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 01/09/2025

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

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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: 13 Number of tenants with cognitive impairment: 11 Total census: 24 No regulatory insufficiencies were cited during the investigation into Incident #124682-I, Complaints #122874-C, #124665-C, #124562-C or the revisit to determine progress made in correcting FC10356. The following regulatory insufficiencies were cited during the investigation into Complaints #122690-C, #122875-C, #123359-C, #124506-C, #124872-C, #124058-C and the revisit to determine progress made in correcting FC10597.	A 000	The Plan of Correction is attached	
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	A 130		

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program failed to document all accidents and unusual occurrences on incident reports involving 1 of 3 discharged tenants reviewed (Tenant C1) and 3 of 15 current tenants reviewed (Tenant #4, Tenant #11 and Tenant #1). Findings include but are not limited to:

1) On 12/17/24 review of a hospital discharge record dated 7/7/24 revealed Tenant C1 was an 86 year old female who presented to the emergency room after a fall in which she hit her head. Tenant C1 suffered multiple right-sided subacute rib fractures. She was discharged back to the program.

An interview completed during the onsite visit between 12/9/24 and 1/9/25 revealed Staff K was working in the building when Tenant C1 fell on 7/7/24. Staff K reported she was alerted of the fall by the staff members who were present. Staff K was aware Tenant C1 fell from her wheelchair to the floor, was in pain, and left the building by ambulance. The program had no documentation such as progress notes, witness statements or an incident report documenting Tenant C1's fall on 7/7/24.

2) On 12/12/24 review of Tenant #4's progress notes revealed family found her in her apartment on 8/9/24 at 3:15 PM. The living area was messy with a lamp knocked over, a coffee pot taken apart and dishes out on the counter. A bottle of Lorazepam (a medication used to treat anxiety) was found in the top cupboard in a bowl in the tenant's room. The tenant showed no sign of distress when the nurse arrived. At 5:47 PM, the nurse received a phone call from Tenant #4's Primary Care Provider (PCP) who was notified by Tenant #4's daughter the tenant had a potential overdose of Lorazepam. The PCP asked the staff

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A 130	Continued From page 2 to complete vital signs every 15 minutes. There was no incident report documenting this unusual occurrence on 8/9/24. 3) During tenant interviews on 12/10/24, two tenants said a tenant from the secured memory care unit left the building recently and went to the grocery store across the street. A housekeeping staff was with the tenant, but was unable to get her to return to the program, so police were called. On 12/10/24 at 1:40 PM the Clinical Educator stated Tenant #11 left the building the prior week and crossed the street to the grocery store area. The housekeeper was with the tenant at all times, but was unable to convince her to return to the program. Tenant #11 became combative so the police were called. Tenant #11 went to the emergency room for assessment. The Clinical Educator said she documented the incident in Tenant #11's progress notes, but didn't see the need for an Incident Report since Tenant #11 was not out of staff sight and not injured. On 12/10/24 at 3:00 PM the housekeeper walked inside the building with Tenant #11, but the tenant exited out the front entrance. The housekeeper unsuccessfully tried to prompt Tenant #11 back to the building and tried to block her from crossing the street. It was very cold outside and neither of them had coats. The Life Engagement Coordinator came to assist and she brought coats for them. Tenant #11 was very agitated and resistant. The police were called and the tenant went to the emergency room for assessment. Tenant #11 was not injured. Review of Tenant 11's record revealed a progress	A 130		

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A 130	Continued From page 3 note written by the Clinical Educator on 12/03/34 regarding the incident that same day. The Clinical Educator documented the housekeeper took Tenant #11 for a walk to the grocery store and was unable to get the tenant back to the program. 911 was called after other staff attempted to assist and were unsuccessful with redirection. Tenant #11 went by ambulance to the emergency room, where she received IV fluids. Staff reported the tenant had refused her medication for several days. An incident report for this event could not be located. 4) During a tour of the secured memory care unit on 12/9/24 at 4:20 PM a cup of medication was found in Tenant #1's apartment. The medication was shown to Staff H who collected the pills. She identified the pills as evening medication and believed it must have been from 12/8/24. There was no incident report completed regarding this medication error. 5) The program had an Incident Report policy dated 5/15/24 which identified an incident report form would be completed if a tenant fell or any unusual event occurred. 6) On 1/8/24 at 4:35 PM the Clinical Educator confirmed there were no incident reports documenting these occurrences but there should have been.	A 130		
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.	A 150		

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A 150	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow the fall prevention and reduction policy for 1 of 3 discharged tenants reviewed (Tenant C1). Findings include but are not limited to: Review of an ambulance report dated 7/7/24 revealed the crew was called because Tenant C1 fell and hit her head on the toilet. Upon arrival, the tenant was sitting slumped over in her wheelchair in the dining area. The Emergency Medical Technicians (EMTs) received mixed stories from the staff regarding whether the fall was witnessed or unwitnessed. There was bruising and swelling on Tenant C1's right side next to her right eye and a hematoma to the right side of her head. Staff told the EMTs the tenant being slumped over was not her normal. A hospital discharge note for Tenant C1 revealed she presented to the Emergency Room (ER)after a fall with a head strike. She had multiple right-sided subacute rib fractures present on the CT scan. Tenant C1 was discharged back to the program with instructions regarding symptom management, conditions which should prompt emergent return to the ER and follow-up with her primary care provider. An interview conducted during the onsite visit revealed Staff K was paged by one of the employees working with Tenant C1 on 7/7/24. Other employees were with Tenant C1 in her bathroom and had been trying to get her from the wheelchair to the toilet when the fall occurred.	A 150		

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A 150	Continued From page 5 The tenant was laying on the bathroom floor and moaning. The employees were trying to hold her head up to see if she was coherent. Staff K thought someone may have tried to call the nurse or the lead Resident Assistant, but could not remember. Looking back, leaving Tenant C1 on the floor probably would have been the best option for the tenant. The program had a Falls Prevention and Reduction Policy, effective 10/15/2022, revised on 9/2023. If a fall occurred, timely notification to the nurse, the tenant's primary care provider and responsible party would take place. With a fall incident, staff would obtain a set of vitals, inspect the skin, and try to ascertain the level of pain. With the direction of a nurse, two staff would assist the tenant up with a mechanical lift or the activation of non-emergent emergency medical services. There was no evidence staff notified the nurse, primary care provider or responsible party. On 12/16/24 at 3:20 PM the Clinical Educator confirmed there was no evidence the staff contacted nurse triage to get direction on assisting Tenant C1 at the time of the incident. There was no evidence staff followed the Falls Prevention and Reduction Policy by contacting a nurse when Tenant C1 fell prior to getting her off the ground.	A 150		
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	A 160		

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A 160	Continued From page 6 which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to provide appropriate services to 5 of 15 current tenants reviewed (Tenants #1, #7, #13, #8 and #15). Findings include but are not limited to: 1) Record review on 12/10/24 revealed a note from Tenant #1's primary care provider (PCP) dated 10/31/24 which identified he was brought to the clinic on that date by the housekeeper for concerns of fever, fatigue and frequent bathroom usage. Tenant #1 was unable to provide information due to his underlying dementia. During a physical exam the PCP noted Tenant #1's incontinence brief was saturated with urine and feces. She noted incontinence associated dermatitis to the perineum and buttocks. The PCP notified the activity coordinator and on-call nurse of her concerns related to the incontinence associated dermatitis and tenant's poor hygiene. She recommended A&E ointment twice daily with cares. A review of Tenant #1's service plan, dated 11/6/24, made no note of skin issues. It indicated Tenant #1 required moderate assistance with toileting. Staff were to bring him to the toilet, check his Depends and change them if soiled. They should assist with any clean up necessary.	A 160		

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A 160	Continued From page 7 On 12/9/24 at 4:20 PM during a tour of the building, a staff member approached Tenant #1 to take him to his room to use the toilet. When observed moments later in the apartment, Tenant #1 and the staff member were in his bedroom changing his brief rather than doing this in the bathroom where he could practice good hygiene. An interview completed with Staff F during the course of the onsite visit revealed within the past few weeks she helped Tenant #1 into an incontinence brief on a Friday and he was wearing the same brief on Monday, which was soaked with urine. She knew this because some staff were initialing and dating the briefs during this time. Staff F informed the Clinical Educator about this via the nurse communication log. 2) A review of Tenant #7's service plan dated 9/23/24 revealed she was incontinent of urine. Staff were to cue her to the toilet two times per shift and change her soiled incontinence products. She required hands on assistance with removing her soiled incontinence undergarments, applying clean and dry garments and clothing as needed. Tenant #7's November 2024 Monthly Task Logs reflected staff documented they assisted her to the bathroom once per shift daily, with the exception of 11/13/24, when they cued her to the toilet twice on first shift and once on second shift. Staff documented they cued her to the toilet once per shift throughout the month of December. During the course of the onsite visit Staff C reported she did not think some staff provided incontinence cares to tenants as they should. She reported staff were supposed to initial and date incontinence briefs when they assisted in putting	A 160		

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them on the tenant. She worked on a Monday and when she returned to work on a Wednesday, Tenant #7 was in the same brief. The tenant did resist changing her brief, but it was a matter of knowing how to work with her that sometimes helped. Staff were supposed to notify the nurse when they had issues with things like briefs not being changed. Staff C had written in the nurse communication logs many times when she noticed tenants' briefs not being changed regularly but had seen no results from her reports.

