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
	S0300	A. BUILDING: _____ B. WING _____	C 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 14 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 11 Total Census of Assisted Living Program for People with Dementia: 25 The following regulatory insufficiencies were cited during the investigation of Complaint #103431-C as well as the revisit conducted to determine progress toward correcting regulatory insufficiencies cited during investigations completed on 12/8/2021 (Tenant Rights).	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policies and procedures related to incident reports and medication administration for 3 of 5 current (Tenants #3, #4, #5) and 2 of 3 former (Tenants C1, C2) tenants reviewed. Findings follow:	A 150	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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1. The Program's policy and procedure regarding incident reports indicated staff would notify the nurse or designee if a tenant had fallen or if an unusual event occurred. An incident report form was to be completed by the Registered Nurse (RN) or designee. The incident report was to be factual, timed, dated and signed by the staff. Witnesses of the incident were to provide a factual statement. The incident report would be turned into the nurse as soon as possible. The nurse was responsible to follow up with a review of reportable incidents and enter it into the electronic system. The paper forms were kept for three years and the electronic system forms were kept indefinitely.

a). An incident report dated 3-5-22 indicated at 1:00 a.m. an agency staff (Staff D) completed a visual check on Tenant C1 and found her seated on the floor. Tenant C1 was not able to give an accurate statement regarding what had occurred. She denied any pain or discomfort. The staff attempted to get Tenant C1 up off the floor but she was combative. She called another staff to assist however the tenant continued to be combative. Frequent visual checks were completed and agency staff continued to attempt to get Tenant C1 off the floor. Toileting was also offered frequently. The staff who prepared the report was the Clinical Care Specialist. No witness statements were included with the incident report. There was no indication staff notiifed a nurse of this incident.

When interviewed on 3-31-22 at 1:03 p.m. the Clinical Care Specialist said Clinical Educator #1 called her on Saturday (3-5-22) in the afternoon and said she had been notified by second shift staff that Tenant C1 was on the floor and had possibly been on the floor for a length of time.

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She asked Clinical Educator #1 to interview staff and try to determine the length of time the tenant was on the floor and what interventions were attempted. She entered the incident report into the electronic system based on the conversations that had occurred. She was not sure if any witness statements had been written.

When interviewed on 4-5-22 at 3:50 p.m. and on 4-6-22 at 10:00 a.m. Clinical Educator #2 confirmed there were no witness statements related to the incident with Tenant C1 and there was not a handwritten incident report. She said the Clinical Care Specialist entered the incident report into the system on Monday 3-7-22, when she completed the change of condition.

In summary, an incident report was not completed when the incident occurred on 3-5-22 with Tenant C1. A handwritten incident report was not completed and an electronic incident report was entered into the system on 3-7-22 by the Clinical Care Specialist. The incident report was based on conversations with staff and not by staff who were working in the building when the incident occurred. In addition, staff did not notify the nurse of the incident until the afternoon of 3-5-22.

b). When interviewed on 3-29-22 Tenant #3 reported she had money missing the week before Christmas ($20.00). She told the Former Director about it. She did not hear anything back from the Former Director. She also said she had money missing last April ($400.00).

When interviewed on 3-29-22 and on 4-6-21 at 9:31 a.m. the Director said Tenant #3 had reported missing "Butler Bucks" which was a paper voucher to be used in the local community.

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Tenant #3 went to the Former Director regarding the missing "Butler Bucks" but she had not reported any actual cash was missing. The current Director and the Former Director went through Tenant #3's apartment and the "Butler Bucks" were not found. The Director confirmed there was no documentation related to Tenant #3's report of the missing "Butler Bucks" or missing items.

Documentation of Tenant #3's alleged missing money or "Butler Bucks" was requested and was not provided. An incident report was not completed related to allegation of missing money or property for Tenant #3.

c). When interviewed on 3-30-22 at 3:09 p.m. Staff C reported several days prior two tenants (Tenants #4 and Tenant #5) left the memory care unit and went to the AL side. Tenant #5's electronic wandering monitoring device sounded. Tenant #5 put in the four digit code, which was her birth date. First shift reported this incident to second shift.

Record review revealed Tenant #4 resided in the memory care unit and had a Global Deterioration Scale (GDS) of five, which indicated moderately severe cognitive decline. Tenant #5 resided in the memory care unit and had a GDS of four, which indicated moderate cognitive decline.

When interviewed on 3-30-22 at approximately 4:40 p.m. and 4-5-22 at 3:50 p.m. Clinical Educator #2 said staff notified her of the incident as she was the on-call nurse. Staff said Tenant #4 and Tenant #5 left the memory care unit. An electronic wandering monitoring device alarmed and staff responded. Staff sat with Tenant #5 as she was upset and Tenant #4 was redirected. The

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tenants did not leave the building. She told the staff to complete write a "staff note to the nurse" document but no document was completed. She did not direct staff to complete an incident report, as it was not an elopement.

An incident report was not completed related to Tenant #4 and Tenant #5 putting in the key pad code, exiting the secured memory care unit and setting off the electronic wandering monitoring device alarm at the front door.

2. Review of the Program's policy and procedure for medications indicated staff must follow the six "Rights" for medication administration, including right time and right documentation, with recording the initials after on the correct date on the MAR. Any violation of the rights constituted a medication error. A medication error form would be completed and submitted to the nurse.

Review of Tenant C2's file on 3-29-22 and 3-30-22 revealed medication administration records (MARs) reflected an order for Haldol Decanoate Solution 50 milligram (mg)/milliters (ml), 0.5 ml intramuscular (IM) in the afternoon every 30 days. The injection was to be given by the healthcare coordinator or hospice nurse.

- The January 2022 MAR reflected on 1-6-22 direct care staff initialed and charted a "9", which indicated "Other/See Progress Notes" related to the administration of Haldol. Progress notes dated 1-6-22 indicated the hospice nurse did not come that day.
- The February 2022 MAR reflected on 2-5-22 direct care staff initiated and charted a "9" which indicated "Other/See Progress Notes" related to the administration of Haldol. Progress notes dated 2-5-22 reflected the order; however, no

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explanation was given. Progress notes dated 2-7-22 indicated the Haldol IM injection was given late due to not having licensed staff in the building on the weekend. The injection was administered to the left deltoid.
- The March 2022 MAR reflected on 3-7-22 direct care staff initialed and a check mark was documented (documented as administered) related to the administration of Haldol.

Continued record review revealed the Controlled Drug Record for Tenant C2's Haldol injection reflected the following doses administered:
- On 1-7-22 at 12:15 p.m. 0.5 ml was given.
- On 2-7-22 at 2:45 p.m. 0.5 ml was given. The dose was documented as given by Clinical Educator #1.
- On 3-7-22 at 10:00 p.m. 0.5 ml was given. The dose was documented as given by Clinical Educator #1.

The January MAR did not reflect the dose documented as given on 1-7-22 on the narcotic record. It also did not reflect who administered the dose on the MAR. The medication was not administered on the scheduled date of 1-6-22.

The February MAR did not reflect the dose given on 2-7-22 as noted on the narcotic record and did not reflect who administered the dose on the MAR. The notes indicated it was administered late due to lack of licensed nursing staff in the building.

The March MARs reflected a dose administered; however, it was documented as administered by non-licensed nursing staff on the MAR. The narcotic record reflected the dose was administered by Clinical Educator #1 on 3-7-22 at 10:00 p.m.

