Progress Notes indicated the following: - On 12/9/22 (late entry) Tenant #2 was not feeling well, had some swelling and drooping to the left side of his face. There was mild weakness noted to the left hand. Family was notified and encouraged to take Tenant #2 to be seen. There were no appointments available with Tenant #2's primary care provider or other providers. Tenant #2's family indicated they would decide if he needed to go to the emergency	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0277	A. BUILDING: _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CEDAR RAPIDS	2903 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 290	Continued From page 13 department. - On 12/11/23 (late entry) Tenant #2 was weak, needed more assistance with transfers, ate breakfast in his apartment and complained of left leg pain. Tenant #2's family was notified and was coming to the to the Program. Tenant #2 denied needing to go to the hospital. - On 12/16/22 it was noted the Director called the hospital and an update was provided regarding Tenant #2. He had been diagnosed with a stroke. - On 12/19/22 Tenant #2 returned to the building. Further record review revealed nurse's notes were not documented by exception for regarding when and why the tenant was taken to the hospital. When interviewed on 1/25/23 at 11:53 a.m. the Director confirmed this finding.	A 290		
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 review the Program to update service plans as needed for 2 of 3 current tenants reviewed	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0277	A. BUILDING: _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CEDAR RAPIDS	2903 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 14 (Tenants #2 and #3). Findings follow: 1. Review of Tenant #2's file on 1/24/23 and 1/25/23 revealed Progress Notes indicated the following: - On 11/15/22 Tenant #2 reported he had congestion and headache at bedtime and had been using a nasal spray. Tenant #2 wanted to know if it was okay to keep using the nasal spray or if there were other suggestions. A fax was sent to the primary care provider (PCP). - On 11/15/22 a new order was received for Tenant #2 to keep the nasal spray at bedside and to start Zyrtec 10 milligram (mg) daily. - On 11/22/22 Tenant #2 showed the nurse his nails, which were "black green" in color under the nail. Tenant #2 reported the right nail started about two weeks ago and the left nail discoloration started that day. Tenant #2's PCP was notified. - On 11/28/22 the discoloration to Tenant #2's nail beds had worsened. A request for an order was re-faxed to the PCP. - On 11/28/22 an order was received for bacitracin ointment, four times per day, to the nails. When observed during the medication pass on 1/19/23 at approximately 12:30 p.m. Staff A applied bacitracin ointment to Tenant #2's fingernail. The tenant's most recent signed service plan was dated 12/21/22 and reflected staff administered medications. The service plan was not updated to reflect medication Tenant #2 administered independently and kept at beside including the nasal spray. The service plan also did not reflect the issue with Tenant #2's nail discoloration and treatment.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0277	A. BUILDING: _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CEDAR RAPIDS	2903 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 15 2. Review of Tenant #3's file on 1/25/23 revealed a service plan was dated 10/18/21. The next signed service plan provided was dated 12/27/22. The service plan was not updated as least annually for Tenant #3. Continued record review revealed Progress Notes indicated the following: - On 1/18/23 the primary care provider (PCP) was faxed regarding Tenant #3's excoriated bilateral buttocks. An order for Calmoseptine was requested three times daily and as needed. - On 1/18/23 new orders were received including for Calmoseptine three times daily and as needed. - On 1/23/23 the PCP was notified the area on Tenant #3's buttock was bleeding, bilateral buttocks were excoriated and Calmoseptine was not staying on. A request was sent for therapies for transfers and a wound care consult. - On 1/24/23 new orders were received for physical therapy (PT) and occupational therapy (OT) and a wound clinic consultation. The tenant's most recent signed service plan was dated 12/27/22. Although the service plan was updated on 1/24/23 to include the open areas to Tenant #3's buttocks. treatment and the referral to the wound clinic, the plan was not based on evaluations as required. The change with Tenant #3 was not minor or discretionary as there was a change in Tenant #3's skin related to excoriated bilateral buttocks with bleeding. The PCP was contacted and new orders were received including for wound treatment, PT and OT ordered for transfers, and the wound care consultation. 3. When interviewed on 1/25/23 at 11:53 a.m. the	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0277	A. BUILDING: _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CEDAR RAPIDS	2903 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 16 Director confirmed all requested service plans for the tenants listed above were provided.	A 350		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure orientation on sanitation and safe food handling prior to handling food was provided to 1 of 7 staff reviewed (Staff C). Findings follow: Review of Staff C's training documents on 1/19/23 revealed a hire date of 8/26/22. Staff C was a cook at the Program. Staff C had a food safety training; however, it was not completed until 10/18/22. When interviewed on 1/25/23 at 11:53 a.m. the Director confirmed this finding.	A 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0277-Prairie Hills at Cedar Rapids	DATE SURVEY COMPLETED: 1/25/23