3) A review of Tenant #13's service plan dated 9/13/24 noted the tenant was independent with toileting and was usually continent of bladder. However staff assisted the tenant with dressing and were to help her remove any soiled clothing and perform peri-care as needed.

An interview completed during the onsite visit revealed Staff J worked on a Monday and came back on a Wednesday and saw the same initials on Tenant #13's brief. On that Wednesday, there was runny bowel movement in her brief. Staff J assisted the tenant with a shower.

An interview completed during the onsite visit revealed over the summer Staff B expressed concerns to the nurse with tenants not getting incontinence cares performed regularly overly the summer.

4) On 12/10/24 at 9:50 A.M., Tenant #8 said she was concerned about waiting long periods of time after using her pendant to summon staff. Tenant #8's husband also voiced concern and said there were times when he visited his wife and found her sitting in a feces soiled brief as she waited for staff to respond.

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A 160	Continued From page 9 Review of pendant response times for November 2024 revealed seven times when Tenant #8 waited over 15 minutes for staff response, as follows: - 30 minutes on 11/22/24 - 25 minutes on 11/11/24 - 21 minutes twice on 11/20/24 - 19 minutes on 11/16/24 - 17 minutes on 11/14/24 and 11/22/24. Tenant #15 had 14 instances of waiting over 15 minutes during the month of November, varying from 32 minutes to 16 minutes. Other tenants also had wait times of over 15 minutes during the month of November, with a maximum response time of 39 minutes. 5) The policy for the Emergency Pendant System Alarm noted the program provided each resident with a 24-hour personal emergency response pendant. Staff were to go to the resident's apartment when notified of the pendant alert. When asked about the expectation for pendant response times on 1/08/25 at 9:50 AM, the Community Director consulted with the Clinical Educator. The Community Director then said they "strive for" a five minute response, but sometimes staff could not respond that quickly. The Clinical Educator confirmed these findings on 1/8/24 at 4:35 PM.	A 160		
A 275	481-67.5(2)f(2) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following:	A 275		

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A 275	Continued From page 10 f. When medications are administered traditionally by the program: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to ensure medications were kept in a locked place for 4 of 15 current tenants reviewed (Tenant #1, Tenant #6, Tenant #4 and Tenant #3). Findings follow: 1) During a tour of the secured memory care unit on 12/9/24 at 4:20 PM a cup of medication was found in Tenant #1's apartment. The medication was shown to Staff H who collected the pills. She identified them as evening medication and believed it must have been left there on 12/8/24. During the course of the onsite investigation Staff B recalled when she worked the day shift on 12/9/24 she found a cup of pills on Tenant #1's bedside table. She thought her co-worker, Staff I, put the pills in the medication room afterwards but was not sure about this. During the course of the investigation, Staff I stated she also saw the cup of medication on Tenant #1's bedside table. She reported this to Staff B who was the medication passer. Staff I was not responsible for passing medication, so she left it to Staff B to handle the situation. Record review on 12/10/24 revealed the Program's Medication and Medication	A 275		

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Administration Policy, revised 5/2024. The Policy directed medications should be kept in a locked location that was not accessible to persons other than employees responsible for the supervision of medications.

On 12/11/24 at 2:00 PM, the Clinical Educator confirmed it was not appropriate for staff to leave pills out on Tenant #1's table.

2) Observations on 12/23/24 at 10:55 AM revealed Staff F prepared Tenant #6's Oxycodone 2.5 ml (a narcotic used to treat severe pain) by placing it in thickened juice. Staff F handed the glass of juice with Oxycodone in it to Tenant #6. At 11:05 AM Staff F walked away from Tenant #6 to encourage other tenants to come to the dining room for lunch. Tenant #6 sat in a chair with the thickened juice and Oxycodone on her walker tray from 11:05 AM - 11:55 AM, occasionally taking sips. Other tenants and family members were present in the area during this time. At 12:00 PM Staff F placed the juice in the common area refrigerator as she and the hospice staff approached the tenant and assisted her back to her room. At 12:10 PM Staff F and the hospice worker returned to the common area where four tenants sat in front of the television. The juice with Oxycodone remained in the refrigerator unsecured from 12:00 PM - 12:10 PM while tenants and family members ate lunch and wandered the area. From 11:05 AM - 12:00 PM Staff F failed to encourage/interact with Tenant #6 as the juice and Oxycodone sat on the tray of her walker.

When interviewed on 12/23/24 at 12:15 p.m. the Director confirmed staff failed to follow policy by placing the Oxycodone in the unsecured refrigerator in the dining room while she assisted

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the hospice staff with Tenant #6. She added she went to memory care and made sure the juice with medication was placed in the secured refrigerator in the medication room.

3) Review of progress notes on 12/12/14 revealed Tenant #4's family found her in her apartment on 8/9/24 at 3:15 PM. The living area was messy with a lamp knocked over, coffee pot taken apart and dishes out on the counter. A bottle of Lorazepam (a medication used to treat anxiety) was found in the top cupboard in a bowl in the tenant's room. The tenant showed no signs of distress when the nurse arrived.

During the course of the onsite investigation Staff J recalled a period of time in the past couple of months when Tenant #4 was sleeping significantly more than normal. She was also tearing apart her lamp and throwing pillows. This was all out of character for the tenant. They eventually realized Tenant #4 had gotten into two bottles of pills that had been in her medication drawer.

During the course of the investigation, Staff H recalled two incidents in which Tenant #4's medication cabinet was unlocked, giving her access to her pills.

On 12/16/24 at 3:20 PM the Clinical Educator reported sometime in November, someone put bubble packs of medication in Tenant #4's apartment, leaving the pills in an unlocked cabinet. Tenant #4 then had access to her medication as the cabinet drawer did not properly lock. Since that time, her medication has been returned to the staff office.

4) On 12/16/24 review of Tenant #3's service plan dated 9/9/24 revealed staff were responsible for

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administering her medication. Her medication was to be kept in a locked cupboard in her apartment.

An interview with Tenant #3's daughter on 1/6/25 at 1:25 PM revealed sometime in October she took her mother out of the building and when loading up her walker, found about ten prescription pills in the pouch under her seat. She gave the pills to an employee who said she would dispose of them. The daughter was really concerned about her mother getting her pills as prescribed due to her mother's health conditions.

On 1/7/25 at 3:25 PM, the Clinical Educator was observed looking through the pouch under Tenant #3's walker after being informed of the results of the interview with the tenant's daughter the day prior. She found 4 loose pills and multiple pill cups in the pouch which she identified as 1 Atenelol, 2 Amlodipine Besylate (both types of pills to treat high blood pressure), and one unidentified pill.

A review of a 12/30/24 note from Tenant #3's PCP revealed she was prescribed Tremolo. Tenant #3's Amlodipine Besylate was discontinued on 12/30/24.

On 1/7/25 at 3:40 PM the Clinical Educator confirmed Tenant #3 was no longer taking Amlodipine Besylate. She did not know what the unidentified pill was in Tenant #3's possession. She confirmed it was not acceptable for Tenant #3 to have loose pills in her possession. She was not aware Tenant #3's family found pills in her possession in October 2024.

5) On 1/8/25 at 4:35 PM, the Clinical Educator confirmed the program did not ensure tenants'

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A 275	Continued From page 14 medication were kept secured at all times.	A 275		
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 follow physician's orders relating to medication and labs for 5 of 15 current tenants reviewed (Tenants #5, #4, #3, #6 and #1). Findings include, but are not limited to: 1) Record review on 12/11/24 revealed Tenant #5 was 83 years old, with diagnoses including diabetes, occlusion and stenosis of unspecified carotid artery, obesity and dementia. Tenant #5 received oral medications and insulin to manage his diabetes. According to his most recent service plan, dated 11/05/24, the program provided medication management services. On 12/12/24 at 8:30 AM Tenant #5's primary care provider (PCP) expressed concern regarding the program's management of the tenant's diabetes. The PCP stated Tenant #5 was recently hospitalized related to low blood sugar (BS). The PCP said Tenant #5's blood sugars had been	A 285		

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running high in November 2024, so she increased his insulin dose (medication used to treat high BS). The PCP later reviewed Tenant #5's November 2024 Medication Administration Record (MAR), which showed he did not always receive his insulin as ordered and staff had not consistently checked his BS four times per day, as ordered.

