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 07/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 21 Number of tenants with cognitive impairment: 18 Total census: 39 No regulatory insufficiencies were cited during the investigation of Incident #120601-I. The following regulatory insufficiencies were cited during the investigation of Investigations #121894-I, 121893-C and 122009-C.	A 000	The Plan of Correction is attached	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the established medication policy affecting 3 of 5 tenants reviewed (Tenants #1, #4 and #6). Findings follow: On 7/29/24 review of the Program's Medication and Medication Administration policy (revised 5/15/24) revealed staff must follow the six "rights" for proper and accurate administration of medications. A violation of any right constituted a medication administration error. If any mistake was made, it should be reported immediately to	A 150		

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

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A 150	Continued From page 1 the on-call nurse so counter measures to solve any resulting problems could be taken. A medication error report form must also be completed and submitted to the RN on-call. The medication error must also be documented on the resident's MAR. Review of June and July 2024 medication administration records (MARs) revealed multiple incidents of medications not administered for Tenants #1, #4 and #6. On 7/15/24 medication error reports were requested. On 7/18/24 the Program provided one medication error report dated 6/14/24 for another tenant not included in the sample. When interviewed on 7/18/24 at 2:26 p.m. the Director confirmed the Program failed to complete medication error reports per policy. See the regulatory insufficiency written at 67.5(2)f(4) for further details regarding medications not administered as ordered.	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 which are adequate and appropriate. This REQUIREMENT is not met as evidenced by:	A 160		

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A 160	Continued From page 2 Based on observations, interview and record review the Program failed to consistently ensure tenants received cares and services that were adequate and appropriate. This specifically pertained to 1 of 1 current tenants (Tenant #1) and 1 of 1 former tenants (Tenant C2) reviewed. It potentially affected all other 17 tenants residing in the memory care unit. Observations on 7/15/24 at 1:35 p.m. revealed Tenant #1 wandered throughout the memory care unit including near former Tenant C2's room. He attempted to enter other rooms but found the doors locked. Observations on 7/17/24 at 11:45 a.m. revealed Tenant #1 carried items including clothing down the hallway towards his room after attempting to leave the memory care unit. Staff described Tenant #1's behavior of gathering items as "shopping." Staff said the items belonged to other tenants and they let Tenant #1 take the items to his room because if they attempted to stop him he would punch them. Observations on 7/17/24 at 1:05 p.m. revealed items including clothing stacked on Tenant #1's bed, dresser and in the corner of his room. Tenant #1 refused to take his medication. After another attempt he did take his buspirone. Staff J said the items (clothing) stacked in Tenant #1's room belonged to other tenants but Tenant #1 usually became aggressive if staff tried to remove the items. She said staff were afraid they would be punched/hit if they tried to remove the other tenants' items. Record review on 7/16/24 revealed an Incident Report (IR) dated 7/6/24 for Tenant #1. The IR said staff heard someone "hollering" and	A 160		

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A 160	Continued From page 3 responded to see Tenant C2 on the floor. Tenant C2 told staff Tenant #1 attempted to take her belongings. She told Tenant #1 "no" and he became upset and pushed her causing her to lose balance and land on her right side. An IR dated 7/6/24 for Tenant C2 described the same incident. The IR for Tenant C2 stated she complained of pain. Staff were instructed to not move Tenant C2 and call the ambulance for transport to the Emergency Room (ER) for evaluation. The IR noted Tenant C2 had a fractured right hip with surgery scheduled for 7/7/24. Tenant C2 required a higher level of care after surgery and did not return to her apartment. When interviewed on 7/15/24 at 1:50 p.m. Staff G said she worked the morning of the incident and heard Tenant C2 yell "get out" so she went to see what happened and found Tenant C2 on the floor. Tenant C2 said Tenant #1 hit her when she tried to prevent him from taking her papers. Staff G said Tenant #1 had a history of entering C2's apartment and taking items. She said Tenant #1 had become aggressive towards people who tried to take items away from him. On 7/15/24 at 2:12 p.m. Staff H said she worked the morning of the incident and heard a noise. When she arrived at the room Tenant C2 laid on the floor and said Tenant #1 had pushed her when she tried to prevent him from taking her papers. Staff H said Tenant #1 had a history of entering C2's apartment and taking items. When interviewed on 7/15/24 at 3:00 p.m. Staff I said she had worked the overnight shift and had been meeting with a.m. shift when she heard a "blood curdling" scream. She said she called the triage nurse, the delegating nurse and 911. She said Tenant C2 told her Tenant #1 had hit and	A 160		

