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
	S0288	A. BUILDING: _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF MUSCATINE	3515 DIANA QUEEN DRIVE MUSCATINE, IA 52761

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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. Number of tenants without cognitive impairment: 40 Number of tenants with cognitive impairment: 10 Total census: 50 No regulatory insufficiencies were cited during the investigation into Incident #121453-I and Incident #121337-I. The following regulatory insufficiencies were cited during the investigation into Complaint #119531-C.	A 000		
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 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 medication and treatments as ordered to 2 of 3 discharged tenants reviewed (Tenant C2 and Tenant C3). Findings include: 1. Record review on 10/1/24 of a Heart and	A 285	The Plan of Correction is attached	

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

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Vascular office visit note from 1/17/24 revealed Tenant C3 was diagnosed with coronary artery disease, hypertension, atrial fibrillation and cognitive impairment. He was being seen for an annual cardiology follow up. Tenant C3 was wearing tubigrips for venous insufficiency and venous stasis ulcers. He wasn't sure when the tubigrips were last changed. During the physical exam, Tenant C3's tubigrips were removed and found to be saturated with fluid and malodorous. Four large Band-Aids were removed from different sites on the right left extremity below the knee with the appearance of venous stasis ulcers with purulence. There were venous stasis changes to the bilateral lower extremities with 2+ pitting edema. Tenant C3's daughter was going to attempt to get Tenant C3 into a wound clinic within the week.

A review of physician's orders from the wound clinic revealed Tenant C3 appeared to have had weekly visits from 1/19/24 until he was discharged from their care on 3/28/24. The program did not have all of Tenant #1's weekly orders from the wound clinic, but did have notes from the following dates:
- Tenant C3 visited the wound clinic on 1/25/24 and received the following orders: A two layer compression system was applied to wounds identified as #8 and #9 on Tenant C3's right medial lower leg and right lateral lower leg. Staff were to leave the dressing in place until his next appointment. If his wraps slid down, they needed to be removed and 2 layers of tubigrip applied until his follow-up appointment in one week. In addition, the program was to ensure Tenant C3 had his CPAP machine on every night, including proper application and fit.
- On 2/22/24, Tenant C3 visited the wound clinic for treatment of a new wound to his left, lateral

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lower leg (#11) and to wounds on his right medial (#13) and lateral lower leg (#14). The wounds were still treated with a two layer compression system which was applied in the clinic. The physician's orders directed staff to observe the leg wraps daily. They were to leave the dressings in place until his next appointment. If the legs wraps slid down, they needed to be removed, two layers of tubigrip applied and the wound center should be called immediately. In addition, staff should continue to ensure Tenant C3 had his CPAP on every night and encourage him to elevate his legs to the heart level or above for 30 minutes daily three times per day. Wounds #8 and #9 were resolved.

- Tenant C3 returned to the wound clinic on 3/7/24 and received new treatments for his wounds. Wound #11 was treated with Mepilex dressing which was to stay in place over his open wounds for 1 week unless saturated. Tenant C3 was to wear two layers of tubigrip size F which were to be changed every day. Wounds #13 and #14 on Tenant C3's right lower leg were to be re-wrapped with kerlix dressing daily and two layers of tubigrips size F applied daily. The tubigrips were to go from his toes to the bend of the knee. Staff were to make sure there were no wrinkles and the dressings were not falling down. Staff were to ensure Tenant C3 was elevating his legs three times a day and wearing his CPAP machine every night.

- Tenant C3 had an appointment in Internal Medicine on 3/12/24 as he was experiencing shortness of breath and leg swelling. The provider indicated the tenant's symptoms were most likely a result of his chronic venous stasis (a long-term condition which occurs when the veins in the legs have trouble moving blood back to the heart) and when his compression stockings were not being changed regularly. Tenant C3 was to be

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weighed daily. If he gained more than 5 pounds in 5 days, staff should call his primary care provider (PCP).
- On 3/14/24, Tenant C3 received orders to wear two layers of tubigrips on his left leg, which were to be changed every day. Wound #13 was healed. He was able to return to wearing one layer of tubigrip size F to his right leg on 3/14/24. The orders of wearing his CPAP every night and elevating his legs three times daily continued.
- Tenant C3 discharged from the wound clinic on 3/28/24. All of his wounds were healed. Tenant C3 was to elevate his legs four times a day for thirty minutes daily. He was to wear 2 layers of tubigrip size F from his toes to the bend of the knee without wrinkles.