Review of Tenant #5's physicians orders, MAR and BS log for November 2024 revealed the following:

a. An order for Lantus (insulin) 62 units in the morning from 11/01/24 to 11/11/24. The Lantus was increased by the PCP to 64 units on 11/12/24 and then again increased to 66 units on 11/19/24, due to high BS levels. The order for PM Lantus was increased from 40 units to 42 units on 11/18/24. Additional orders included checking BS readings four times per day: 7:00 AM., 11:00 AM, 4:00 AM and 8:00 AM. Report to nurse if BS above 400 or below 65. Give Glucose chewable 4mg tablet if BS under 60, if no improvement after 15 minutes, may repeat. Tenant #5 also received Metformin and Glipizide (oral medications used to treat diabetes) twice per day. Tenant #5 used a Dexcom device to monitor his blood sugar readings.

b. AM doses of Lantus were not documented as given on 11/9/24, 11/10/24 and 11/11/24. PM doses of Lantus 40 units were not documented as given on 11/08/24, 11/09/24 and 11/10/24. There was no explanation on the MAR or in progress notes regarding why the Lantus was not given.

c. The November MAR blood sugar log indicated the staff failed to document the blood sugar reading ten times between 11/01/24 and 11/29/24.

d. The blood sugar log revealed a blood sugar of

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428 at 8:00 p.m. on 11/12/24. Nursing progress notes indicated staff notified the nurse of the high BS and she provided directives.

e. Nursing progress note for 11/18/24 indicated BS of over 400. PCP notified and increased Lantus to 66 units in AM and 42 units in PM.

f. Nursing progress note on 11/21/24 noted BS reading of 440 at 7:45 p.m. PCP notified.

g. Blood sugar log noted BS was 59 on 12/05/24 at 7:00 AM. According to the orders in place, staff should have notified the program nurse of the low BS and the tenant given a glucose tablet, with a 15 minute check. There was no documentation this was done. The MAR reflected Tenant #5 received his routine 8:00 AM Lantus injection.

h. Nursing progress note on 12/05/24 indicated Tenant #5 received first injection of Mounjaro (non-insulin diabetic medication) in the morning. When staff went to get him for lunch, his BS reading was "urgently low." Orange juice and glucose tablet brought BS up to 76. Tenant #5 requested 911 be called and he went to the emergency room, where he was admitted to the hospital. The progress note provided no information regarding a BS of 59 on the morning of 12/05/24.

i. November MAR had no documentation of a Mounjaro injection given on 12/05/24.

j. Nursing progress note on 12/06/24 indicated Tenant #5 returned to the program after an overnight stay at the hospital. According to the note, Tenant #5 had hypoglycemia related to medication. New orders were to discontinue the Mounjaro and Glipizide and to continue Metformin and Lantus 62 units in AM.

k. Nursing progress note on 12/11/24 noted multiple new orders from the PCP related to diabetes management, which included the following: call the PCP office if BS under 60 and hold insulin until hear back from provider; give a

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glucose tablet or juice for BS under 70 and recheck fingerstick glucose after 15 minutes; call office - do not fax - if BS below 70 and does not respond to glucose tablet or juice; if no Dexcom reading or if reading is below 70 or above 375 - double check reading with finger prick; check BS at 3:00 AM and 5:00 AM and give food if under 80. These orders were not listed on the December or January MAR.

On 12/12/24 at 1:20 PM the Clinical Educator (the covering registered nurse) said she didn't know why Tenant #5's Lantus was not documented as given from the evening of 11/08/24 through the morning of 11/11/24. She said she wasn't made aware the Lantus wasn't given during that time.

On 1/06/25 at 1:10 PM the Clinical Educator (CE) confirmed no documentation on the December MAR for the Mounjaro injection given on the morning of 12/05/24. She said she saw the staff person give Tenant #5 the injection. The CE indicated she didn't know why the injection was not documented on the MAR. Regarding the low BS of 59 on the morning of 12/05/24, the CE confirmed staff should have notified the nurse and given the tenant glucose or juice, but there was no documentation of this. The CE verified the order to notify the PCP office for BS under 60 and to hold the insulin injection until the program heard back from the provider was not listed on the December MAR after 12/11/24 or on the January MAR. She noted there was an order on the MAR to notify the nurse if the BS was under 65 and the nurse would contact the PCP office if BS was under 60. The CE also confirmed the MAR had an order to give a glucose tablet for BS under 70, but it did not indicate the BS should be checked again by a finger prick 15 minutes later or to notify the PCP office if the there was no

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response to the juice/glucose. She confirmed the MAR also failed to include the 3:00 AM and 5:00 AM blood sugar checks, with food given for BS under 80. The CE said she thought the 3:00 AM and 5:00 AM blood sugar checks were on the overnight task sheets, but was unable to locate this information.

2) Review of a PCP visit note dated 7/22/24 revealed the tenant was seen at her apartment to establish care and for concerns of agitation and anxiety. Tenant #4's diagnoses included Alzheimer's disease, dementia with agitation, history of pulmonary embolism (PE) and chronic anticoagulation. Tenant #4 was previously prescribed 5 mg. of Warfarin once daily (every day except Friday) and 7.5 mg. of Warfarin on Friday. Warfarin is a medication used to prevent blood clots. The provider requested the program send a copy of Tenant #4's last INR, a lab test indicating how long it takes blood to clot, as well as have the lab repeated. She was to return to see the new PCP in two weeks. Tenant #4's service plans dated 5/10/24 and 9/6/24 revealed the program administered her medication.

A review of PCP visits notes, MARs, pharmacy records and progress notes revealed the following:

a. Tenant #4 returned to see her new PCP on 8/8/24. The PCP's note revealed the tenant had not been receiving Warfarin since approximately 7/21/24 because it was not re-ordered by the former PCP. The program did not follow-up with the former provider to ensure the tenant had her medication. Tenant #4 had a history of Pulmonary Embolism (PE) requiring chronic Anticoagulation. The new PCP re-ordered the Warfarin on this date, a 30-day supply, with 11 refills.

b. A document provided by the program titled

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"Med Error Warfarin" identified Tenant #4's new PCP did not receive communication or orders on her INR results from 7/29/24. The program nurse investigated by looking at the tenant's EMAR, progress notes, uploaded documents, medication drawer and called the pharmacy. Tenant #4 had not received Warfarin since approximately 7/24/24. Adding to the confusion was the issue staff documented they administered Warfarin to Tenant #4 when there was no medication available on the following dates: 7/25/24, 7/26/24, 7/27/24, 7/30/24, 7/31/24, 8/1/24, 8/3/24, 8/4/24, 8/5/24, 8/6/24 and 8/7/24.

c. Tenant #4 met with her physician on 9/9/24 and no concerns were noted. Tenant #4's INR was due on this date. A progress note indicated a lab tech drew blood to test for the INR.

d. The pharmacist for Tenant #4 reported on 12/17/24 at 1:17 PM the program had a practice in which the pharmacy could only send out enough Warfarin to cover until the next INR date plus two days. The pharmacy provided a fill history document noting it provided the program with 10 Warfarin tablets for Tenant #4 on 8/30/24 which would have supplied her with enough medication for 9/1/24 - 9/11/24.

e. A review of the September MAR revealed staff documented they administered Warfarin to Tenant #4 every day 9/12/24 - 9/30/24 (with the exception of 9/13/24 when it was marked as DNA "did not administer") even though the medication was not at the building to provide to the tenant.

f. The program progress notes indicated on 9/30/24 Tenant #4 and her daughter met with her physician and requested to discontinue Warfarin and change to a different anticoagulant medication, Rivaroxaban, where INR checks were not required.

g. On 10/15/24 the program received an order from Tenant #4's physician to stop Rivaroxaban

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due to the cost of the medication. The family wanted to return to using the medication Warfarin. A lab order for an INR on 10/29/24 was placed. The program was to stop Rivaroxaban and begin administering Warfarin 5 mg. daily.

h. A review of the October 2024 and November 2024 MARs revealed the program continued to administer Rivaroxaban/Xarelto through the month of October until November 6th. There was no indication they alerted the physician they did not follow her orders and delayed starting the Warfarin. A progress note dated 1/7/25 indicated Tenant #4's daughter notified the nurse she wanted to use all of the Rivaroxaban prior to starting the Warfarin.

i. A review of the November 2024 MAR revealed staff began administering Warfarin to Tenant #4 beginning on 11/6/24. Staff documented they administered the medication throughout the month.

j. A review of a fill history from the pharmacy indicated 13 pills of 5 mg. Warfarin were dispensed to the program on 11/4/24 to start on 11/6/24. These pills would have lasted until 11/18/24.

k. A review of the December 2024 MAR revealed between 12/1/24 - 12/17/24, staff documented they administered 7 pills of Warfarin to Tenant #4. Other entries on the MAR were left blank or staff indicated they did not administer the medication.

l. Tenant #4 saw her physician at the program for ear pain on 12/9/24. She was due for an INR and staff were directed to obtain the lab test. The PCP made a medication change to stop Tenant #4's 10 mg. Olanzapine daily and 5mg. AM dose of Olanzapine. The program was to start Tenant #4 on 5 mg. of Olanzapine at noon and bedtime.

m. On 12/17/24, Tenant #4 was seen by her physician for a feeling of a plugged ear and a

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request for an INR. Tenant #4's daughter reported the program asked her to get an INR as they were late in obtaining this test. The PCP informed the daughter she had learned Tenant #4 had not received Warfarin for several weeks. The PCP had contacted the pharmacy and learned a 13 day supply of Warfarin was sent on 11/4/24 with no refills. The PCP ordered a new INR for 12/31/24. The PCP noted Tenant #4's medication change to Olanzapine from 12/9/24 had not been made and asked the program to correct it.

n. A review of progress notes indicated Tenant #4 was unable to get her INR test when the program tried to arrange this on 1/2/25 (the INR was due on 12/31/24). The PCP called the program on 1/3/25 and staff took the tenant to the hospital for the lab on that date. Tenant #4 discharged from the program on 1/4/25.