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A 160	Continued From page 4 pushed her to the ground. Staff I said Tenant C2 had been told to leave the door open to her apartment so the staff could hear her husband's (Tenant C3) bed alarm. Staff I said Tenant #1 had a history of entering C2's apartment and taking items including roast beef and personal items such as bills and mail. Staff I explained Tenant C2 had been told to leave her door unlocked so staff could hear her husband's alarm used to prevent falls. She said Tenant #1 could be very difficult. He often remained awake at night, wandered and attempted to go into other tenant's rooms. She said Tenant #1's behavior frightened her. Review of Tenant #1's medication administration record (MAR) on 7/18/24 revealed the Program failed to administer the following medications (examples include but are not limited to): Buspirone (anti-anxiety) 10 mg 1 tablet three times a day - 6/7/24, 6/9/24, 6/10/24, 6/17/24, 6/23/24, 6/24/24 and 6/25/24 at 9:00 p.m. - 6/17/24 and 6/28/24 at 2:00 p.m. - 7/7/24 at 2:00 p.m. and 9:00 p.m. - 7/9/24 at 2:00 p.m. and 9:00 p.m. Memantine (cognition-enhancing) 10 mg 1 tablet two times a day - 6/7/24, 6/9/24, 6/10/24, 6/17/24, 6/23/24, 6/24/24, 6/25/24, 6/28/24, 6/29/24, 7/7/24 and 7/9/24 at 9:00 p.m. Quetiapine (antipsychotic) 50 mg 1 tablet two times daily - 6/7/24, 6/9/24, 6/10/24, 6/17/24, 6/23/24, 6/24/24, 6/25/24, 6/28/24, 6/29/24, 7/7/24, 7/9/24 and 7/12/24 at 9:00 p.m. Trintellix (anti-depressant) 5 mg 1 tablet at bedtime - 7/1/24, 7/2/24, 7/7/24, 7/9/24 and 7/12/24 When interviewed on 7/22/24 at 11:45 a.m. Tenant #1's physician said missed medications including anti-anxiety, antipsychotic and	A 160		

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A 160	Continued From page 5 anti-depressants could have contributed to Tenant #1's increased/intense behaviors of taking others things and displaying aggressive behavior towards others. Review of the Trintellix website on 9/5/24 revealed the following important safety information regarding discontinuation syndrome; suddenly stopping Trintellix may cause serious side effects; changes in mood, irritability and agitation, anxiety, confusion, problems sleeping and hypomania. Review of Tenant #1's file on 7/24/25 revealed pertinent diagnoses included unspecified dementia without behavioral disturbance, chronic kidney disease, major depressive disorder, recurrent and generalized anxiety disorder. His Global Deterioration Scale indicated Stage 6 severe cognitive decline (moderately severe dementia). His service plan did not address his behavior of taking items that belonged to other residents. During the exit on 7/29/24 at 2:45 p.m. the administrative staff acknowledged the above findings.	A 160		
A 270	481-67.5(2)f(1) 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: (1) The administration of medications shall be provided by a registered nurse, licensed practical	A 270		

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A 270	Continued From page 6 nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure medications were administered by staff who had successfully completed a department-approved medication aide or medication manager course. This pertained to 2 of 2 former staff reviewed (Staff C and D). Finding follows: Record review on 7/18/24 failed to reveal documentation of medication aide or medication manager training for Staff C and D. On 7/25/24 review of the Program's Medication and Medication Administration policy (revised 5/15/24) revealed staff who administered medications would be trained and monitored according the Department of Inspections and Appeals requirement for staff to complete an approved medication management class. During the exit on 7/29/24 at 2:45 p.m. administrative staff confirmed documentation of the department approved medication training could not be located for either staff.	A 270		