Staff at the program were given instructions on treatments to provide to tenants on the Documentation Survey Report. A new task was added for Tenant C3 on 1/13/24, alerting them Tenant C3 should wear tubigrips at all times. They should only be removed for showers, then placed back on. Staff should help him change to a clean pair of tubigrips daily. Staff should wash Tenant C3's feet before putting tubigrips on. This task was not amended when Tenant C3 received new wound orders on 1/25/24 to reflect he should not have tubigrips put on or taken off due to wearing a two-layer compression system. Staff documented they were taking the tubigrips on and off his legs from 1/13/24 until 3/31/24. Staff were not given instructions by the program nurse to apply two layers of tubigrips to Tenant C3's legs when the physician's orders directed them to do so. Staff were not instructed to check the dressings, watch for slippage or saturation and to notify the nurse or wound clinic immediately if these things occurred. Tenant C3 was not weighed daily to ensure he did not gain more than

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A 285	Continued From page 4 five pounds in five days. A review of Tenant C3's Documentation Survey Report dated 1/1/24 through 3/31/24 revealed staff were not directed to remind Tenant C3 to use his CPAP until 3/15/24. In addition, the January, February or March MARs contained any information or orders regarding wound care or utilization of tubigrips. On 10/2/24 at 11:07 AM, Tenant C3's daughter reported each time her father went to the wound clinic she would leave the wound clinic orders on the receptionist's desk when her father returned. There were issues with the staff following the orders, such as removing the tubigrips, and when they did not do this it caused the wounds. She asked the Assistant Director of Nursing and the previous nurse to help her father with his CPAP machine but this was never done. During an interview on 10/4/24 at 3:45 PM, Tenant C3's wound nurse reported if staff were applying tubigrips to Tenant C3's legs in addition to the 2-layer system which was put on at the wound clinic, this would have increased the pressure to his legs which was not good. Tenant C3's wounds did worsen throughout the month of February when his compression wraps slid down which was why the physician's orders stressed staff needed to monitor the wounds daily. It was also important for Tenant C3 to use his CPAP machine as his wounds would heal better if he had proper oxygenation. They noted in the clinic his lips were discolored and his oxygen levels were low. If his CPAP machine was used, the fluid would have come off his legs better and his healing would have improved. The wound nurse recalled Tenant C3's family was adamant about all of the wound care instructions being in the	A 285		

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Physician's orders due to concerns with the program following the orders.

On 10/2/24 at 2:15 PM, the Assistant Director of Health and Wellness confirmed the program did not follow Tenant C3's orders from the wound clinic..

In addition, Tenant C3 was seen for Anticoagulation Case Management Services (ACMS) for ongoing management of warfarin therapy on 2/12/24, according to an ACMS note. Tenant C3 was also diagnosed with atrial fibrillation and a history of transient ischemic attack for which he was treated with an anticoagulant medication, warfarin. Individuals on warfarin received a test called INR (international normalized ratio) which was a blood test that measured how long it takes for blood to clot.

Tenant C3's INR level was 1.6 on 2/12/24, with the target INR range being 2.0-3.0. The clinic staff attempted to speak with program staff on 2/12/24, 2/13/24 and 2/14/24 but were unable to connect with them. They left a message with the program receptionist on 2/13/24 and 2/14/24 but did not receive a call back. They faxed a note to the program and received a call from the former Assistant Director of Nursing (ADON) on 2/15/24 who confirmed Tenant C3's dose of warfarin but was unsure if he missed any medication.