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A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide services, cares and treatment that was adequate and appropriate for 2 of 5 current (Tenants #1, #2) and 2 of 3 former (Tenant C1, Tenant C2) tenants reviewed. Findings follow: 1. Review of Tenant C-1's file on 3-30-22 and 4-4-22 revealed a diagnosis of unspecified dementia without behavioral disturbance. Tenant C1 was staged at a six on the Global Deterioration Scale (GDS) on 3-7-22 which indicated severe cognitive decline, and a seven on 3-10-22 which indicated very severe cognitive decline. The service plan dated 3-3-22 reflected Tenant C1 had a history of falls, was an assist of one with mobility with a gait belt, and required stand pivot transfers to and from the wheelchair. Tenant C1 had days with increased pain and may need an occasional assistance with a wheelchair for transportation. Staff might need to use a gait belt as needed when she was unsteady. The service plan indicated Tenant C1 could not ambulate long distances without guidance or assistance. The service plan reflected Tenant C1 liked to climb out bed and onto the floor. She refused to let staff assist her and was aggressive or combative at times. If Tenant C1 refused to let	A 160		

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staff assist her, they should notify the nurse and call Tenant C1's family to see if they could come in to help. Tenant C1 was scheduled to receive eight safety checks per shift. The service plan also reflected Tenant C1 received hospice services. Tenant C1 died on 3-12-22.

Progress Notes indicated the following:
- On 3-2-22 at 2:30 p.m. it was noted staff completing rounds found Tenant C1 sitting on the floor on her buttocks next to the bed. Staff reported Tenant C1 moved her extremities well and had no reddened areas, bumps, or tender areas noted to her head. The tenant was "agitated/grumpy" and had pain in the left and right hip; however, more pain in the right hip. Tenant C1's legs were equal and no internal or external rotation was needed. Tenant C1 tried to stand but grabbed her left groin then favored her right leg.
- On 3-2-22 at 5:15 p.m. it was noted staff completed a check on Tenant C1 and observed her kneeling next to her bed. Tenant C1 was agitated and resistive to staff.
- On 3-2-22 at 8:51 p.m. it was noted hospice was contacted regarding Tenant C1's falls and complaints of pain to the right hip. Hospice was in the building at that time. Tenant C1's family and doctor were notified by hospice. Tenant C1's family did not want her sent out for x-rays and wanted her kept comfortable. Pain medications would be discussed in the morning and an attempt would be made to get orders for increased pain medications.
- On 3-2-22 at 11:45 p.m. it was noted staff completed rounds and observed Tenant C1 laying on her floor. Tenant C1 moved all extremities well and had no reddened areas, bumps or tender areas noted to the head. Tenant C1 said to help her and that she "hurt so bad."

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- On 3-3-22 staff reported Tenant C1 was a one person assist with transfers. Observations indicated Tenant C1 stood up with assistance and appeared to guard her left hip. Tenant C1 refused to pivot transfer.
- On 3-3-22 a phone call was received from Tenant C1's family with concerns regarding pain control and if an x-ray should be done. Family was told the nurse was waiting for a call back from hospice and would voice her concerns.
- On 3-3-22 a call was placed to hospice and a status update was given. Staff were concerned with her pain control and a visit to the Program was requested. Hospice was made aware of family's concern regarding pain control and questioning if an x-ray was needed.
- On 3-3-22 the hospice nurse and Clinical Educator #1 met at the Program and completed an assessment. The hospice nurse palpitated the right and left hip. There was no reaction to the left hip but Tenant C1 said "ouch" to a spot on the mid right hip. Tenant C1 grabbed her left groin when she stood. She favored her right leg more than left but alternated weight on both legs. Tenant C1's family arrived and options were discussed. Staff assisted Tenant C1 with toileting and back to the wheelchair. Tenant C1 was in pain with transfers and toileting cares. Tenant C1's family was going to decide if they wanted an x-ray done.
- On 3-4-22 staff notified the nurse Tenant C1's family decided they wanted an x-ray done. Hospice was contacted regarding the request.
- On 3-5-22 it was noted agency staff completed a visual check on Tenant C1 and she was seated on the floor. Tenant C1 was not able to give an accurate statement regarding what had occurred. Tenant C1 denied any pain or discomfort. Agency staff attempted to get Tenant C1 up off the floor but she was combative.Frequent visual checks

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were completed and agency staff continued to attempt to get Tenant C1 off the floor. Toileting was also offered frequently.

- On 3-5-22 a phone call was received from evening shift staff to notify the nurse that Tenant C1 had been observed on the floor that morning. Night shift staff had reported Tenant C1 sat down on the floor and was combative with attempts to get her up. Staff reported Tenant C1's family member was at the Program and assisted staff due to combativeness. Staff reported Tenant C1 did not allow for skin assessment or vitals to be completed.
- On 3-5-22 hospice was notified of Tenant C1 being on the floor. There were no injuries or pain reported by staff. Hospice said someone would be out Sunday or Monday.
- On 3-6-22 staff observed Tenant C1 sitting on the floor in the bathroom doorway. She scooted on her buttocks to the toilet using her hands and legs. Tenant C1 continued to have right hip pain and was assisted with two staff and a mechanical lift to the wheelchair.
- On 3-7-22 a change of condition assessment was completed due to multiple falls. The assessment revealed a small fluid-filled blister to the left knee (1 centimeter (cm) x 1 cm), a scabbed area to the left foot 2nd toe (0.4 cm x 0.4 cm) and two small reddened areas on the right buttock (1 cm x 1.5 cm each).
- On 3-7-22 a call was placed to Tenant C1's family regarding the skin issues noted above. The family was concerned about the pain to her groin and right hip area. The family had requested an x-ray be completed but talked to hospice and hospice said "no to the x-ray."
- On 3-7-22 it was noted hospice was informed of the skin issues and that Tenant C1's family now wanted portable x-rays completed. It was also requested to schedule morphine to better

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control her pain.
- On 3-7-22 hospice called and a new order was received for portable x-rays of the bilateral hips and pelvis.
- On 3-8-22 new orders were received for morphine sulfate 1 milliliter (ml) as needed every three hours, to increase fentanyl patch to 50 micrograms, to increase Haldol concentrate to 1 milligram (mg) as needed every 6 hours and to add Haldol intramuscular.
- On 3-9-22 x-ray results were received and there was a right femoral head fracture.
- On 3-12-22 Tenant C1 passed away.

An incident report dated 3-5-22 indicated at 1:00 a.m. an agency staff (Staff D) completed a visual check on Tenant C1 and found her seated on the floor. Tenant C1 was not able to give an accurate statement regarding what had occurred. She denied any pain or discomfort. The staff attempted to get Tenant C1 up off the floor but she was combative. She called another staff to assist however the tenant continued to be combative. Frequent visual checks were completed and agency staff continued to attempt to get Tenant C1 off the floor. Toileting was also offered frequently. The staff who prepared the report was the Clinical Care Specialist.

Further record review revealed a Patient Report document (date of service 3-8-22) indicating Tenant C1 had a "basocervical fracture of the right femoral neck. There is a mild superior translation of the shaft or the femur." It was noted on 3-9-22.

Review of the tenant's Documentation Survey Report for March 2022 (3-1-22 to 3-5-22) reflected visual checks eight times per shift. The checks for Tenant C1 on 3-4-22 at 10:00 p.m.,

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11:00 p.m. were documented at 11:55 p.m. The checks for 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m. and 5:00 a.m. were all documented at 5:15 a.m. by agency staff.

The tenant's Medication Administration Record (MAR) for March 2022 reflected an order for Sertraline HCl tablet 50 milligram (mg), one tablet per day for anxiety at 12:00 p.m. It was charted as refused on 3-5-22. Tenant C1 had orders for acetaminophen 325 mg, two tablets every six hours as needed for pain. It was not documented as administered as needed for March, including on 3-5-22. There was an order for halolperidol lactate concentrate 2 mg/milliliters (ml), 1 ml every six hours as needed for behaviors/agitation for 7 days. The first documented dose administered was on 3-5-22 at 3:19 p.m. and was charted as effective. Hydroxyine pamaote capsule, 25 mg, one capsule every 8 hours as needed for behaviors/agitation was ordered. It was not documented as administered on 3-5-22. The MAR reflected an order for morphine sulfate (concentrate) solution 20 mg/ml, 0.5 ml every three hours as needed for pain. The first dose administered on 3-5-22 was at 12:03 p.m. and was charted as effective.