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A 285	Continued From page 7	A 285		
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 observations, interview and record review the Program failed to consistently ensure tenants received medications and treatments as ordered. This pertained to 4 of 5 tenants reviewed (Tenants #1, #4, #5, #6). Findings follow: 1. Review of Tenant #1's medication administration records (MARs) for June and July 2024 on 7/18/24 revealed Program staff failed to administer medications as ordered. Examples include but are not limited to the following: - Atorvastatin 80 mg 1 tablet at bedtime - 7/7/24, 7/9/24 and 7/15/24 - Buspirone 10 mg 1 tablet three times a day 6/7/24, 6/9/24, 6/10/24, 6/17/24, 6/23/24, 6/24/24, 6/25/24 at 9:00 p.m. 6/17/24, 6/28/24, 7/19/24 at 2:00 p.m. 7/7/24, 7/9/24 at 2:00 p.m. and 9:00 p.m. - Memantine 10 mg 1 tablet two times a day - 6/7/24, 6/9/24, 6/10/24, 6/17/24, 6/23/24, 6/24/24, 6/25/24, 6/28/24, 6/29/24, 7/7/24 and 7/9/24 at 9:00 p.m. - Metoprolol 25 mg 1 tablet two times daily -	A 285		

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A 285	Continued From page 8 6/7/24, 6/9/24, 6/10/24, 6/17/24, 6/23/24, 6/24/24, 6/25/24, 6/28/24, 6/29/24, 7/7/24, 7/9/24 and 7/12/24 at 9:00 p.m. - Quetiapine 50 mg 1 tablet two times daily - 6/7/24, 6/9/24, 6/10/24, 6/17/24, 6/23/24, 6/24/24, 6/25/24, 6/28/24, 6/29/24, 7/7/24, 7/9/24 and 7/12/24 at 9:00 p.m. - Trintellix 5 mg 1 tablet at bedtime - 7/1/24, 7/2/24, 7/7/24, 7/9/24 and 7/12/24 On 7/29/24 review of Trintellix's website revealed information regarding what to know before using the medication. According to the website Trintellix may cause serious side effects if stopped too quickly. If stopped quickly it may lead to serious side effects including anxiety, irritability, high or low mood change in sleep habits and feeling restless. Record review on 7/24/25 revealed Tenant #1's pertinent diagnoses included unspecified dementia without behavioral disturbance, chronic kidney disease, major depressive disorder, recurrent and generalized anxiety disorder. His Global Deterioration Scale indicated Stage 6 severe cognitive decline (moderately severe dementia). Tenant #1's service plan (activation date 7/8/24) documented it was the Program's responsibility for medication administration. 2. Record review on 7/18/24 revealed an after visit summary for Tenant #4 following a hospitalization from 6/10/24 to 6/13/24 for jaundice, dementia without behavioral disturbance, diastolic heart failure, hyperlipemia and essential hypertension, benign. The document noted Tenant #4's medications had changed and encouraged review of the medication list for details about medication changes. The document included a new	A 285		