An ACMS note dated 2/27/24 identified Tenant C3 returned to the Anticoagulation Clinic on 2/27/24 for another blood test. His INR value was 1.3, a subtherapeutic value. The clinician reached the former ADON and learned Tenant C3 missed his warfarin on 2/1/24, 2/15/24 and 2/22/24 due to being "out of the facility." Tenant C3's daughter

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reported her father was often gone for wound care on these days from about 2:30 PM - 5:30 PM, but was surprised the program was not ensuring he received his 5:00 PM dose of warfarin on these days. They agreed to move the administration time to the morning to ensure he would be at the program to receive his medication.

An ACMS note dated 3/13/24 documented Tenant C3 had another subtherapeutic INR level of 1.2 due to multiple missed doses in the past week. The Clinician spoke with the former ADON who noted Tenant C3 missed doses of warfarin on 3/6/24, 3/7/24, 3/10/24 and 3/13/24. The former ADON was investigating why Tenant C3 did not receive his medication. He provided education to staff on the importance of giving warfarin consistently and hoped it would not be an issue moving forward.

On 10/3/24 at 11:39 AM, the Executive Director reported she was told Tenant C3 was out of the building and missed his warfarin in February. She was told there was no warfarin available for Tenant C3 on the dates he did not receive it in March. There was no evidence staff received any training or education to prevent these situations from occurring again.

2. Review of Home Care Visit Notes on 10/3/24 revealed Tenant C2 began receiving Home Care nursing services on 12/12/23 for treatment of venous ulcers on her lower legs due to poorly controlled edema. Tenant C2 was diagnosed with hypertensive heart disease with heart failure, venous insufficiency, chronic diastolic heart failure and vascular dementia. At the time of Tenant C2's assessment for nursing services. she had multiple fluid filled blisters on her bilateral

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lower legs. One was open and one had drained through her tubigrips. Tenant C2 qualified for weekly visits.

On 1/1/24, the Home Care RN visited with Tenant C2 and noted during the 12/28/23 visit, the tenant's skin was intact with tubigrips in place. On 1/1/24, Tenant C2's legs were not in tubigrips. They had fluid filled blisters and the right lower leg was open. An unknown staff put a thick white substance on the wound, put a telfa pad on it and wrapped a strip of coban around her leg to hold the pad in place. Tenant C2 denied getting a full bath or shower, stating she just got sponge baths and nobody had put compression stockings on her since the last nursing visit. Tenant C2's legs were caked in dry skin. The patient said staff were not applying lotion to her legs and her husband was concerned about the patient not getting the proper care for her legs because they were just as bad as when Tenant C2 was admitted. The Home Care RN noted on 1/1/24 she was going to call Tenant C2's Primary Care Provider (PCP) the next business day to report below standard of care to her legs which had returned to a blistered and open state. The legs had been healed 4 days prior but now needed the wound care orders updated.

The Home Care RN documented in her notes the PCP provided the following wound care orders for Tenant C2 on 1/3/24: the Home Care RN was to perform dressing change to wound and instruct program staff regarding wound care procedure as appropriate. After return demonstration, program to perform dressing when the Home Care RN was not present. Staff were to remove the old dressing to Tenant C2's ulcers on the lower left and right legs, cleanse with saline, dry the area gently, apply unna boot, apply coban, apply

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tubigrip and change the dressing twice weekly.

The former Director of Health and Wellness documented in the program's progress notes she was informed by the Home Care RN of a new open area to Tenant C2's right lower extremity. She was informed the PCP would be sending new treatment orders.

The Home Care RN met with Tenant C2 on 1/5/24 and discovered her tubigrips were not on and her legs were openly weeping. Red wound bases were surrounded by large amounts of dry, flaky skin. The Home Care RN contacted the PCP about the condition of the tenant's legs and he discontinued the use of tubigrips. The Home Care RN reapplied Tenant C2's unna boots. She explained Tenant C2's healing was delayed due to the new lesion outbreaks bilaterally due to the program not using the tubular compression.