3) Record review on 12/16/24 revealed Tenant #3 was diagnosed with hypertension, depression, hyperlipidemia, alzheimer's disease, dementia with mood disturbance and COPD (chronic obstructive pulmonary disease).

A review of service plans dated 1/5/24 and 9/9/24 noted staff were responsible for administering Tenant #3's medication.

a. A note from Tenant #3's PCP dated 5/13/24 identified she had a history of a GI (gastro-intestinal) bleed. She directed the program to discontinue Tenant #3's Pantoprazole Sodium, 40 mg. She noted this medication was discontinued at the last appointment as well, but remained on the medication list. The PCP ordered the following labs due to hyperlipidemia, hypothyroidism and hypertension, respectively: lipid profile, TSH (test to check thyroid level) and comprehensive metabolic panel.

b. A review of labs ordered on 5/13/24 revealed

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they were not completed until 7/1/24. Tenant #3's TSH was elevated, a value of 15.7 when a normal value is 0.27 - 4.20. The PCP increased her Synthroid dosage from 88 mcg. to 100 mcg. daily.

c. Tenant #3 returned to see her PCP on 7/16/24 according to a visit note. Her Pantoprazole had been discontinued in both March and May but remained on the medication list. The PCP discontinued it again. The PCP directed the program to check the tenant's TSH (thyroid level) on 8/14/24.

d. A review of the program MARs revealed Pantoprazole Sodium 40mg. was administered from 4/1/24 through the morning of 7/2/24.

e. The program submitted medication orders to Tenant #3's PCP for review on 9/9/24. The PCP signed these and added a note reminding them the tenant was overdue for a TSH (ordered for 8/14/24). If the lab could not be drawn at the program, they could bring Tenant #3 to the clinic.

f. Tenant #3 was seen at the program on 9/12/24 by her PCP following a hospitalization for community acquired pneumonia, hypoxia and enterocolitis from 9/1/24 to 9/6/24. The PCP again ordered the TSH which the program had not obtained.

g. The PCP met with Tenant #3 at the program on 10/15/24 for a follow up appointment. Tenant #3 had not yet received a TSH to monitor her thyroid level.

h. Tenant #3 received her TSH lab test on 11/7/24. (Originally ordered on 8/14/24. Re-ordered on 9/12/24). The result was 16.00, with a normal range of 0.27 - 4.20. The PCP increased the tenant's Synthroid from 100 mcg. daily to 125 mcg. daily.

4) On 12/23/24 at 10:55 AM observations revealed Staff F prepared Tenant #6's Oxycodone 2.5 ml by placing it in thickened juice. Staff F

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handed the glass of juice with Oxycodone in it to Tenant #6.

Tenant #6 diagnoses included polyneuropathy, polyosteoarthritis and dementia. According to her most recent service plan, dated 9/09/24, Tenant #6 began hospice services on 3/15/24 related to end stage dementia.

Tenant #6's December physician's orders included orders for regularly scheduled Oxycodone oral solution 2.5 ml two times per day at 6:00 AM and 6:00 PM, and Oxycodone oral solution 2.5 ml as needed (PRN), every six hours.

Tenant #6's December MAR revealed she received no PRN Oxycodone during the month. The December narcotic count sheet for the PRN Oxycodone also indicated it was not given. The MAR indicated Staff F documented she administered the 6 AM Oxycodone on 12/23/24.

On 1/08/25 at 9:10 AM, Staff F confirmed she passed Tenant #6's medication on the morning of 12/23/24 in the presence of a state surveyor. Staff F didn't recall if she administered Tenant #6's AM Oxycodone when observed or if she administered the PRN Oxycodone. When told the MAR and the narcotic count sheet showed no PRN Oxycodone was given on 12/23/24, Staff F said she must have given Tenant #6 her 6:00 AM dose at approximately 11:00 AM. Staff F indicated she probably gave the medication late because she was the only staff person working in the Memory Care unit that morning. She usually got Tenant #6 up last in the morning because she needed supervision when eating.

On 1/08/25 at 11:30 AM, the Clinical Educator confirmed tenant medication should be passed

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around the time noted in the physician orders. She said the expectation was for medication to be passed within an hour before or an hour after the specified time. Tenant #6's 6:00 AM Oxycodone should have been administered by 7:00 AM.

The Medication and Medication Administration policy indicated specific timing may be important for certain drugs to be effective. If a certain time was specified for a medication, it needed to be given only at that time.

5) Record review on 12/10/24 revealed Tenant #1 had a diagnosis of unspecified dementia. A hospital discharge note revealed he was hospitalized from 11/2/24 to 11/5/24 with sepsis, acute metabolic encephalopathy, acute cystitis, transaminitis, lactic acidosis, hypokalemia, hyponatremia and E coli bacteremia. Tenant #1 completed his antibiotic on 11/14/24 without any signs of infection remaining. His 11/6/24 service plan noted staff were responsible for administering his medication.

a. On 12/9/24, Tenant #1 saw his PCP for a routine visit according to the visit note. Staff reported Tenant #1 was experiencing urinary frequency. A lab was ordered for a urinalysis and culture due to the urinary frequency.

b. On 12/24/24, the 60-day medication orders were sent to the PCP by the program. The PCP signed the orders and added a note she was waiting for results of the urinalysis ordered on 12/9/24. Staff were notified to collect the urine sample.

c. On 12/27/24, a urine sample was sent to the lab. The urine was assessed as acute cystitis with hematuria. The PCP ordered Cipro 500 mg., twice daily for 5 days.

The Clinical Educator confirmed these findings on

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A 285	Continued From page 25 1/8/25 at 4:35 PM.	A 285		
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 observation, interview and record review, the program failed to ensure an adequate number of staff were available to meet tenant's needs, potentially affecting 24 of 24 tenants living at the program. Findings follow: 1) Interviews with tenants, staff, providers and a review of documents during the course of the onsite investigation about their ability to meet the needs of tenants revealed the following: a. Staff F reported when there were two caregivers working in the building it was not enough staff because there were so many tenants with cognitive impairment who wandered. It was difficult to work in the secured memory care unit and complete showers, laundry, administer medication and serve meals by yourself. Staff F was aware of a time two weeks prior when she assisted a tenant into an incontinence brief on a Friday, which she dated and initialed and he was still wearing it the following Monday. It was very wet with urine that Monday. b. Staff A stated she believed tenants weren't receiving their eye drops and creams the way they were supposed to. She also said tenants in the memory care unit had been going out the back door. Tenant #1 and Tenant #11 were	A 325		

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leaving the unit and trying to exit the building through a door by a tenant's apartment. This tenant helped to redirect the #1 and #11 back to the memory care unit, which a tenant should never have to do. Staff A felt as if there just wasn't enough staff to properly supervise the tenants.

c. Staff C reported when she was the only staff member in memory care unit it was hard to respond to door alarms, get tenants up for the day, manage incontinence needs, complete the laundry and administer medication on time.

d. Tenant #10 reported staff administered her medication. She stated about 4 times a week, staff provided her pills more than one hour past the time they should be administered to her.

e. Medical Provider A served a number of tenants at the building and expressed concerns related to a lack of medical, housekeeping and maintenance needs being met. The provider expressed concerns for tenant safety.

f. During the November monthly Resident Meeting on 11/12/24, tenants reported the tenants from the secured memory care unit were leaving through the back door in the evenings, per the meeting minutes.

g. During the December monthly Resident Meeting on 12/12/24, tenants reported Tenant #1, Tenant #4 and Tenant #11 were noted to leave the unit in the evening, per the meeting minutes.

2) A review of a staff schedules for 12/1/24 - 12/12/24 revealed the following:

- on 1st shift from 12/1/24 - 12/12/24: 6 out of 12 days there were 2 Resident Assistants/Medication aides working the floor
- on 2nd shift from 12/1/24 - 12/11/24: 5 out of 11 days there were 2 Resident Assistants/Medication aides working the floor

On 12/12/24 at 1:00 PM, the Regional Director of

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A 325	Continued From page 27 Operations reported tenant needs could be met with two shift working if the right staff were in place.	A 325		
A 360	481-67.9(4)e Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: e. The program's registered nurse(s) shall provide direct or indirect supervision of all certified and noncertified staff as necessary in the professional judgment of the program's registered nurse and in accordance with the needs of the tenants and certified and noncertified staff. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the program failed to adequately train staff regarding 2 of 2 tenants reviewed with special dietary needs (Tenant #9 and Tenant #6). Findings follow: 1) During tenant interviews on 12/10/24, two tenants noted concerns regarding Tenant #9 related to eating. They said Tenant #9 had difficulty eating, so staff fed her. They noted Tenant #9 often coughed when eating. On 12/10/24 at 11:00 AM a dietary staff said only two tenants had special textured diets, including	A 360		

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Tenant #9, who had ground/soft food and thickened liquids.