When interviewed on 3-31-22 at 3:09 p.m. Staff D said she was an agency staff who worked 10:00 p.m. to 6:00 a.m. in the memory care unit on 3-4-22 into 3-5-22. She had worked at the Program a couple of times before. She said at one point after 12:00 a.m., she observed Tenant C1 crawling on the floor by her bed. She called on the walkie-talkie to the staff on the assisted living (AL) side and told her that Tenant C1 would not let her get her up. The staff on the AL side (Staff E) told Staff D if Tenant C1 was not hurting herself to just let her be. Staff E did not come

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back at that time. Staff D checked on Tenant C1 frequently and every time she was in a different spot, either sitting or crawling in her apartment. She said the first time she observed her on the floor she was crawling and the other times she was sitting. At one point Staff E came back and both Staff E and Staff D tried to get her up. Tenant C1 responded to leave her alone and was aggressive. Staff E said to leave her alone. No one called the nurse. She was not aware she needed to notify the nurse until after the incident when a corporate staff told her. She was also not aware Tenant C1 was on hospice so the hospice nurse was not contacted. She said Staff E attempted one time physically to get Tenant C1 up. Staff D asked Tenant C1 if she wanted to use the bathroom but she did not allow assistance. At shift report Staff D told Staff E to explain the situation to first shift as Staff E was the person who said to leave the tenant on the floor. A day shift staff (oncoming staff) said "I'm not poking the bear." Staff D said Tenant C1 did not express pain and did not seem to be in distress. She confirmed some of her visual checks were charted late. She said she should have insisted they get the tenant off the floor but she was following the direction of Staff E who worked at the Program permanently.

When interviewed on 3-31-22 at 4:49 p.m. Staff E said she worked 10:00 p.m. to 6:00 a.m. on the AL side. She said an agency staff (Staff D) had called for help at 1:00 a.m. and she went over to the memory care unit. Tenant C1 was sitting on her kitchen floor on her buttocks with her legs out in front of her and was looking for something. Staff E got to her level but Tenant C1 did not allow staff to assist. She believed Staff D kept checking on her every 30 minutes and Tenant C1 was not hurting herself and was okay. Staff E

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checked on Tenant C1 at 3:00 a.m. and found her asleep on the floor in her bedroom. She was laying on her side and had blankets on the floor. At 4:00 a.m. she came back to the memory care unit and Tenant C1 was sitting on the floor in the kitchen awake. She tried to get her up but Tenant C1 dug her fingernails into her and said to leave her alone. Tenant C1 did not have any complaints of pain, bruising or injury. She did not offer her medications, food or beverages. She did not go back to the memory care unit after 4:00 a.m. Staff F and Staff G were the staff coming on for first shift and she told them Tenant C1 had been on the floor most of the night. Staff F said "I'm not going to poke the bear." Neither the hospice nurse nor the on-call nurse were notified.

When interviewed on 3-31-22 at 2:38 p.m. Staff F said she worked 6:00 a.m. to 2:00 p.m. in memory care. When she came in on 3-5-22 Staff D was in the memory care unit. She was told Tenant C1 was on the floor, was combative and in pain. She said Staff G was in memory care with her. At the start of her shift Staff F observed Tenant C1 in the open doorway of her apartment. She checked her over and there was no bleeding but it seemed like she was in a lot of pain. Tenant C1 was seated on her buttocks with her legs out. She tried to help Tenant C1 up and got part way up but she was instantly in pain. Staff G stayed with the tenant while Staff F administered medications to other tenants. From 6:00 a.m. to 10:00 a.m. she and Staff G attempted to get her up 15 times but Tenant C1 wanted to be left alone and did not have any interest. She did not have pain unless she was touched. She was given breakfast (on the floor) but did not eat much. Sometime after 10:00 a.m. Tenant C1's family member came in. Tenant C1 was seated in the hallway in the doorway across from her

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apartment. The family member saw staff attempt to get the tenant up and said she was in too much pain. Staff F and Staff G finally got Tenant C1 into a wheelchair around 12:00 p.m. Her protective undergarment was removed and it was barely wet. When asked what her pain level was when her undergarments were being changed the tenant said it was a 7. Tenant C1 took her scheduled medications (no as needed pain meds were given). First shift fed her breakfast and a snack. Neither the on-call nurse nor hospice nurse were notified regarding the tenant on her shift.

When interviewed on 3-30-22 at 12:38 p.m. Staff H said at 7:00 a.m. on 3-5-22 she brought the cart to memory care for breakfast. Tenant C1 was in the doorway of her apartment with the door open. She was just inside the doorway with her back up against the door jam, picking at the carpet. She said hello to her and Tenant C1 nodded acknowledgement. She told staff breakfast was there via the walkie-talkie. Staff H said she was back in memory care for 15 minutes. When she left Tenant C1 was still seated on the floor. Staff brought the cart back up after breakfast. Staff H returned to the memory care unit at 11:00 a.m. and Tenant C1 had moved from her doorway to sitting against the wall across the hall.

When interviewed on 3-28-22 at 3:34 p.m. Staff B said when she arrived at 2:30 p.m. the tenant was on the floor and second shift was trying to get her up. She was sitting on the floor in front of her bed with no pants on. The tenant was given a PRN (as needed) medication for pain. She said Clinical Educator #1 was called.

When interviewed on 3-31-22 at 3:58 p.m. Staff I

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said she worked with Staff B and L on second shift. She was told Tenant C1 had fallen on third shift and was left on the floor. Staff I said Tenant C1 was off the floor when second shift arrived.

When interviewed on 3-30-22 at 11:18 a.m. Clinical Educator #1 (CE #1) said she received a telephone call from second shift staff on 3-5-22 regarding Tenant C1 on the floor. Someone had gotten the tenant up and the staff wanted to know if the Clinical Educator #1 was aware she had been on the floor. CE #1 said she had not received any telephone calls regarding Tenant C1 being on the floor prior to notification from second shift staff. She spoke with Staff F who said Tenant C1 was on the floor when she first observed her at 6:00 a.m. Staff F said the tenant was very combative and staff had attempted numerous times on first shift. She had no pain and was content. Medication and food was offered to her. Staff fed her on the floor. Staff checked on her more than the one hour frequency. CE #1 said Staff F had training on when to call the nurse but Staff F did not provide an answer regarding why she had not called. She also spoke with Staff E who worked the 10:00 p.m. to 6:00 a.m. shift. Staff E said she was notified Tenant C1 was on the floor and staff attempted several times to get her up but she was combative. Staff E said she did not want to bother CE #1 regarding why she had not called her. CE #1 notified the Clinical Care Specialist (CCS). The CCS did an assessment and noted a scab on the tenant's toe and possibly an abrasion.

An email from CE #1 to other corporate staff indicated she received a telephone at 2:30 p.m. on Saturday from agency staff, who was very upset. She asked if she had received a call regarding Tenant C1 on the floor and she told her

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no. She said another agency staff saw Tenant C1 on the floor from 9:30 a.m. to 10:30 a.m. She called Staff F and she said Tenant C1 was on the floor at 6:00 a.m. when she came on her shift. When asked why she did not call the on-call nurse, Staff F did not have much of answer, except that she should have called. Staff F said Tenant C1 was being combative and staff could not get near her. She said Tenant C1's family came in around 12:00 p.m. and helped get her off of the floor and to bed. The mechanical lift was not used due to her combativeness. CE #1 notified hospice at 3:00 p.m. but the hospice nurse did not come out as it was after the fact and there were no new injuries. The email indicated "Hospice only knows she was on the floor and I did not get a call until later." She spoke with Staff E who worked 10:00 p.m. to 6:00 a.m. and she said she worked with an agency staff. She said Tenant C1 had been on the floor all night sleeping and "scooting" herself around. Staff E said she went to back to help in memory care. Staff E did not give a reason as to why the on-call nurse was not notified. She was also told Staff H observed her on the floor when she delivered breakfast and she was still there when she went back to get breakfast.