On 1/5/24, the PCP ordered daily weights for Tenant C2. If Tenant C2 gained 3 pounds or more in one day or 5 pounds or more in 1 week, the program should notify the Home Care RN or PCP.

On 1/25/24, the Home Care RN noted Tenant C2's dressings were intact. The skin underneath had small, red circular lesions which were nondraining and slightly raised. Tenant C2 was confused about why she had to wear the unna boots if she had no open areas. Staff were still not weighing Tenant C2 despite the order directing them to do so.

On 1/31/24, Tenant C2 was found in her apartment with tubigrips on, but over her socks. Her legs did not have lotion on them. There were no open sores. The Home Care RN gave report

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A 285	Continued From page 9 to the former ADON informing him staff needed to ensure they were washing, applying lotion and tubigrips correctly to prevent skin breakdown. Tenant C2 was discharged from Home Care nursing on 2/5/24 as her wounds were healed. A review of the tenant's January MAR revealed no revisions had been made after receiving the orders from the PCP on 1/5/24. A review of the January 2024 Documentation Survey Report for Tenant C2 revealed staff were instructed to put Tubigrips on both of her lower legs in the morning and remove them before bed. There were no instructions about applying the unna boot, coban or changing the dressing twice weekly. There were no instructions about cleansing Tenant C2's legs with saline or drying the area gently. Staff weighed Tenant C2 13 out of 31 days in January and the first 8 days of February, but not daily. A review of physician orders revealed an order dated 8/14/23 for Triamcinolone Acetonide External Cream twice a week to her legs. On 10/3/24 at 2:00 PM, the Executive Director confirmed staff did not follow the primary care providers orders when caring for Tenant C2's wounds.	A 285		
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	A 350		

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A 350	Continued From page 10 needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plans for 1 of 3 discharged tenants reviewed when their needs changed (Tenant C3). Findings include: 1. Record review on 10/1/24 of a Heart and Vascular office visit note dated 1/17/24 revealed Tenant C3 was diagnosed with coronary artery disease, hypertension and atrial fibrillation. He was being seeing for an annual cardiology follow up. Tenant C3 had a known cognitive impairment. Tenant C3 was wearing tubigrips for venous insufficiency and venous stasis ulcers. He wasn't sure when the tubigrips were last changed. During the physical exam, Tenant C3's tubigrips were removed and found to be saturated with fluid and malodorous. Four large Band-Aids were removed from different sites on the right left extremity below the knee with the appearance of venous stasis ulcers with purulence. There were venous stasis changes to the bilateral lower extremities with 2+ pitting edema. Tenant C3's daughter was going to attempt to get Tenant C3 into a wound clinic within the week. The program had some of Tenant C3's wound clinic orders (1/25/24, 2/22/24, 3/7/24, 3/14/24, 3/28/24) which indicated he received treatment weekly to the ulcers on his legs. The orders included instructions for the program regarding treatment needed for Tenant C3's wounds. There	A 350		

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A 350	Continued From page 11 were also recommendations for edema control, such as elevating Tenant C3's legs daily. Staff were to ensure Tenant C3 had his CPAP on every night, including proper application and fit of the mask. Tenant C3 had a service plan dated 8/22/23. The service plan identified Tenant C3 requested assistance with putting on his tubigrips in the morning and removing them in the afternoon. There was no update to the service plan to identify Tenant C3's new wound care needs beginning in January 2024, which often did not include wearing tubigrips daily. The 8/22/23 service plan identified Tenant C3 preferred no assistance with his CPAP/BIPAP. However, in January 2024 the program received physician's orders identifying staff were to ensure he was wearing his CPAP every night. There were no recommendations included for staff to encourage Tenant C3 to elevate his legs daily. The program did not update Tenant C3's service plan to address his increased needs beginning in January 2024. The Executive Director confirmed these findings on 10/3/24 at 2:00 PM.	A 350		
A 420	481-69.27(1)a Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: a. To monitor, at least every 90 days, or after a	A 420		