ID PREFIX 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 81-67.2(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 multiple policy and procedures including insulin administration, medications, incident report completion and the Drug and Alcohol policy for 2 of 3 tenants observed on the medication pass (Tenant #1 and Tenant #2), and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2).	A 150	**What initial correction was made?** Staff D is no longer an employee, effective 1/7/23. Tenant C2 was discharged from the community on 10/30/22. Staff re-education regarding the Drug & Alcohol Policy by 3/31/2023. Insulin Administration and Re-Delegation of medication managers completed by 3/31/2023. Staff re-education regarding Medication Policy completed by 3/31/2023.	**How will we ensure and maintain compliance going forward?** All staff will be educated upon hire to our current medication administration policy, proper storage of medications in a secure location, Insulin Administration, Incident Reporting Policy, and Drug and Alcohol Policy. The new Health Care Coordinator will be trained upon hire in the following: Medication policy, Insulin Administration, Delegation Process, Incident Reporting Policies, and Drug and Alcohol Policy. Director and or designee will monitor that New staff	**Implementation Date:** 1/31/23 **Completion Date:** Ongoing **Responsible Party:** Director and Designee

			Staff re-education regarding Incident Reporting Policy completed by 3/31/2023.	orientation checklist is utilized for all new employees. Director or Designee will monitor that incident reports are completed when appropriate. Director or Designee will complete medication pass audits periodically with medication managers to assure that proper procedures are followed and that medications are secured appropriately.	
Tag#2	**Regulation and Reg Number** **481-67.5(2)f(4) Medications** 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications as prescribed for 2 of 3 current (Tenant #1 and Tenant #3) and 1 of 1 discharged (Tenant C2) tenants who received medications administered by staff.	A 285	**What initial correction was made?** Prefilled med planners are stored in the locked Health Care Coordinators office. Staff will bring any empty med planner to the nurse and the nurse will exchange the med planner with a new filled one with the Residents current medication orders. All Medication Managers will be reeducated on medication administration policy and the 6 rights of medication by 3/31/2023.	**How will we ensure and maintain compliance going forward?** Medication Planners will be delivered to the residents' apartments by the Nurse or Director or Designee. Director or Designee will complete medication pass audits periodically with medication managers to assure that proper procedures are followed and that medications are secured appropriately.	**Implementation Date:** 1/31/23 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

			Staff re-education regarding Medication Policy completed by 3/31/2023.		
Tag#3	**Regulation and Reg Number** **481-69.22(3) Evaluation of Tenant** 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 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 evaluations as needed with significant change and annually for 1 of 3 current tenants reviewed (Tenant #3).	A 145	**What initial correction was made?** Tenant #3-Comprehensive assessment completed on 12/22/22.	**How will we ensure and maintain compliance going forward?** The new Health Care Coordinator will be trained on assessment requirements per state regulations upon hire.	**Implementation Date:** 1/31/23 **Completion Date:** Ongoing **Responsible Party**: Director and Designee
Tag#4	**Regulation and Reg Number** **481-69.25(1)i Tenant Documents** 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals'	A 290	**What initial correction was made?** Tenant #2 progress notes were updated to reflect hospitalization 2/22/23.	**How will we ensure and maintain compliance going forward?** The new Health Care Coordinator will be trained on how to chart by exception.	**Implementation Date:** 1/31/23 **Completion Date:**

	orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception for 1 of 3 current tenants reviewed (Tenants #2)		Tenant #1 progress notes were updated to reflect insulin medication error on 2/2/23.	Any hospitalized residents/incidents will be reviewed during community stand-up meetings.	Ongoing **Responsible Party:** Director and designee
Tag#5	**Regulation and Reg Number** **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 review the Program to update service plans as needed for 2 of 3 current tenants reviewed. (Tenants #2 and #3).	A 350	**What initial correction was made?** Tenant #3 current ISP does have treatment orders identified on it. Copy given to monitor 1/25/23. Tenant #2 ISP updated 2/3/23.	**How will we ensure and maintain compliance going forward?** New HCC will be trained on ISP process All residents will have an Annual Update of their service plan with their annual assessment. Any residents with significant changes will have a service plan update completed along with a comprehensive assessment.	**Implementation Date:** 2/2/23 **Completion Date:** Ongoing **Responsible Party:** Director and designee

Tag#6	**Regulation and Reg Number** **481-69.28(5) Food Service** 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure orientation on sanitation and safe food handling prior to handling food was provided to 1 of 7 staff reviewed (Staff C).	A 465	**What initial correction was made?** Food Safety course was completed on 10/18/22.	**How will we ensure and maintain compliance going forward?** All new employees will complete training for food safety prior to orientation being completed. Director and or designee will monitor that New staff orientation checklist is utilized for all new employees.	**Implementation Date**:1/31/2023 **Completion Date:** Ongoing **Responsible Party:** Director or designee

Compliance Date: 3/31/2023

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.

✓ 3/31/23