When interviewed on 3-31-22 at 1:03 p.m. the CCS said CE #1 called her on Saturday (3-5-22) in the afternoon and said she had been notified by second shift staff that Tenant C1 was on the floor and had possibly been on the floor for a length of time. She asked CE #1 to interview staff and try to determine the length of time the tenant was on the floor and what interventions were attempted. The CCS did a skin assessment on 3-7-22 at 10:30 a.m. and Tenant C1 had a small fluid filled blister (1 cm x 1 cm) and a scabbed area on the left foot, second toe. She had two

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small reddened areas that were 1 cm x 1.5 cm. In the week prior to this incident Tenant C1 had three falls. Neither the family or hospice wanted the tenant sent out for x-rays but wanted her kept comfortable. A fentanyl patch was ordered to control pain. On 3-3-22 an evaluation was completed related to multiple falls and Tenant C1 was a contact guard for transfers. On 3-7-22 she called the family and portable x-rays were ordered and scheduled for 3-8-22. On 3-9-22 she was notified Tenant C1 had a right femoral head fracture. Tenant C1 was bed bound. There were no staff write ups related to the incident so it was decided to provide education to all staff. Staff D (agency staff) on third shift had charted some visual checks early and some late. She said visual checks should be documented when staff put visualized the tenant.

When interviewed on 4-5-22 at 1:15 p.m. Hospice Nurse #1 said Tenant C1 had multiple falls. She was in the building the last time the tenant fell and completed an assessment. There was no shortening or rotation noted. Tenant C1 always walked with a limp. After her last fall she stopped walking and did not bear weight. Initially family did not want an x-ray, then either family or the Clinical Educator #1 wanted one and asked if they could get an x-ray. She said yes but hospice would not pay for it. The x-ray was completed and Tenant C1 had a fracture. She said Tenant C1 should have been at a higher level of care related to her dementia and safety, including wandering, ambulation and frequent falls. She was not always notified of all falls and said the expectation was to be notified within 24 hours.

When interviewed on 4-5-22 at 3:30 p.m. the Director of Clinical Services with hospice said a telephone call was received on 3-5-22 at 3:05

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p.m. from Clinical Educator #1. The notification provided was that Tenant C1 was on the floor before breakfast, the family was present and assisted with getting her back in bed. There were no other notifications regarding Tenant C1 on 3-5-22. On 3-6-22 at 10:48 a.m. Clinical Educator #1 notified hospice that tenant C1 was having behaviors with cares and they needed syringes filled. A hospice nurse went out to that day.

Further record review revealed an Instant In-Service document dated 3-7-22. The topics included visual checks and when to notify the on-call nurse. The document indicated visual must be done timely and documented "in real time." Checks were to be documented in the electronic system according to the scheduled time. It was not acceptable to sign off visual checks two to three hours later or at the end of the shift. The document indicated staff must call the on-call nurse when a tenant was found on the floor before moving the tenant.

In summary, Tenant C1 had multiple falls on 3-2-22 and had complaints of pain, including to the right hip. A change of condition was completed on 3-3-22 and it was noted Tenant C1 was an assist of one with mobility with a gait belt and stand pivot transfers to and from the wheelchair. Interviews indicated Tenant C1 was non-weight bearing after the last fall and staff reported concerns of Tenant C1's pain control on 3-3-22. On 3-5-22 at 1:00 a.m. Staff D observed Tenant C1 on the floor and she refused staff assistance to get up. Staff D called for Staff E to help and was told to let her be if she was not hurting herself and was not hurt. Staff D reported they physically attempted to help her up twice and she checked on her frequently on the shift. The report given at shift change to first shift staff

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coming on included Tenant C1 was on the floor and had been during the night shift. Staff F reported she observed Tenant C1 on the floor when she arrived for work at 6:00 a.m. and attempts were made to get Tenant C1 up but she refused and was in pain when moved. Tenant C1 was assisted up from the floor at approximately 12:00 p.m. per interview. Staff working on third shift when she was first noted on the floor, did not call the on-call nurse regarding Tenant C1 being on the floor. Staff working on first shift did not call the on-call nurse regarding Tenant C1 being on the floor. A second shift staff called to ensure the on-call nurse knew Tenant C1 had been on the floor. Staff also did not notify the hospice nurse of Tenant C1 being on the floor and Staff D, the agency staff, was not aware she was on hospice. An assessment was completed on 3-7-22 (two days after the incident) and skin issues were noted including a small fluid-filled blister to the left knee, a scabbed area to the left foot 2nd toe and two small reddened areas on the right buttock. On 3-8-22 portable x-rays were taken and on 3-9-22 it was determined Tenant C1 had a "basocervical fracture of the right femoral neck." Third staff and first shift staff reported Tenant C1 was combative when attempts were made to assist her up off the floor. First staff reported Tenant C1 was in pain when moved. The MARs did not reflect any PRN medications administered for anxiety, agitation or pain during the time Tenant C1 was on the floor on 3-5-22. Tenant C1, who had falls with complaints of hip pain and changes in mobility in the days prior to the incident, was first observed on the floor at 1:00 a.m. and was not assisted up until about 11 hours later. There were at least six staff who observed her on the floor in that time period. As needed medications were not administered, nursing (hospice and on-call) staff were not notified, an

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assessment was not completed until two days after the incident and hourly visual checks on third shift were not documented at the scheduled times.

2. When interviewed on 3-31-22 at 3:58 p.m. Staff I said once in the past month she came on shift and Tenant C2 was in the same clothes she was in the prior shift when she worked. The tenant was in bed and was urine soaked. Staff I voiced concerns regarding Tenant C2 not getting up to eat during the shift prior. On that same shift she noted Tenant #1 was drenched in urine. He went to get up and the urine went down to his socks. He was also in the same clothing as the last shift Staff I worked.

When interviewed on 3-30-22 at 3:09 p.m. Staff C said it was dependent on the staff working regarding bathing services. He said some staff (agency/hospice) avoided giving a full shower due to behaviors. A couple of the tenants were violent, both verbally and physically.

Review of Tenant #1's file on 3-29-22 revealed the Documentation Survey Report for March of 2022 reflected the following:
- The intervention/task indicated to assist Tenant #1 to the toilet four times per shift and to provide incontinent care if needed. For March 2022 there were six omissions at 10:00 p.m. Additionally, there were tasks signed off; however, the tasks were not signed off when the task was scheduled. On 3-11-22 at 10:00 p.m. the assistance was signed off at 1:20 a.m. On 3-25-22 at 10:00 p.m. it was signed off at 5:15 a.m. and on 3-26-22 at 10:00 p.m. it was signed off at 2:20 a.m.
- The intervention/task indicated to complete visual checks eight times per shift. For March 2022 there were 11 omissions. Additionally, there

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were tasks signed off; however, they were not signed off when the task was scheduled. On 3-7-22 the 1:00 a.m., 2:00 a.m., 3:00 a.m. 4:00 a.m. and 5:00 a.m. checks were all signed off at 5:39 a.m. On 3-25-22 the 12:00 a.m. and 1:00 a.m. check were documented at 5:14 a.m. The 2:00 a.m., 3:00 a.m., 4:00 a.m. and 5:00 a.m. checks were signed off at 5:15 a.m. On 3-27-22 the 1:00 a.m., 2:00 a.m., 3:00 a.m. 4:00 a.m. and 5:00 a.m. checks were all signed off at 4:34 a.m. and 4:35 a.m.