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A 285	Continued From page 9 prescription summary on which the delegating nurse signed acknowledgement on 6/13/24 at 5:02 p.m. Review of Tenant #4's June MAR on 7/16/24 revealed Program staff administered the discontinued medication Lisinopril from 6/14/24 to 6/17/24. Further review revealed the Program failed to administer Amoxicillin/clavulanate (Augmentin) as ordered from 6/15/24 to 6/17/24. A notation on the MAR stated DNA (drug not available) for 8:00 a.m. on 6/15/24, 6/16/24, 6/17/24 and 8:00 p.m on 6/17/24. On 7/16/24 at 4:45 p.m. the delegating nurse admitted she noted the medication change for Tenant #4 but failed to ensure Amoxicillin/clavulanate (Augmentin) had arrived and Lisinopril had been discontinued. Review of Tenant #4's MARs on 7/24/24 revealed Program staff failed to administer medications as ordered. Examples include but are not limited to the following: - Fiberlax two tabs every evening - 7/5/24, 7/7/24, 7/9/24 and 7/15/24. - Nitrofur MAC 50 one capsule at bedtime - 7/5/24, 7/7/24, 7/9/24 and 7/15/24. - Quetiapine 50 mg one tablet by mouth at 8:00 p.m. - 7/3/24, 7/4/24, 7/7/24, 7/9/24, 7/12/24 and 7/15/24 On 7/25/24 review of Tenant #4's medication list attached to the hospital after visit summary dated 6/13/24 and signed by his physician included the above medications. Tenant #4's pertinent diagnoses included unspecified dementia, alcohol abuse counseling and surveillance of alcoholic, and dementia	A 285		

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A 285	Continued From page 10 without behavioral disturbance. His Global Deterioration Scale indicated Stage 5 moderately severe cognitive decline (moderate dementia). 3. Record review on 7/16/24 of Tenant #5's Medication Administration Record (MAR) revealed Program staff administered discontinued medication Jardiance to Tenant #5 from 5/28/24 to 6/5/24. Review of Tenant #5's medication list dated 5/28/24 included in a hospital discharge instructions/after visit summary did not include Jardiance. On 7/22/24 review revealed a communication form dated 7/9/24 from the Program nurse to Tenant #5's physician verifying a new order for Jardiance. The physician's comments dated 7/15/24 said medication (Jardiance) had been discontinued during her hospitalization months ago and had not been re-ordered. The physician noted she had discussed the issue with the delegating nurse in person as well. When interviewed on 7/16/24 at 4:45 p.m., the delegating nurse said the Jardiance for Tenant #5 had been noted by another nurse, so she couldn't speak to it. When asked how the Program ensured tenants received ordered medications she failed to answer. When interviewed on 7/17/24 at 2:45 p.m. Tenant #5's health care provider said administering Jardiance for Type 1 diabetes mellitus increased the risk of diabetic ketoacidosis which she had been hospitalized for prior. Further review revealed Tenant #5's discharge instructions from Unity Point Health - Allen Hospital dated 5/28/24 directed the Program to provide Point of Care Testing (POCT) for Glucose	A 285		

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A 285	Continued From page 11 four times daily, before meals and at bedtime, and notify the Primary Care Physician (PCP) if blood glucose (BC) measured less than 70 or greater than 300. The Program failed to complete glucose testing as instructed and/or notify the PCP of blood sugar glucose greater than 300. Examples include but are not limited to the following: 5/28/24 5:00 p.m. BG=315 - no testing at bedtime 5/29/24 BG=317, noon BG=426, bedtime BG=315 5/30/24 no readings at 8:00 before breakfast, lunch or evening meal, 8:00 p.m. BG=327 5/31/24 no readings before breakfast, evening meal and bedtime, lunch 11:00 a.m. =325 and noon =352 6/1/24 no readings before breakfast, noon meal or bedtime, before evening meal BG=368 6/2/24 no readings for breakfast and noon meal, evening meal BG=389 and bedtime BG=471 6/3/24 no readings for breakfast, evening meal and bedtime, noon meal BG=471 6/5/24 no reading for bedtime, noon meal BG= 490, breakfast 8:00 a.m. BG=511 Record review on 7/25/24 revealed Tenant #5's Cedar Valley Medical Specialists Progress Note dated 6/4/24 for follow up from hospitalization. The note revealed Tenant #5 was seen for follow up from hospitalization from 5/23/24 to 5/28/24 for altered mental status secondary to diabetic ketoacidosis (DKA) and severe dehydration. Upon admission to the hospital Tenant #5's hemoglobin (A1C/HbA1c) measured 13. Normal A1C for women over 60 years old should measure between 4.4 - 6.5. According to the note Jardiance had been discontinued during the hospital stay. The Provider's review of blood glucose/sugar testing since 6/1/24 revealed	A 285		