On 12/10/24 at 11:35 AM observation revealed Staff E sat next to Tenant #9 at the dining table during lunch. The staff person used an adaptive built up handled fork to feed the tenant. Tenant #9 had thickened liquid with a straw. Her food consisted of a meatball cut into small pieces, soft fruits and vegetables. Staff E indicated staff routinely fed Tenant #9.

Interviews completed during the onsite visit revealed the following:
a. Staff A stated fed Tenant #9 in the past, but received no training on feeding her.
b. Staff C reported she had fed Tenant #9, but had not been trained on feeding her.
c. Staff E stated she had not been trained on how to feed Tenant #9. She said Tenant #9 had difficulty feeding herself due to a contracted hand.
d. Staff F said she fed Tenant #9 last week, but was not very familiar with her. She was not trained to feed Tenant #9 and heard staff were not supposed to feed her.

Record review revealed a speech therapy evaluation completed on 8/12/24 for Tenant #9 due to concerns of difficulty swallowing and coughing at meals. The evaluation noted Tenant #9 presented with Oropharyngeal Dysphagia characterized by coughing and pocketing food (holding food in mouth without swallowing). The evaluation noted Tenant #9 was at increased risk for aspiration and choking and made multiple recommendations and suggestions for feeding strategies.

Review of nursing progress notes revealed a note on 8/08/24 indicating staff reported Tenant #9

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coughed during meals. The nurse requested a speech therapy referral from the primary care physician (PCP). A progress note from the the nurse on 8/15/24 noted the speech therapist recommendations for a mechanical soft diet, nectar thick liquids, avoid fruit snacks, remain upright at 90 degrees for all oral intake and upright for 30 minutes after eating, and alternate cold and hot foods at meals.

Tenant #9's most recent Comprehensive Assessment dated 8/15/24 noted the diet change to mechanical soft diet and nectar thick liquids. The assessment indicated problems with swallowing, but provided no other information related to the speech therapy evaluation and the recommendations. According to the assessment, Tenant #9 ate independently.

Tenant #9's most recent service plan dated 8/15/24 indicated staff provided hands on assistance at meals, but also noted Tenant #9 was independent with eating. The service plan indicated the tenant was on a regular diet, with nectar thick liquids. Nursing services were listed as minimal, with occasional/monthly services such as ordering supplies and scheduling appointments. The service plan failed to contain the recommendations and feeding strategies listed in the speech therapy evaluation.

On 1/08/24 at 2:55 p.m. the Clinical Educator (CE) indicated she was not aware of the speech therapy evaluation for Tenant #9. She confirmed the information and recommendations should have been included in the service plan and trained to the staff. The CE said staff should assist Tenant #9 with eating, which could include feeding her.

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2) On 12/09/24 at 10:50 AM a family member of a memory care tenant said a female tenant on the memory care unit who was supposed to have thickened liquids, grabbed and ate some of her family member's bowl of cereal and milk. The other tenant began coughing after eating the cereal and milk. The family member said she reported the incident to a staff person, who said it was not her problem. The name of the tenant on the special texture diet was unknown.

On 12/10/24 at 11:00 AM a dietary staff indicated Tenant #6 was the only tenant in the memory care unit who had a special textured diet, which was a ground/soft food and thickened liquids.

On 12/10/24 at 11:40 AM Tenant #6 was observed at a small table with three other tenants as lunch finished. Tenant #6 had eaten the food on her plate. A tenant next to her had regular textured food on her plate. Staff F said Tenant #6 received soft or ground foods and thickened liquids. She said Tenant #6 frequently tried to take food from other tenants at the table. When asked why Tenant #6 was seated so close to other tenants who had regular textured diets, Staff F said Tenant #6 tried to take other people's food only when she didn't have her own plate of food in front of her. Staff F stated Tenant #6 chose where she wanted to sit for meals.

Interviews completed during the onsite visit revealed the following:
a. Staff H stated Tenant #6 received a soft diet with ground meat and thickened liquids. She said the tenant ate with her hands and quickly shoved food into her mouth. Tenant #6 tried to grab food from table mates during meals. Staff H said she usually sat Tenant #6 at the long table during mealtimes, with no other tenants next to her. Staff

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H stated she had not received any training on how to manage Tenant #6's eating concerns.

b. Staff I said Tenant #6 ate quickly with her hands, pocketed her food and resisted staff assistance. The kitchen sent ground meat, but it was often dry. Tenant #6 frequently coughed when eating. Staff I said the tenant frequently tried to grab food from the other tenants. Staff I stated she had not received any training on how to manage Tenant #6's eating concerns.

c. Staff A stated Tenant #6 ate and drank quickly, pocketed her food and resisted staff assistance. She coughed when she ate. Tenant #6 sometimes grabbed other tenants' food to eat it. Staff A said when she had the time, she sat by Tenant #6 as she ate and sometimes gave her small portions of food and drink at a time, but she was aware this was not in Tenant #6's service plan. Staff A said she had no training specific to assisting Tenant #6 with eating or how to address the food grabbing.

Record review revealed Tenant #6's most recent service plan dated 9/09/24 indicated she had swallowing difficulty and was at risk for choking. Tenant #6 coughed, choked or gagged when eating. She was also noted to overfill her mouth and pocket food. The service plan contained no interventions related to eating, other than an order for nectar thick liquids. The service plan made no mention of taking food from others, eating too fast or eating with hands. Diet texture was listed as general.

3) On 1/08/25 at 3:00 p.m. the Clinical Educator confirmed staff should have been training regarding eating concerns such as eating and drinking quickly, pocketing food and taking food from others.

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A 365	Continued From page 32	A 365		
A 365	481-67.9(4)g Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to retain a communication log for a period of not less than three years. Findings follow: Record review on 12/11/24 revealed the program could not provide all entries from the communication book from 8/1/24 through 12/11/24. On 12/11/24 at 2:00 PM the Clinical Educator confirmed she could not find all entries from 8/1/24 through 12/11/24 from the communication	A 365		

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A 365	Continued From page 33 book, reporting she would throw away some notes she received from staff about tenants if they came in on loose sheets of paper.	A 365		
A 345	481-69.25(3) Tenant Documents 69.25(3) All records shall be protected from loss, damage and unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to ensure tenant and personnel records were protected from loss and damage. Findings follow: On 12/11/24 at 8:35 AM a tour of Apt. 204 with the Clinical Educator revealed a bedroom that contained approximately 10 boxes filled with records from 6 former tenants. There were also employee records which included copies of driver's licenses and social security cards. The boxes and papers appeared crinkled, as if they had experienced water damage. During the course of the onsite investigation Staff G reported seeing boxes outside of the building by a shed on the program grounds. The former Director reportedly had staff take the boxes outside where they remained for about a week. When corporate staff saw the boxes outside, they were told to bring them back inside the building. During the course of the onsite investigation Staff D recalled someone reportedly told the former Director to clean up her office resulting in tenant and staff documents being placed by the dumpster. Staff D told the former Director she could get in trouble for this.	A 345		

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A 345	Continued From page 34 On 12/11/24 at 8:35 AM, the Clinical Educator confirmed the program records appeared to have been damaged when left outdoors for a week.	A 345		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to ensure the service plan identified the needs and preferences of 4 of 15 current tenants reviewed (Tenant #9, Tenant #10, Tenant #2 and Tenant #1). Findings include, but are not limited to: 1) During tenant interviews on 12/10/24, two tenants noted concerns regarding Tenant #9 related to eating. They said Tenant #9 had difficulty eating, so staff fed her. They noted Tenant #9 often coughed when eating. On 12/10/24 at 11:00 AM a dietary staff said only two tenants had special texture diets, including Tenant #9, who had ground/soft food and thickened liquids. Observation on 12/10/24 at 11:35 AM revealed Staff E sat next to Tenant #9 at the dining table during lunch. The staff person used an adaptive built up handle fork to feed the tenant. Tenant #9	A 395		

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had thickened liquid with a straw. Her food consisted of a meatball cut into small pieces, soft fruits and vegetables. Staff E indicated staff routinely fed Tenant #9.

Record review revealed a speech therapy evaluation dated 8/12/24 for Tenant #9 due to concerns of difficulty swallowing and coughing at meals. The evaluation noted Tenant #9 presented with Oropharyngeal Dysphagia characterized by coughing and pocketing food (holding food in the mouth without swallowing). The evaluation noted Tenant #9 was at increased risk for aspiration and choking. Recommendations included the following:

a. Pureed and mechanical soft consistencies with ground meat, nectar thick liquids

b. Sit upright at 90 degrees for all oral intake, remain upright for 30 minutes after meals.

c. Feeds self independently, but staff should provide cues to clear oral cavity when pocketing foods during meals.

d. Nursing should check for lung sounds and oxygen saturations (sats) 30-60 minutes following meals due to patient being at risk for increased aspiration. If patient presents with fever, nursing should contact physician.

e. Complete oral cares after meals.

f. Recommend patient complete a video swallow study to rule out aspiration.

The speech therapy evaluation also listed additional feeding strategies of feeding/eating slowly; taking small bites, alternating temperatures of food during meals; allowing bolus (mass of chewed food) to clear before initiating another bolus and to serve ground meat with gravy/sauce.