Review of Tenant #2's file on 3-29-22 and 3-30-22 revealed the Documentation Survey Report for March 2022 reflected the following:
- The intervention/task indicated to take Tenant #2 to the restroom four times per shift to prevent "accidents" in the hallways. Staff were to ensure Tenant #2 at least attempted to go in the toilet. Staff was to visualize Tenant #2 attempting to use the toileting to prevent "accidents." For March 2022 there were six omissions. Additionally, there were tasks signed off; however they were not signed off when the task was scheduled. On 3-9-22 the 10:00 p.m. task was left blank and the checks on 3-10-22 at 2:00 a.m. and 4:00 a.m. were both signed off at 5:39 a.m. and were charted as refusals. On 3-22-22 the 12:00 a.m. 2:00 a.m. and 4:00 a.m. tasks were all signed off at 5:29 a.m. and were all charted as refusals. On 3-26-22 at 10:00 p.m. and 3-27-22 the 12:00 a.m., 2:00 a.m. and 4:00 a.m. tasks were all signed off at 4:36 a.m. and all were charted as refusals.
- The intervention/task indicated to complete visual checks eight times per shift. For March 2022 there were 11 omissions. Additionally, there were tasks signed off; however, they were not signed off when the task was scheduled. On 3-5-22 the 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00

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a.m. and 5:00 a.m. checks were all signed off at 5:14 a.m. and 5:15 a.m. On 3-7-22 the 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m. and 5:00 a.m. checks were all signed off at 5:37 a.m. On 3-10-22 at 2:00 a.m., 3:00 a.m., 4:00 a.m. and 5:00 a.m. the checks were signed off at 5:39 a.m. and 5:40 a.m. On 3-27-22 the 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., and 5:00 a.m. checks were all signed off at 4:36 a.m.

Review of Tenant C1's file revealed the Documentation Survey Report for March 2022 reflected the following:
- The intervention/task indicated to complete visual checks eight times per shift from 3-1-22 to 3-5-22 and then visual checks 16 times per shift from 3-5-22 to 3-12-22. For March 2022 (until her death on 3-12-22) the checks reflected omissions, including on 3-2-22 and 3-9-22. Additionally, there were tasks signed off; however, they were not signed off when the task was scheduled. On 3-4-22 the 6:00 p.m. check was documented at 8:51 p.m. The 7:00 p.m., 8:00 p.m. and 9:00 p.m. checks were documented at 8:52 p.m. On 3-5-22 the 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m. and 5:00 a.m. checks were documented at 5:15 a.m. On 3-10-22 the 10:00 p.m., 10:30 p.m., 11:00 p.m., 11:30 p.m. were all documented at 12:38 a.m. On 3-11-22 the 10:00 p.m., 10:30 p.m., 11:00 p.m. and 11:30 p.m. checks were all documented at 1:22 a.m.

Review of Tenant C2's file revealed the Documentation Survey Report for March 2022 reflected the following:
- The intervention/task indicated to encourage Tenant C2 to use the restroom and to assist with changing and removal of soiled protective undergarments. Staff were to attempt three times

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before documenting a refusal and if Tenant C2 did not wake up at night to use the restroom, staff were to check and change her protective undergarment. The task was scheduled every two hours. For March 2022 (until her death on 3-17-22) there were four omissions when the task was not documented as completed. Additionally, there were tasks signed off; however, were not signed off when the task was scheduled. On 3-6-22 the 4:00 a.m. check was signed off; however, was it was not completed until 5:52 a.m. On 3-13-22 the 12:00 a.m. task for toileting was signed off; however, it was completed at 3:17 a.m.

- The intervention/task indicated to reposition Tenant C2 four time per shift while in bed and to use pillows for positioning. For March 2022 (until 3-17-22) there were three omissions when the task was not documented as completed. Additionally, there were tasks signed off; however, were not signed off when the task was scheduled. On 3-5-22 the 1:00 a.m. task was signed off; however, it was completed at 5:12 a.m. On 3-6-22 the 1:00 a.m. task was signed off; however, was not completed until 2:46 a.m. On 3-17-22 the 1:00 a.m. task was signed off at 2:07 a.m.

- The intervention/task indicated to complete visual checks eight times per shift. For March 2022 (until 3-17-22) there were seven omissions when the task was not documented as completed. Additionally, there were tasks signed off; however, they were not signed off when the task was scheduled. On 3-5-22 the 1:00 a.m., 2:00 a.m. and 3:00 a.m. checks were signed off at 5:12 a.m. The 4:00 a.m. check was signed off at 5:13 a.m. On 3-6-22 the 1:00 a.m., 2:00 a.m. and 3:00 a.m. checks were signed off at 2:46 a.m. The 4:00 a.m. check was signed off at 5:52 a.m. On 3-14-22 the 12:00 a.m. check was

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A 160	Continued From page 24 signed off at 1:05 a.m. The 2:00 a.m. and 3:00 checks were signed off at 4:47 a.m. When interviewed on 4-5-22 at 3:50 p.m. Clinical Educator #2 confirmed these findings.	A 160		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide sufficient trained staff available to meet the needs of the tenants. This potentially pertained to all tenants (census of 25). Findings follow: 1. A tenant meeting was held with the monitor on 3-29-22 at approximately 12:15 p.m. with 11 tenants in attendance. The tenants said they did not have a housekeeper and their apartments were supposed to be cleaned every week but it wasn't happening. One tenant's bathroom had not been cleaned in a month. The tenants said bathing was supposed to be twice weekly, however bathing generally occurred every 2 weeks. Staff responded to the pendants in 20 to 30 minutes on average and one tenant waited 40 minutes. The tenants said there was one staff on the assisted living (AL) side and they were short staffed. There was no maintenance staff to fix things. One tenant mentioned missing several appointments as there was no transportation staff to take him. Tenants mentioned not enough activities were offered. In addition the public	A 325		

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restrooms were kept locked and they had to find someone to unlock them to use them. Several of the tenants wanted the public restrooms unlocked.

2. When interviewed on 3-28-22 at approximately 1:15 p.m. Staff A said some staff had left abruptly without a two week notice. Lately on first shift there was one staff in memory care and one staff in AL. The average pendant response was 10 minutes. Showers and morning cares were the biggest struggle. For activities the resident assistants (RAs) tried to do two or three quick activities per week. It used to be three activities per day however there currently was not a Life Enrichment Coordinator (LEC). Apartments were not getting cleaned as expected. The housekeeper quit without notice and the RA's now did the cleaning. The apartments were cleaned once every two weeks. Tenants were not getting showers and shower days were traded. There was no one available to transport tenants to doctor appointments.

On 3-28-22 at 3:34 p.m. Staff B said second shift was supposed to be three staff on and a floater. It had been one staff in memory care and one staff in the AL for a month. Showers, laundry and housekeeping got pushed back. Housekeeping was scheduled twice per week and was completed once every two weeks. The housekeeper left in February. She could not get baths and showers done and respond to pendants at the same time. She said tenants complained about not getting their apartments cleaned and not getting showers.

On 3-30-22 at 3:09 p.m. Staff C said the majority of the time there were two or more staff in memory care. Two to three times out of ten there

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was one person in memory care. Three out of seven days per week there was one medication manager in the building on second shift. That person administered medications for both memory care and the AL side. It took an hour to pass medications for both the memory care and AL side. Sup

3. Review of the Occupancy Agreement indicated Rent included all inside and outside building maintenance, and cleaning of common areas. Board included nurse availability for supervision, delegation and charting and scheduled transportation. Services included the emergency call system, personal laundry (two loads per week), linens changed once weekly, activities and exercise programs, weekly housekeeping and personal transportation.