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A 420	Continued From page 12 significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to monitor the condition of 1 of 3 discharged tenants reviewed when they experienced a significant change (Tenant C3). Findings include: Record review on 10/1/24 of a Heart and Vascular office visit note from 1/17/24 when Tenant C3 was being seeing for an annual cardiology follow up. Tenant C3 was wearing tubigrips for venous insufficiency and venous stasis ulcers. He wasn't sure when the tubigrips were last changed. During the physical exam, Tenant C3's tubigrips were removed and found to be saturated with fluid and malodorous. Four large Band-Aids were removed from different sites on the right left extremity below the knee with the appearance of venous stasis ulcers with purulence. There were venous stasis changes to the bilateral lower extremities with 2+ pitting edema. Tenant C3's daughter was going to attempt to get Tenant C3 into a wound clinic within the week. The program had some of Tenant C3's 1/25/24 wound clinic order which listed new instructions for dressings, edema control and use of his CPAP.	A 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0288	A. BUILDING: _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF MUSCATINE	**3515 DIANA QUEEN DRIVE MUSCATINE, IA 52761**

(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 420	Continued From page 13 When Tenant C3 developed new ulcers on his bilateral extremities, the program nurse did not complete a nurse review to monitor his health status, prescriptions, and treatment orders. The Executive Director confirmed these findings on 10/3/24 at 2:00 PM.	A 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: Addington Place of Muscatine	DATE SURVEY COMPLETED: 12/2/24

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 A 285	**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.	**Tag #** A 285	**What initial correction was made?** DHW will be educated on Policy MP20 – Missed or Refused Medications, CL08 – Wound and Skin Care, CL09 – Compression/Anti-Embolism Stockings (TED Hose), and CP06 – Weights by 12/22/24 by the Division Director of Resident Care. MP20 – Missed or Refused Medications 1. Any missed or refused medications are documented in the resident's medication record in the narrative notes. 2. The prescribing physician/practitioner is immediately notified of the missed or refused medications using the Refusal of Medication Notification Form. a. If the prescribing physician/practitioner has outlined a timeframe and parameters for reporting missed or refused medications Med Techs will report according to	**How will we ensure and maintain compliance going forward?** DHW or designee will perform daily audits of medication administration for 8 weeks. Once the initial audit is completed, medication administration will be audited on an ongoing basis monthly. Going forward, if resident needs wound care, the resident will be put on home health. And will collaborate with home health and physicians to make sure physicians orders are being followed appropriately. DHW or designee will perform weekly audits of compression socks/ted hose tasks for 8 weeks. Once the initial audit is completed, compression	**Implementation Date:** 12/12/2024 **Completion Date:** Ongoing **Responsible Party:** Director of Health and Wellness or designee

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			those parameters. i. Physician/practitioner parameters must be retained in writing in the resident's chart under Physician Orders. CL08 – Wound and Skin Care Evaluate and manage resident skin care needs with an individualized Service Plan. a. Evaluate the need for assistance with showering, cleansing, and drying at risk areas. All wound care is to be provided by an appropriately licensed medical professional. a. The Community nurse may provide basic care to wounds such as skin tears. b. Any complex dressing changes or care of pressure injuries must be done by an outside agency/clinician. The Director of Health and Wellness will work with the resident's physician, other healthcare providers (physical therapists, dietitians, etc.), care staff, the resident, and family to identify appropriate services. Possible interventions may include but are not limited to: a. Provide the appropriate pressure reducing products for the area involved. b. Obtain consult with wound care/ostomy specialist. c. Obtain consult with physical therapy for seating evaluation if in wheelchair.	socks/ted hose tasks will be audited on an ongoing basis quarterly. Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant and will be followed by facility. DHW or designee will perform weekly audits of weight tasks for 8 weeks. Once the initial audit is completed, weight tasks will be audited on an ongoing basis monthly.	