Review of nursing progress notes revealed a note

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on 8/08/24 indicating staff reported Tenant #9 coughed during meals. The nurse requested a speech therapy referral from the primary care physician (PCP). A progress note by the nurse on 8/15/24 noted the speech therapy recommendations for mechanical soft diet, nectar thick liquids, avoid fruit snacks, remain upright at 90 degrees for all oral intake and upright for 30 minutes after and alternate cold and hot foods at meals.

Tenant #9's most recent Comprehensive Assessment dated 8/15/24 noted the diet change to mechanical soft diet and nectar thick liquids. The assessment indicated problems with swallowing, but provided no other information related to the speech therapy evaluation and the recommendations. According to the assessment, Tenant #9 ate independently.

Tenant #9's most recent Service Plan dated 8/15/24 indicated staff provided hands on assistance at meals, but also noted Tenant #9 was independent with eating. The service plan indicated the tenant was on a regular diet, with nectar thick liquids. Nursing services were listed as minimal, with occasional/monthly services such as ordering supplies and scheduling appointments. The service plan failed to contain the recommendations and feeding strategies listed in the speech therapy evaluation.

On 1/08/24 at 2:55 p.m. the Clinical Educator (CE) indicated she was not aware of the speech therapy evaluation for Tenant #9. She confirmed the information and recommendations should have been included in the service plan. The current service plan was in error when it indicated the tenant was on a regular diet. The CE said staff should assist Tenant #9 with eating, which

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could include feeding her. She also confirmed the recommendation for nursing staff to listen to Tenant #9's lung sounds after meals was not being done and should have been addressed in the service plan.

2) On 12/09/24 at 10:50 AM a family member of a memory care tenant said a female tenant on the unit who was supposed to have thickened liquids grabbed and ate some of her family member's bowl of cereal and milk. The other tenant began coughing after eating the cereal and milk. The family member said she reported the incident to a staff person, who said it was not her problem. The name of the tenant on the special texture diet was unknown.

On 12/10/24 at 11:00 AM a dietary staff indicated Tenant #6 was the only tenant in the memory care unit with a special texture diet, which was ground/soft food and thickened liquids.

On 12/10/24 at 11:40 AM Tenant #6 was observed at a small table with three other tenants as lunch finished. Tenant #6 had eaten the food on her plate. A tenant next to her had regular textured food on her plate. Staff F said Tenant #6 received soft or ground foods and thickened liquids. She said Tenant #6 frequently tried to take food from other tenants at the table. When asked why Tenant #6 was seated so close to other tenants who had regular textured diets, Staff F said Tenant #6 tried to take other people's food only when she didn't have her own plate of food in front of her. Staff F stated Tenant #6 chose where she wanted to sit for meals.

During the course of the onsite investigation Staff H stated Tenant #6 received a soft diet with ground meat and thickened liquids. The tenant

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ate with her hands and quickly shoved food into her mouth. Tenant #6 tried to grab food from table mates during meals. Staff H said she usually sat Tenant #6 at the long table during mealtimes, with no other tenants next to her.

During the course of the onsite investigation Staff I said Tenant #6 ate quickly with her hands, pocketed her food and resisted staff assistance. The kitchen sent ground meat, but it was often dry. Tenant #6 frequently coughed when eating. Staff I said the tenant frequently tried to grab food from other tenants.

During the course of the onsite investigation Staff A reported Tenant #6 ate and drank quickly, pocketed her food and resisted staff assistance. She coughed when she ate. Tenant #6 sometimes grabbed other tenants' food to eat it. Staff A said when she had the time, she sat by Tenant #6 as she ate and sometimes gave her small portions of food and drink at a time, but she was aware this was not in Tenant #6's service plan.

On 1/06/25 at 2:05 p.m. Tenant #6's family member stated the tenant ate and drank rapidly, shoved food in her mouth and pocketed food when eating. When the family member visited in November, he noticed staff didn't monitor Tenant #6 as she ate. The family member said he tried to discuss this concern with an administrative staff, but felt his efforts were unsuccessful.

Record review revealed Tenant #6's physician's orders signed 12/23/24 included thickened liquids, but gave no indication of a special textured diet. No reference to a special textured diet could be located in orders or nursing progress notes.

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A 395	Continued From page 39 Tenant #6's most recent service plan dated 9/09/24 indicated she had swallowing difficulty and was at risk for choking. Tenant #6 coughed, choked or gagged when eating. She was also noted to overfill her mouth and pocket food. The service plan contained no interventions related to eating, other than an order for nectar thick liquids. The service plan made no mention of taking food from others, eating too fast or eating with her hands. Tenant #6's diet texture was listed as general. On 1/08/25 at 3:00 p.m. the Clinical Educator said she wasn't aware of a physician's order for a mechanical soft diet for Tenant #6. She said the order referred to by staff was likely based on a recommendation from the hospice nurse. The CE confirmed the eating concerns such as eating and drinking quickly, pocketing food and taking food from others should have been addressed in Tenant #6's service plan. 3) Review of progress notes for Tenant #2 dated 11/12/24 identified staff walked into his apartment and found him masturbating to a picture of his grandchild. Staff removed pictures of the grandchild from the apartment and communicated with the Clinical Educator. A care conference was held with the tenant's wife and his PCP was notified of the event. Review of Tenant #2's service plan dated 9/11/24 revealed the tenant might display socially inappropriate behavior such as banging on walls or yelling out during the day. There were no comments about acting out sexually. Staff were also to apply and remove Tenant #2's TED hose. He required physical assistance to dress and undress.	A 395		

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A 395	Continued From page 40 During the course of the onsite investigation Staff J stated she walked into Tenant #2's apartment and found him masturbating to pictures of his infant granddaughter. She removed the pictures from his apartment. During the course of the onsite investigation Staff C recalled hearing Tenant #2 saying odd things about children such as he would like to take a 10 year old into a closet and then started laughing. She entered his room several times and saw him in bed with the picture of his grandchild, but never with a picture of his wife. During the course of the onsite investigation Staff F reported Tenant #2 seemed to be increasingly confused and scared. She saw him in bed with the picture of his grandchild. She's heard the report of his sexual acting out but hadn't seen anything herself. No one directed her what to do if she saw him acting in a sexual nature. During the course of the onsite investigation Staff H reported when she came into work in the afternoon, Tenant #2 rarely had his TED hose on. The first shift workers would tell her they put the hose on, but the hose were laying in the same spot as when she took them off the night before. She knew Tenant #2 sometimes took his hose off, but did not think he would return them to the same spot where she left them. Tenant #2 had edema in his legs. Her biggest concern was Tenant #2's leg swelling. During the course of the onsite investigation Staff B reported there were times when she was busy administering medication to other tenants and the staff who was doing cares left Tenant #2's TED hose sitting on the table all day without putting	A 395		

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A 395	Continued From page 41	A 395		

them on his legs.

On 12/17/24 at 10:46 AM, Tenant #2's wife reported her husband often did not have his TED hose on when she came to visit him, which was almost daily. She found the hose sitting in the same position they were in when the 2nd shift staff removed the hose the previous evening. If her husband did remove his TED hose on 1st shift, she would like staff to help put them back on because his legs were really swollen when not wearing his hose. She did not think Tenant #2 would be able to take his hose off and put them in the same position the staff had them in.

Tenant #2's service plan was not updated to include interventions for staff on how to manage his sexual acting out or interventions on encouraging him to leave his TED hose on to reduce his edema.

4) Review of a PCP visit note dated 10/31/24 revealed Tenant #1 visited his PCP and was found to have irritant contact dermatitis due to urinary incontinence. His brief was saturated with urine and feces. The PCP ordered staff to apply Vitamin A&D ointment to his perineum and buttocks twice daily for 180 days.

A review of Tenant #1's service plan, dated 11/6/24, revealed he was usually continent of bladder and bowel. Staff were to bring him to the toilet six times daily, check his depends and assist with changing them if they were soiled. The service plan did not identify his dermatitis.