4. Continued record review revealed the following changes or vacancies in leadership or department positions at the program:
- The Former Director left on 2-28-22
- The Former Healthcare Coordinator left on 6-4-21
- The Former Dietary Manager left on 2-28-22
- The Former Housekeeper left on 2-24-22
- The Maintenance Staff was on leave starting on 1-12-22
- The current Director was the previous LEC and there was no current LEC.

The ALP Monitoring Entrance Form reflected staffing patterns on first and second shifts was 1-1.5 staff in the memory care unit and 1-1.5 staff on the AL side. Third shift was 1 staff in memory care and 1 staff on the AL side.

Schedules for the weeks of 3-27-22 to 4-2-22 and 4-3-22 to 4-9-22 reflected the following for RAs

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(direct care staff):
- There was one Parker Place staff scheduled to work on the 6 a.m. to 2:00 p.m. shift Monday through Friday and one Parker Place staff on Saturday and Sunday. The remaining staff on first shift were filled from two staffing agencies.
- There were two Parker Place staff scheduled to work on the 2:00 p.m. to 10:00 p.m. shift. The remaining scheduled shifts were filled from two staffing agencies.
- There was one Parker Place staff scheduled to work on the 10:00 p.m. to 6:00 a.m. The remaining scheduled shifts were filled from two staffing agencies.

A review of Device Activity Reports (pendant history) indicated the following:
- From 3-4-22 to 3-6-22 there were three pendant calls that were greater than 15 minutes.
- From 3-16-22 to 3-18-22 there were three pendant calls that were greater than 15 minutes.
- From 3-27-22 to 3-29-22 there were two pendant calls that were greater than 15 minutes.

Resident Council minutes for the past three months were reviewed and indicated the following:
- On 12-13-21 at 2:00 p.m. it was noted tenant's pendants were not getting answered in a "decent" time. For maintenance the tenants said things took "a bit" to get fixed and the maintenance staff was out.
- On 1-24-22 it was noted they were hiring a new maintenance staff/driver and were looking to hire new RAs.
- On 2-21-22 it was noted they were hiring a new maintenance staff/driver and were looking to hire RAs.
- On 3-28-22 at 2:00 p.m. a meeting was held with the Director and 10 tenants in attendance. It

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A 325	Continued From page 28 was noted the current Community Relations Coordinator was leaving, they were working on a maintenance staff, a new nurse had accepted the position and driver (no explanation provided). For activities they were currently hiring for a LEC. They were currently looking for housekeeping staff and a nurse had accepted the healthcare coordinator position. The tenants said their apartments were not cleaned to expectations, the windows needed cleaned, the kitchen was cold, the handrails were not cleaned and to please vacuum before 8:00 p.m. When interviewed on 4-5-22 at 2:20 p.m. the Director said the tenant apartments were cleaned one time per week by RAs. They were hiring a housekeeper. She knew of no tenant complaints regarding housekeeping. When asked about the complaint related to housekeeping at the recent meeting lead by the Director (3-28-22), the Director said it was a pre-move in and was related to vacuuming and things not wiped down. There were no tenant complaints regarding the frequency of the cleaning. Regarding transportation, she said she and one of the RAs could provide transportation and they had hired a transportation staff the previous day. She was not aware of any tenants who missed appointments related to transportation. She had not heard any tenant concerns related to bathing services. She had not received any complaints related to the pendant response.	A 325		
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	A 350		

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specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to update service plans to reflect current needs for 1 of 2 current (Tenant #2) and 2 of 3 former (Tenants C1, C2) tenants reviewed. Findings follow:

1. Review of Tenant #2's file on 3-29-22 and 3-30-22 revealed he was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline.

When interviewed on 3-30-22 at 3:09 p.m. Staff C said there were three to four times Tenant #2 had choked staff to near unconsciousness. He had tried to exit the door but had not left the building. Tenant #2 was incontinent of bladder and bowel. He wore a protective undergarment and did not always allow staff assistance.

A Staff Communication to Nurse document dated 1-4-22 indicated staff walked down the hallway with Tenant #2 after attempting to get him back to his apartment. He went towards the door and told staff to open it. Staff told him it was a locked door and he acted like was to going to punch staff but did not. He backed away and then came at staff and pushed her into the wall with his hand at her throat. Tenant #2 had been up all night and maybe slept one hour. A Staff to Nurse document dated 2-8-22 indicated Tenant #2 got out of the memory care doors and staff redirected him. He had been trying to elope since supper. A Staff Communication to Nurse document dated

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2-20-22 indicated Tenant #2 had been in bed all shift. He refused all medications and did not eat or drink.

A review of Tenant #1's Progress Notes revealed the following:
- On 12-28-21 staff reported Tenant #2 yelled at staff and approached them. Staff provided reassurance and Tenant #2 grabbed staff's arms. Tenant #2 was redirected and no injuries were noted.
- On 1-5-22 Tenant #2 wanted to go home during second shift. He pounded on doors, yelled, cried, made fists, was exit seeking and set off several memory care door alarms. Tenant #2 calmed down before supper and then began exit seeking and yelling.
- On 1-17-22 it was noted Tenant #2 was agitated and aggressive with staff and said he wanted to go home. He threw the belongings he was holding on the floor and started crying. Tenant #2 pushed staff against the wall. No injuries were noted.
- On 1-27-22 staff entered memory care and walked past the tenant. He came up behind and put his arm around the staff's neck, squeezed and then pulled up. Another staff intervened and Tenant #2 released the first staff. He then then grabbed the second staff's arm, pushed them against the wall and held his forearm on their throat. Staff redirected Tenant #2 and there were no injuries noted.
- On 2-8-22 Tenant #2 approached another tenant sitting in a recliner and pulled the other tenant up by her wrists and arms.
- On 2-8-22 it was noted Tenant #2 was "very aggressive and agitated this shift." He attempted to urinate in another tenant's garbage can. Tenant #2 was redirected out of the room and he kicked staff in the knees. No injuries were noted.

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A 350	Continued From page 31 Tenant #2's service plan reflected a history of agitation/aggressive behavior. He had had increased behaviors/aggression, thought to be attributed to his pain from the skin cancer to his head. The doctor was adjusting his medications as needed. The service plan also reflected Tenant #2 was incontinent of bladder at times. Staff took Tenant #2 to the restroom four times per shift. Staff were to visualize him attempting to use the toilet. The service plan did not address the use of protective undergarments and staff assistance with protective undergarments. The service plan also did not reflect the physical behaviors displayed towards staff and tenants and the exit seeking behavior. 2. Review of Tenant C1's file on 3-30-22 and 4-4-22 revealed diagnoses included unspecified dementia without behavioral disturbance. Tenant C1 was staged at a six on the GDS, which indicated severe cognitive decline on 3-7-22 and a seven on 3-10-22, which indicated very severe cognitive decline. Tenant C1 received hospice services and died on 3-12-22. Progress Notes indicated the following: - On 3-2-22 at 2:30 p.m. it was noted staff completing rounds found Tenant C1 sitting on the floor on her buttocks next to the bed. Staff reported Tenant C1 moved her extremities well and had no reddened areas, bumps, or tender areas noted to her head. The tenant was "agitated/grumpy" and had pain in the left and right hip; however, more pain in the right hip. Tenant C1's legs were equal and no internal or external rotation was needed. Tenant C1 tried to stand but grabbed her left groin then favored her right leg. - On 3-2-22 at 5:15 p.m. it was noted staff	A 350		

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completed a check on Tenant C1 and observed her kneeling next to her bed. Tenant C1 was agitated and resistive to staff.