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			d. Request nutritional supplements. e. Initiate repositioning schedule. f. Encourage 6-8 glasses of water daily (if not contraindicated by physician). g. Moisturize dry skin. h. Obtain orders for the appropriate treatment according to the specific skin problem. CL09 – Compression/Anti-Embolism Stockings (TED Hose) Residents will receive assistance with anti-embolism/compression stockings (e.g., TED Hose) as instructed by their physician. CP06 – Weights Weights are measured upon admission to obtain a baseline and monthly thereafter. a. Weights will be taken more frequently: i. When ordered by the resident's physician. Tenant C3 had been discharged prior to state survey. And a new assessment was done on March 19, 2024 prior to discharge. Tenant C2 had been discharged prior to state survey. And no new assessment was done prior to discharge when new orders were in place.		

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Tag #2 A 350	**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.	**Tag #** A 350	**What initial correction was made?** DHW will be educated on Policy AS05-Service Plans by 12/22/24 by the Division Director of Resident Care. Service Plans are created/updated: a. Prior to or at the time of move-in. b. 30 days after move-in. c. Every six (6) months. d. Whenever there is significant change in resident status. Tenant C3 had been discharged prior to state survey. And a new assessment was done on March 19, 2024 prior to discharge.	**How will we ensure and maintain compliance going forward?** DHW or designee will audit six resident's charts once per week for eight weeks to ensure all residents residing in the community have functional, cognitive and health status evaluations and service plans documented accurately. Once the initial audit is completed, resident charts will be audited on an ongoing basis quarterly.	**Implementation Date:** 12/12/2024 **Completion Date:** On Going **Responsible Party:** DHW or Designee
Tag #3 A 420	**Regulation and Reg Number** 481-69.27(1)a Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription	**Tag #** A 420	**What initial correction was made?** DHW will educate on Policy AS05-Service Plans and Nurse Review by 12/22/24 conducted by Divisional Director of Resident Care Nurse Reviews: (3) a. Nurse reviews will be conducted by a registered nurse (RN). b. Any resident experiencing a significant change in condition will have a nurse review. i. Residents not receiving personal or health-related services who are observed having a significant change in condition will be assessed by a registered nurse. ii. Residents receiving personal or health-related services will be:	**How will we ensure and maintain compliance going forward?** DHW or designee will audit six resident's charts once per week for eight weeks to ensure all residents residing in the community have a nurse review every 90 days. Once the initial audit is completed, resident charts will be audited on a quarterly basis.	**Implementation Date:** 12/12/2024 **Completion Date:** Ongoing **Responsible Party:** DHW or Designee

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	medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders.		1. Monitored quarterly or after the change in condition for any adverse reactions to medications and to make appropriate interventions. Assessment system was updated to trigger assessments and service plans prior to move in, 30 days after moving in and every 6 months. 2. Assessed for their health status and have recommendations and referrals made as needed. a. Implemented recommendations and referrals will be monitored for at least ninety (90) days for progress related to previous change in condition. Tenant C3 had been discharged prior to state survey. And a new nurse review was done on March 19, 2024 prior to discharge.		
Tag #4	**Regulation and Reg Number**	**Tag #**	**What initial correction was made?**	**How will we ensure and maintain compliance going forward?**	**Implementation Date:** **Completion Date:** **Responsible Party:**
Tag #5	**Regulation and Reg Number**	**Tag #**	**What initial correction was made?**	**How will we ensure and maintain compliance going forward?**	**Implementation Date:** **Completion Date:**

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					Responsible Party:
Tag #6	**Regulation and Reg Number**	**Tag #**	**What initial correction was made?**	**How will we ensure and maintain compliance going forward?**	**Implementation Date:** **Completion Date:** **Responsible Party:**
Tag #7	**Regulation and Reg Number**	**Tag #**	**What initial correction was made?**	**How will we ensure and maintain compliance going forward?**	**Implementation Date:** **Completion Date:** **Responsible Party:**

√ 5/14/25

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