During the course of the onsite investigation Staff F reported Tenant #1 took himself to the bathroom more than any other tenant. He also regularly refused his A&D ointment when she

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A 395	Continued From page 42 attempted to put it on him. Staff F reported Tenant #1's refusals to the Clinical Educator by filling out the nurse communication log. During the course of the onsite investigation Staff A expressed she also experienced Tenant #1 refused to allow her to put on the A&D ointment when requested. Tenant #1's service plan did not reflect his skin issues, his tendency to refuse the Vitamin A&D Ointment or provide interventions for staff on how to encourage him to utilize the treatment. 5) On 1/8/24 at 4:35 PM the Clinical Educator confirmed she had not updated these tenant's service plans to reflect their needs and preferences.	A 395		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to have an operating alarm system connected to the front entrance door. Findings include: On 12/09/24 at 1:50 PM and 4:50 PM observations revealed the front entrance doors opened without difficulty and did not alarm when opened.	A 635		

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A 635	Continued From page 43 Observation on 12/10/24 at 8:00 AM revealed the same. On 12/10/24 at 12:50 PM, the Clinical Educator and the Life Engagement Coordinator verified the front entrance doors of the building did not have a general alarm system or alert staff when opened. The alarm system was operational before the end of the investigation.	A 635		
A 710	481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the program failed to maintain a sanitary environment in the secured memory care unit in which 12 of 24 tenants resided. Findings follow: 1) Observation on 12/09/24 at 2:25 PM revealed an unpleasant odor in Tenant #7's apartment, which smelled like feces. The smell was very strong in Tenant #7's bathroom. A brown substance, that appeared to be feces, was smeared all over the front of the toilet bowl and edge of the toilet rim. The same brown substance was also smeared on the floor in front of the toilet. Sheets and bedding were in a laundry basket under the bathroom sink. Four brown spots were observed in the bedroom carpet near the head of Tenant #7's bed and nightstand. This same brown substance was noted on her shoes	A 710		

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A 710	Continued From page 44 in the living room. At 4:20 PM the brown substance remained on Tenant #7's toilet and bathroom floor, as did the brown spots in the bedroom carpet. At 4:35 PM two staff exited Tenant #7's apartment, carrying a laundry basket with the sheets and bedding. The laundry basket was previously under the bathroom sink, which indicated the two staff had entered Tenant #7's bathroom. Observation revealed the brown substance remained on Tenant #7's toilet and bathroom floor after the two staff exited her apartment with the laundry basket. On 12/11/24 at 9:45 AM the brown spots remained on Tenant #7's bedroom carpet. 2) Observation on 12/9/24 at approximately 2:35 PM revealed Tenant #2's apartment with a wet spot on the carpet outside the bathroom door. The wet area was approximately four feet by one foot. When interviewed at 2:50 PM Tenant #2's wife stated she planned to move her husband out of the program by the end of the month. She indicated the tenant apartments were not cleaned well. The wife said Tenant #2 sometimes flooded his toilet and the toilet water would spread to the carpet in his living area. She said the carpet had not been shampooed in about a year. She was told the program shampooer was broken. Tenant #2's wife said she usually visited her husband daily. 3) On 12/10/24 at 11:40 AM, the top of Tenant #12's toilet lid was observed smeared with a brown substance or stain. Fecal material was	A 710		

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A 710	Continued From page 45	A 710		

splattered all over her toilet seat, inside of toilet lid and inside toilet bowl. An incontinence brief with bowel movement (BM) was in the bathroom trash can.

On 12/11/24 at 9:45 AM, the top of Tenant #12's toilet seat continued to be smeared with a brown substance or stain. A soiled brief lay on the bathroom floor.

On 12/12/24 at 10:45 A.M., Tenant #12's hospice nurse said she had concerns regarding the cleanliness of the tenant's bathroom. The hospice nurse and bath aide had noted BM in Tenant #12's carpet and on her bathroom floor. The nurse recalled an incident the week prior when she saw diarrhea consistency BM on Tenant #12's bathroom floor, as well as a soiled brief. Staff didn't respond promptly to clean the area when notified by the nurse. The hospice nurse said she cleaned the floor with wipes, but notified the staff the bathroom floor needed to be mopped. The hospice bath aide reported when she arrived approximately two hours later, the bathroom floor had not been mopped and toilet was not cleaned.

4) On 12/09/24 at 2:40 PM Tenant #7 was observed napping in a dark blue recliner in the common area. The left arm of the recliner appeared to have small pieces of food on it/ground into it. A strong odor was coming from the vicinity of the chair.

On 12/11/24 at 9:45 AM the left arm of the dark blue recliner in the common area continued to be soiled with what appeared to be bits of food. A light blue recliner in the common area had stains on the arms of the chair, as did an off-white easy chair.

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A 710	Continued From page 46 5) During a tour of Tenant #1's apartment on 12/9/24 at 4:20 PM, his bathroom was found to have a sticky substance on the floor as well as a brown substance on the floor on the inside and outside of the toilet bowl. On 12/10/24 at 8:29 AM, Tenant #1's toilet was filled with BM and there were drops of it on his floor. On 12/10/24 at 11:05 AM, Staff F reported she had not seen Tenant #1's toilet since approximately 8:30 AM, however the tenant generally did not turn on the light to request assistance when he used the toilet and was known to get BM all over the toilet and floor. During the course of the onsite investigation Staff C reported she believed the housekeeping in the memory care unit could be better. She reported management staff rarely went to the memory care unit so the area was forgotten. She has seen BM on the toilets, floors and walls a few times a week. She described the smell as horrible. During the course of the onsite investigation from Staff J expressed concerns related to the cleanliness of the memory care unit. She said the area always smells, which she thought was related to the furniture. She believed the housekeeper was to clean tenants' bathrooms daily. On 12/16/24 at 3:20 PM the Clinical Educator confirmed the housekeeping conditions in the secured memory care unit were not acceptable.	A 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0300	DATE SURVEY COMPLETED: 01/09/2025

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Tag #1	**481-67.2(1)e Program Policies and Procedures:** 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to document all accidents and unusual occurrences on incident reports involving 1 of 3 discharged tenants reviewed (Tenant C1) and 3 of 15 current tenants reviewed (Tenant #4, Tenant #11, and Tenant #1).	**A 130**	Staff will receive re-education on incident report process and expectations, to include medication errors by 3/30/2025. Incident Report for Tenant C1 was completed on 2/27/25. Progress notes were updated to reflect ER visit on 2/27/25. Tenant 4 moved out of community on 1/4/2025. Incident Reports for Tenant 4 were completed as follows: 8/9/24 Lorazepam potential overdose on 2/27/25. 9/12/24-9/30/24 Missed warfarin on 2/28/25. 12/9/24 Olanzapine Med Error on 2/28/25. 12/31/24 missed INR on 2/28/25.	All new hires will receive training on Incident Report process and expectations, to include medication errors, during new hire orientation. The new HCC will be trained in Incident Report Process and expectations, to include medication errors, within 30 days of hire. Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	**Implementation Date:** **Completion Date:** Ongoing **Responsible Party:** Director or designee

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			Incident Report for Tenant 11 was completed on 2/28/25. Incident report for Tenant 1 was completed on 2/28/25.		
Tag #2	**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 the fall prevention and reduction policy for 1 of 3 discharged tenants reviewed (Tenant C1).	**A 150**	Staff received initial re-education on Safe Resident Handling Policy (includes Fall Policy) and when to notify the nurse on 1/23/2025, all staff will complete by 3/30/2025.	All new hires will receive training on Safe Resident Handling (including Fall Policy) and when staff should notify the nurse during new hire orientation. The new HCC will be trained in Safe Resident Handling and when staff should notify the nurse within 30 days of hire. Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	**Implementation Date**: 12/12/2024 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee
Tag #3	**481-67.3 Tenant rights**. **(recitation)** 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 observation, interview and record review, the program failed to provide appropriate	**A 160**	An audit of all current tenants' service plans was completed on 1/14/25 to ensure that toileting needs are identified and scheduled appropriately to meet tenants' needs. All care staff will be re-delegated on cares to include toileting and incontinence cares by 3/30/25.	All new hires will complete care delegations to include toileting and incontinence cares with the RN within 30 days of hire. All new hires will receive training on pendant response expectations and use of pendant exception report during new hire orientation.	**Implementation Date**: 1/16/2025 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee

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	services to 5 of 15 current tenants reviewed (Tenants #1, #7, #13, #8 and #15).		All staff will receive re-educated on Pendant Response expectations and use of pendant exception report by 3/30/25. Staff received initial re-education on Residents Rights on 1/23/2025, all staff will complete training by 3/30/2025. Care audits were started on 1/16/2025 and will be completed weekly to ensure compliance. Tenant 1's toileting task was updated in ISP to reflect accurate toileting schedule and interventions on 1/13/25. Tenant 7's toileting task was updated in ISP to reflect accurate toileting schedule and interventions on 1/13/25. Tenant 13's toileting task was updated in ISP to reflect accurate toileting schedule and interventions on 1/13/2025.	All new hires will receive education on Resident Rights during new hire orientation. The new HCC will be trained in the Care Delegations process and pendant response expectations/exception report within 30 days of hire. The new HCC will receive training on Resident Rights within 30 days of hire. Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	

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			Tenant 8 moved out of the community on 12/28/24.		
Tag #4	**481-67.5(2)f(2) 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: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to ensure medications were kept in a locked place for 4 of 15 current tenants reviewed (Tenant #1, Tenant #6, Tenant #4, and Tenant #3).	**A 275**	Tenant T 1's cup of medications was immediately secured by staff. Tenant 6 medications were secured by the community staff on 12/23/2024. Tenant 4's Lorazepam was given to the RN and secured on 8/9/2024. Tenant 3's walker seat was searched by RN and any medications were removed on 1/7/2025. An audit of all medication managed residents' apartments was completed on 1/10/2025 to ensure all medications are secured. Medication storage audits will be completed at a minimum of weekly starting 2/18/25. Staff will receive education regarding Medication policy highlighting medication storage by 3/30/2025. The medication cabinet lock on apartment 204 medication cabinet will be fixed by 3/30/25.	All new hire direct care staff will receive training on Medication Policy highlighting medication storage during new hire orientation. The new HCC will be trained on Medication Policy highlighting medication storage within 30 days of hire. The new HCC will be trained on Medication Delegation Process within 30 days of hire. Director and/or designee will complete routine audits of medication managed residents' apartments weekly, monthly, as needed, as determined by the Director, Nurse, or designee to ensure compliance.	**Implementation Date:** **12/23/2024** **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee

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			All medication delegated staff will be re-delegated on Medications by 3/30/25.		
Tag #5	**481-67.5(2)f(4) Medications: (recitation)** 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 follow physician's orders relating to medication and labs for 5 of 15 current tenants reviewed (Tenants #5, #4, #3, #6 and #1).	A 285	A Lab binder was created on 1/16/25 to better track lab draws for residents. Nurse training was completed on use of lab book and order processing expectations on 1/16/2025 with onsite nurse. Allen Hospital lab will be conducting lab draws routinely 1-2 times per week as needed based on lab orders. Staff will receive re-education regarding Medication Policy by 3/30/2025. Tenant 5 incident report/med error for not receiving Lantus 11/8/24-11/11/24 was completed on 2/28/25. Tenant 4 moved out of community on 1/4/2025. Incident Reports for Tenant 4 were completed as follows: 8/9/24 Lorazepam potential overdose on 2/27/25. 9/12/24-9/30/24 Missed warfarin on 2/28/25. 12/9/24 Olanzapine Med Error on 2/28/25.	All new hire direct care staff will receive training on Medication Policy during new hire orientation. The new HCC will be trained on Medication Policy within 30 days of hire. The new HCC will be trained in the use of the lab book, specimen collection expectation and order processing expectations and follow-up within 30 days of hire. All new hires will receive training on Incident Report process and expectations, to include medication errors, during new hire orientation. The new HCC will be trained in Incident Report Process and expectations, to include medication errors, within 30 days of hire. Director and/or designee will complete routine audits of orders, to include lab draw completion and that results were received, weekly, monthly, as needed, as	**Implementation Date:** 1/16/2025 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

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			12/31/24 missed INR on 2/28/25. Tenant 6 incident report/med error for Oxycodone being administered late was completed on 12/23/24. Tenant 1 incident report was complete for UA not being collected as ordered on 12/9/24 on 2/28/25. Progress notes will be updated to reflect receiving of UA order on 12/9/24 and issues with specimen collection by 3/30/25. Tenant 3 incident reports for missing TSH lab draws on 5/13/24, 8/14/24 and 9/12/24 were completed on 2/28/25. Tenant 3 incident report/medication error for Pantoprazole was completed on 2/28/25. Staff counseling(s) were completed on 12/19/2024 for all staff who documented administration of Tenant 4's warfarin for date range of 11/19/2024 to 12/17/2024.	determined by the director or designee to ensure compliance.	

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			A medication error report was completed on 12/20/2024 for Tenant 4 for warfarin error. Staff will receive re-education regarding the Medication Policy to include 6 Rights of Medication Administration by 3/30/25. Medication cabinet audits were implemented on 12/18/2024 and will be completed at minimum of weekly to ensure compliance. Medication documentation reports will be run and followed up at minimum weekly, implemented the week of 1/10/2025. The On-site nurse will receive re-training on order processing and appropriate follow-up and specimen collection expectations by 3/30/2025. All medication errors will be completed and reported to DIAL within 24 hours or on the next business day. All on-site nurses will receive training on medication error reporting to DIAL by 2/25/25.		
Tag #6	**481-67.9(1) Staffing** 67.9(1) Number of staff. A sufficient number of trained staff shall be	**A 325**	All staff will receive re-educated on documentation expectations by 3/30/25.	All new hires will receive training on documentation expectations during new hire orientation.	**Implementation Date**: 1/16/2025

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	available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to ensure an adequate number of staff were available to meet tenant's needs, potentially affecting 24 of 24 tenants living at the program.		All care staff will be re-delegated on care delegations by RN by 3/30/25. Care audits were started on 1/16/2025 and will be completed weekly. Tenant 1's ISP was updated on 1/20/25 to reflect wandering behaviors and interventions for staff to utilize. Tenant 1 passed away on 2/15/2025. Tenant 4 moved out of community on 1/4/2025. Tenant 11's ISP was updated on 1/28/25 to reflect exit seeking behaviors and interventions for staff to utilize. A late medication report will be run and addressed with medication passers at minimum of weekly to ensure medications are being administered timely, effective 2/24/25.	All new hires will complete care delegations with the RN within 30 days of hire. The new HCC will receive training on the Care Delegations process within 30 days of hire. The new HCC will receive training on Care Audit expectations within 30 days of hire. The new HCC will receive training on late medication report and expectation within 30 days of hire. Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	**Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee

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Tag #7	**481-67.9(4)e Staffing:** 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: e. The program's registered nurse(s) shall provide direct or indirect supervision of all certified and noncertified staff as necessary in the professional judgment of the program's registered nurse and in accordance with the needs of the tenants and certified and noncertified staff. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the program failed to adequately train staff regarding 2 of 2 tenants reviewed with special dietary needs (Tenant #9 and Tenant #6).	**A 360**	All staff will receive training for special diet/modified diets by 3/30/2025. Tenant 9 moved out of the community on 1/17/2025. Tenant 6 moved out of the community on 1/17/2025. All staff will receive delegations on providing cueing/hand-over-hand/assistance with eating by 3/30/25. An audit of all current residents' diets was completed by 2/23/25 and all diets are in residents' ISP's and orders.	All new hires will complete a special/modified diet training within 30 days of hire. All new hire direct care staff will complete delegations with RN within 30 days of hire on providing cueing/hand-over-hand/assistance with eating. The new HCC will receive training on ISP updating expectations related to diets and therapy recommendations within 30 days of hire. The new HCC will receive training on adding residents' diets to the ISP and orders within 30 days of hire. Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	**Implementation Date**: 1/27/2025 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee
Tag #8	**481-67.9(4)g Staffing:** 67.9(4) Nurse delegation procedures. The program's registered nurse shall	**A365**	All staff education on Staff to Nurse communication note initiated training	All new hires will receive training on Staff to nurse communication form within 30 days of hire.	

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	ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to retain a communication log for a period of not less than three years.		on 1/23/2025, will complete training with all staff by 3/30/25. A staff to nurse communication form binder was implemented on 1/28/25 and onsite nurse was educated on staff to nurse communication form follow up and binder use on 1/28/25.	The new HCC will receive training for staff to nurse communication form within 30 days of hire. Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	

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Tag#9	**481-69.25(3) Tenant Documents:** 69.25(3) All records shall be protected from loss, damage and unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to ensure tenant and personnel records were protected from loss and damage.	**A 345**	The tenant records in question were secured on 12/20/2024 by the Community Director. All staff will receive re-education on HIPPA and expectations regarding storage of tenant records by 3/30/25.	All new hires will receive training on HIPPA and expectations regarding storage of tenant records during new hire orientation. The new HCC will be trained in HIPPA and expectations regarding storage of tenant records within 30 days of hire. Director and/or designee will complete routine audits of public areas to ensure all records are secured weekly, monthly, as needed, as determined by the director or designee.	**Implementation Date:** 1/23/25 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or Designee
Tag #10	**481-69.26(4)a Service Plans** 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to ensure the service plan identified the needs and preferences of 4 of 15	**A 395**	All current residents had new comprehensive assessments with service plan updates completed by 2/18/2025. Tenant 1 passed away on 2/15/2025. Tenant 2 was discharged on 12/31/2024 Tenant 9 was discharged on 1/17/2025.	All new hires will receive training on staff use to nurse communication forms during the new hire orientation. The new HCC will be trained in service plan requirements and the use of staff to nurse communication forms within 30 days of hire. The new HCC will receive training on service plan requirements within 30 days of hire.	**Implementation Date**: 1/23/2025 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee

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	current tenants reviewed (Tenant #9, Tenant #10, Tenant #2 and Tenant #1).		Tenant 6 was discharged on 1/17/2025. Staff received initial re-education on use of staff to nurse communication form initiated 1/23/2025, to be completed with all staff by 3/30/2025. An audit of all current tenants' service plans was completed on 2/23/2025 to ensure that all tenants' diets are correctly identified on the service plan.	Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	
Tag #11	**481-69.32(2) Life Safety -Emergency Policies/Structure:** 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to have an operating alarm system connected to the front entrance door.	**A 635**	The main entrance arial door alarm was implemented on 12/10/2024. Securitas came to the community for repair of the door on 12/31/2024 and a part was ordered for the door, once this is received by the vendor, the new keypad will be installed.	Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	**Implementation Date**: 12/10/2024 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee
Tag #12	**481-69.35(1)b Structural Requirements:** 69.35(1) General requirements. b. The buildings and grounds shall be	**A 710**	Memory care furniture was cleaned on 12/18/24.	All new hires will receive training on cleaning expectations during the new hire orientation.	**Implementation Date**: 1/23/25 **Completion Date:** Ongoing

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	well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the program failed to maintain a sanitary environment in the secured memory care unit in which 12 of 24 tenants resided.		All staff will receive re-education on cleaning expectations of apartments, bathrooms, furniture, common areas, etc. by 3/30/25. A common area cleaning schedule will be completed and implemented by 3/30/25.	Director and/or designee will complete audits daily, weekly, monthly, as needed, as determined by the director or designee to ensure compliance.	**Responsible Party:** Director, Nurse, or designee

Compliance Date: 3/30/2025

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