- On 3-2-22 at 8:51 p.m. it was noted hospice was contacted regarding Tenant C1's falls and complaints of pain to the right hip. Hospice was in the building at that time. Tenant C1's family and doctor were notified by hospice. Tenant C1's family did not want her sent out for x-rays and wanted her kept comfortable. Pain medications would be discussed in the morning and an attempt would be made to get orders for increased pain medications.
- On 3-2-22 at 11:45 p.m. it was noted staff completed rounds and observed Tenant C1 laying on her floor. Tenant C1 moved all extremities well and had no reddened areas, bumps or tender areas noted to the head. Tenant C1 said to help her and that she "hurt so bad."
- On 3-3-22 staff reported Tenant C1 was a one person assist with transfers. Observations indicated Tenant C1 stood up with assistance and appeared to guard her left hip. Tenant C1 refused to pivot transfer.
- On 3-3-22 a phone call was received from Tenant C1's family with concerns regarding pain control and if an x-ray should be done. Family was told the nurse was waiting for a call back from hospice and would voice her concerns.
- On 3-3-22 a call was placed to hospice and a status update was given. Staff were concerned with her pain control and a visit to the Program was requested. Hospice was made aware of family's concern regarding pain control and questioning if an x-ray was needed.
- On 3-3-22 the hospice nurse and Clinical Educator #1 met at the Program and completed an assessment. The hospice nurse palpitated the right and left hip. There was no reaction to the left hip but Tenant C1 said "ouch" to a spot on the

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mid right hip. Tenant C1 grabbed her left groin when she stood. She favored her right leg more than left but alternated weight on both legs. Tenant C1's family arrived and options were discussed. Staff assisted Tenant C1 with toileting and back to the wheelchair. Tenant C1 was in pain with transfers and toileting cares. Tenant C1's family was going to decide if they wanted an x-ray done.

- On 3-4-22 staff notified the nurse Tenant C1's family decided they wanted an x-ray done. Hospice was contacted regarding the request.
- On 3-5-22 it was noted agency staff completed a visual check on Tenant C1 and she was seated on the floor. Tenant C1 was not able to give an accurate statement regarding what had occurred. Tenant C1 denied any pain or discomfort. Agency staff attempted to get Tenant C1 up off the floor but she was combative. Frequent visual checks were completed and agency staff continued to attempt to get Tenant C1 off the floor. Toileting was also offered frequently.
- On 3-5-22 a phone call was received from evening shift staff to notify the nurse that Tenant C1 had been observed on the floor that morning. Night shift staff had reported Tenant C1 sat down on the floor and was combative with attempts to get her up. Staff reported Tenant C1's family member was at the Program and assisted staff due to combativeness. Staff reported Tenant C1 did not allow for skin assessment or vitals to be completed.
- On 3-5-22 hospice was notified of Tenant C1 being on the floor. There were no injuries or pain reported by staff. Hospice said someone would be out Sunday or Monday.
- On 3-6-22 staff observed Tenant C1 sitting on the floor in the bathroom doorway. She scooted on her buttocks to the toilet using her hands and legs. Tenant C1 continued to have right hip pain

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and was assisted with two staff and a mechanical lift to the wheelchair.
- On 3-7-22 a change of condition assessment was completed due to multiple falls. The assessment revealed a small fluid-filled blister to the left knee (1 centimeter (cm) x 1 cm), a scabbed area to the left foot 2nd toe (0.4 cm x 0.4 cm) and two small reddened areas on the right buttock (1 cm x 1.5 cm each).
- On 3-7-22 a call was placed to Tenant C1's family regarding the skin issues noted above. The family was concerned about the pain to her groin and right hip area. The family had requested an x-ray be completed but talked to hospice and hospice said "no to the x-ray."
- On 3-7-22 it was noted hospice was informed of the skin issues and that Tenant C1's family now wanted portable x-rays completed. It was also requested to schedule morphine to better control her pain.
- On 3-7-22 hospice called and a new order was received for portable x-rays of the bilateral hips and pelvis.
- On 3-8-22 new orders were received for morphine sulfate 1 milliliter (ml) as needed every three hours, to increase fentanyl patch to 50 micrograms, to increase Haldol concentrate to 1 milligram (mg) as needed every 6 hours and to add Haldol intramuscular.
- On 3-9-22 x-ray results were received and there was a right femoral head fracture.
- On 3-12-22 Tenant C1 passed away.

When interviewed on 4-5-22 at 1:15 p.m. Hospice Nurse #1 said Tenant C1 had multiple falls. She was in the building the last time the tenant fell and completed an assessment. There was no shortening or rotation noted. Tenant C1 always walked with a limp. After her last fall she stopped walking and did not bear weight. Initially family did

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not want an x-ray, then either family or the Clinical Educator #1 wanted one and asked if they could get an x-ray. She said yes but hospice would not pay for it. The x-ray was completed and Tenant C1 had a fracture. She said Tenant C1 should have been at a higher level of care related to her dementia and safety, including wandering, ambulation and frequent falls. She was not always notified of all falls and said the expectation was to be notified within 24 hours.

When interviewed on 4-5-22 at 3:30 p.m. the Director of Clinical Services with hospice said a telephone call was received on 3-5-22 at 3:05 p.m. from Clinical Educator #1. The notification provided was that Tenant C1 was on the floor before breakfast, the family was present and assisted with getting her back in bed. There were no other notifications regarding Tenant C1 on 3-5-22. On 3-6-22 at 10:48 a.m. Clinical Educator #1 notified hospice that tenant C1 was having behaviors with cares and they needed syringes filled. A hospice nurse went out to that day.
On 4-5-22 at 2:40 p.m. Clinical Educator #1 said staff called her on 3-3-22 due to Tenant C1 having a lot of pain. She met the hospice nurse at the building and an assessment was completed by the hospice nurse. Tenant C1 tried to stand up and grabbed her left groin, which always had issues. She favored her right leg. During the assessment she was going back and forth from the left and right leg. Staff was concerned as Tenant C1 had difficulty getting around. She talked with Tenant C1's family about the x-ray and pain control. She told her to call if she changed her mind and wanted the x-ray done. Staff called and said the family changed their mind and wanted the x-ray done. She notified hospice and they said they would take care of it. She said hospice changed Tenant C1's pain control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: _____ B. WING _____	C 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 36	A 350		

medications.

Tenant C1's service plan dated 3-3-22 reflected Tenant C1 had a history of falls, was an assist of one with mobility with a gait belt, and required stand pivot transfers to and from the wheelchair. Tenant C1 had days with increased pain and may need an occasional assistance with a wheelchair for transportation. Staff might need to use a gait belt as needed when she was unsteady. A service plan dated 3-7-22 reflected Tenant C1 had a history of falls, was an assist of one with mobility with a gait belt, and required stand pivot transfers to and from the wheelchair. A service plan dated 3-10-22 reflected Tenant C1 was not ambulatory and required repositioning in bed. The service plans dated 3-3-22 and 3-7-22 did not reflect Tenant C1's weight bearing status, pain management and interventions related to her pain. The Program received notified of the fractured hip on 3-9-22. The service plan updated on 3-10-22 did not reflect Tenant C1's hip fracture and pain management and interventions related to the injury.

3. Review of Tenant C2's file on 3-29-22 and 3-30-22 revealed a Staff Communication to the Nurse document dated 1-7-22 stating Tenant C2 did not eat unless fed. She only ate a few bites and could drink on her own. The nurse response was to encourage finger foods. A Staff Communication to the Nurse note dated 2-18-22 inquired if the kitchen could send something for Tenant C2 instead of a peanut butter and jelly (sandwich) for lunch and supper. She was eating very little. The nurse responded staff education was provided to the kitchen regarding finger foods.

On 3-30-22 at 3:09 p.m. Staff C said for the past

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	S0300	A. BUILDING: _____ B. WING _____	C 04/06/2022

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A 350	Continued From page 37 three month Tenant C2 ate finger foods. She did not eat a lot in the days before she went on bed rest. When interviewed on 3-30-22 Staff J said Tenant C2 ate finger foods and ate anywhere from 0 to 25% of her meals. Service plans dated 2-9-22 and 3-14-22 reflected Tenant C2 ate in the dining room and was dependent with meals, eating and drinking. Fluids were encouraged throughout the day. Staff were to report any changes in her ability to eat or drink to the nurse. The service plan did not reflect Tenant C2's assistance needed at meals, including the need for finger foods and encouragement provided with finger foods. 4. When interviewed on 4-5-22 at 3:50 p.m. Clinical Educator #2 confirmed these findings.	A 350		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure updated service plans due to a change in condition were signed by all	A 370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: _____ B. WING _____	C 04/06/2022

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A 370	Continued From page 38	A 370		

parties for 2 of 5 current (Tenants #1 and #2) and 3 of 3 former (Tenants C1, C2 and C3) tenants reviewed. Findings follow:

Review of Tenant #1's file on 3-29-22 revealed the service plan was updated on 2-8-22 and 3-24-22 due to changes in condition. The service plans were signed by a nurse; however, were not signed by Tenant #1 or Tenant #1's legal representatives. There were no documented attempts for signature for either party documented on the service plans.

Review of Tenant #2's file on 3-29-22 and 3-30-22 revealed the service plan was updated on 2-9-22 and 3-17-22 due to changes in condition. The service plans were signed by a nurse; however, were not signed by Tenant #2 or Tenant #2's legal representative. There were no documented attempts for signature for either party documented on the service plans.

Review of Tenant C1's file on 3-30-22 revealed the service plan was updated on 3-3-22, 3-7-22 and 3-10-22 due to changes in condition. The service plans were signed by a nurse; however, were not signed by Tenant C1 or Tenant C1's legal representatives. There were no documented attempts for signature for either party documented on the service plans.

Review of Tenant C2's file on 3-29-22 and 3-30-22 revealed the service plan was updated on 2-9-22 and 3-14-22 due to changes in condition. The service plans were signed by a nurse; however, were not signed by Tenant C2 or Tenant C2's legal representatives. There were no documented attempts for signature for either party documented on the service plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 370	Continued From page 39 Review of Tenant C3's file on 3-30-22 revealed the service plan was updated on 12-15-21 for a change in condition. The service plan was signed by a nurse; however, was not signed by Tenant C3 or Tenant C3's legal representative. There were documented attempts for signature for either party documented on the service plan. When interviewed on 4-6-22 at 9:01 a.m. Clinical Educator #2 confirmed the service plans were not signed by the tenants' legal representatives for the tenants reviewed. She said the service plans were discussed with families; however, were not signed.	A 370		

Parker Place
707 Hwy 57
Parkersburg, IA 50665

Date: May 24, 2022

Complaint/Investigation Intake #'s: 103431-C and revisit

Plan of Correction (POC) Submitted For:
- Recert or Investigation Date: 3/24/2022 to 4/06/2022
- Monitors: Stephanie Cummings

POC:

- **A 150 481-67.2(3) Program Policy and Procedures: The Program shall follow the policies and procedures established by the program.**
    - **Regulatory Insufficiency:** *The program failed to follow its policies and procedures related to incident reports and medication administration for 3 of 5 current (Tenants #3, #4,#5) and 2 of 3 former (Tenants C1, C2) tenants reviewed.*
    - **Program POC:**

1. Elements detailing how the insufficiency was corrected.
   a. All staff were re-educated on when to notify the nurse, visual check completion process and incident reporting.

2. Measures taken to ensure the problem does not recur.
   a. All staff were re-educated on when to notify the nurse, visual check completion process and incident reporting.
   b. Additional staff training will be completed to review new Incident Report form (how and when to complete), how and when to complete Staff to RN Communication Form and new Medication Error Report form, how and when to complete.
   c. New HCC will be educated on when staff need to notify the nurse, visual check process/expectations and how, when an incident report needs completed, use of staff to RN communication form and when a medication error form needs completed.

3. How the program plans to monitor performance to ensure compliance.
   a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance

ok 5/26/22

- **A 160 481-67.3(2) <u>Tenant Rights</u>: All tenants have the following: To receive care, treatment and services which are adequate and appropriate.**

    - **<u>Regulatory Insufficiency:</u>** *Program failed to provide adequate and appropriate care, treatment, and services to 2 of 5 current tenants and 2 of 3 former tenants.*
    - **<u>Program POC:</u>**

        1. **Elements detailing how the insufficiency was corrected.**
            a. **All staff were re-educated on visual check completion process**
            b. **Additional staff training will be completed regarding POC documentation and when to use PRN Medications.**

        2. **Measures taken to ensure the problem does not recur.**
            a. **Additional staff training will be completed regarding POC documentation and when to use PRN Medications**
            b. **New HCC will be educated on visual check process/expectations and when to utilize PRN medications.**

        3. **How the program plans to monitor performance to ensure compliance.**
            a. **Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance**

- **A 325 481-67.0(1) <u>Staffing</u>: Number of staff. A sufficient number of trained staff shall be available at all time to fully meet tenants' identified needs.**

    - **<u>Regulatory Insufficiency:</u>** *Program failed to provide sufficient trained staff available to meet the needs of the tenants. This potentially pertained to all tenants (census of 25).*
    - **<u>Program POC:</u>**

        1. **Elements detailing how the insufficiency was corrected.**
            a. **New Housekeeper hired on 4/5/2022**
            b. **Maintenance Director returned from medical leave on 4/29/2022, 2nd Maintenance personnel was hired on 5/16/22.**
            c. **New LEC hired on 4/1/2022**
            d. **New HCC hired on 5/09/2022**
            e. **New Driver hired on 04/27/2022**
            f. **New CRC hired on 04/27/2022**
            g. **Public restroom locks were changed on or around 04/08/2022 – no longer are locked**

        2. **Measures taken to ensure the problem does not recur.**

a. All staff will be educated/ re-delegated on Pendant Response and shower schedules and what to do if a resident refuses.
b. All new hires, as listed in a-f, will be appropriately trained to job duties and functions.

3. How the program plans to monitor performance to ensure compliance.
a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance

- **A 395 481-69.26(4)a <u>Service Plans</u>: 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.**

  - **<u>Regulatory Insufficiency:</u>** *Program failed to develop an individualized service plan to indicate identified needs and preferences for assistance for 1 of 9 discharged tenants reviewed.*
  - **<u>Program POC:</u>**

1. Elements detailing how the insufficiency was corrected.
a. Service plans on current residents have been reviewed by nursing staff to ensure that all needs/preferences are accurately listed on ISP.

2. Measures taken to ensure the problem does not recur.
a. Service plans will be reviewed with each assessment to ensure all residents needs are identified.
b. New HCC will be educated on Service Plan requirements and how/when to update.

3. How the program plans to monitor performance to ensure compliance.
a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance

- **A 370 481-69.26(3)a Service Plans: When a tenant needs personal care of health-related care, the service plan shall be updated with in 30 days of the tenants' occupancy and as needed with significant change, but not less than annually.**
  - **If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.**

  - **<u>Regulatory Insufficiency:</u>** *Based on interview and record review the Program failed to ensure updated service plans due to a change in condition were singed by all parties for 2 of 5 current residents (Tenants #1 and #2) and 3 of 3 former (Tenants C1, C2, AND C3) tenants reviewed.*
  - **<u>Program POC:</u>**

1. **Elements detailing how the insufficiency was corrected.**
   a. **Service plans on current residents have been reviewed by nursing staff to ensure that all needs/preferences are accurately listed on ISP.**

2. **Measures taken to ensure the problem does not recur.**
   a. **Service plans will be reviewed with each assessment to ensure all residents needs are identified.**
   b. **New HCC will be educated on Service Plan requirements and how/when to update.**

3. **How the program plans to monitor performance to ensure compliance.**
   a. **Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance**

Date of compliance 06/03/2022

Megan Kalkwarf
Community Director
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director@parkerplaceretirement.com