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A 285	Continued From page 12 several were missing. Blood sugars recorded ranged from 196 to 471. The Provider noted the office had not been notified of blood sugars less than 70 and over 300 as ordered. The Provider noted her concern that the Program failed to implement medication changes and report blood sugars per discharge parameters since Tenant #5's hospitalization. In addition, she noted her concerns had been communicated to the delegating nurse, administrator and Power of Attorney. Record review on 7/25/24 revealed Tenant #5's Cedar Valley Medical Specialists Progress Note dated 6/27/24 for follow up from hospitalization. It was a one week follow up for diabetes mellitus type 1 and hypertension. The Provider noted review of blood glucose/sugars and missing testing for one - two on some days in the last week. Blood sugars ranged from 135 to 511. The treatment section of the notes directed the Program to fax blood sugars in one week. The order directed staff to check blood sugars before meals and bedtime. Record review on 7/25/24 revealed Tenant #5's Cedar Valley Medical Specialists Progress Note dated 6/27/24 for follow up for Diabetes Mellitus (DM), dementia with agitation and behavioral disturbance. Blood sugars reviewed revealed continued concerns with the Program failing to check blood glucose/sugars as ordered. The Provider noted no documentation of blood sugars on 6/23/24 and 6/25/24. Also noted was Tenant #5's hospitalization for severe hypoglycemia in March 2024. The Provider noted the following under assessments: unspecified urinary incontinence, Type 1 diabetes mellitus with diabetic chronic kidney disease, moderate dementia with psychotic disturbance, unspecified	A 285		

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 07/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 13 type, full incontinence of feces, weight loss, failure to thrive in adult and total self-care deficit. The Provider noted she had notified the DON (Director of Nursing) and administrator of concerns with missed blood sugar testings. Tenant #5's July MARs revealed Program staff failed to administer medications as ordered. Examples include but are not limited to the following: - Carvedilol 6/25 mg 1 tablet two times daily with meals - 7/7/24 and 7/9/24 at 5:00 p.m. - Insulin Lispro 12 unit two times daily 7:00 a.m. and noon - 7/2/24 at noon - Insulin Lispro 7 units one time per day 3:45 p.m. - 7/7/24 and 7/9/24 - Quetiapine 25 mg 1 tablet twice daily at noon and bedtime - 7/2/24 at noon, 7/7/24 and 7/9/24 at 8:00 p.m. Record review on 7/25/24 revealed Tenant #5's pertinent diagnoses included Type 1 diabetes, stage three kidney disease, hypertension and vascular dementia. Her Global Deterioration Scale indicated Stage 5 moderately severe cognitive decline (moderate dementia). Tenant #5's service plan, with an activation date of 7/8/24, revealed the Program's responsibility for medication administration. 4. On 7/24/24 review of Tenant #6's MARs revealed Program staff failed to administer medications as ordered. Examples include but are not limited to the following: - Quetiapine 25 mg 1/2 tablet two times a day 7/2/24 at 8:00 a.m. 7/5/24, 7/7/24 and 7/9/24 at 6:00 p.m. - Donepezil 10 mg one tablet 7/7/24 at bedtime 7/9/24 at 6:00 p.m.	A 285		

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 07/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 14 - Memantine 10 mg two times a day 7/2/24 at 8:00 a.m. 7/7/24, 7/9/24 at 6:00 p.m. - Gabapentin 100 mg 7/7/24 at bedtime 7/9/24 at 6:00 p.m. - Simvastatin 7/7/24 at bedtime 7/9/24 at 6:00 p.m 7/2/24 8:00 a.m. 7/7/24, 7/9/24 at 6:00 p.m. - Cephalexin 500 mg one capsule two times a day 7/9/24 p.m. 7/11/24 a.m. drug not available, 7/11/24 p.m. Record review on 7/25/24 revealed Tenant #6's medication review report dated 12/8/23 and signed by her physician included the above medications. Tenant #6's pertinent diagnoses included; Alzheimer's disease with late onset and recurrent urinary tract infection. Her Global Deterioration Scale indicated Stage 4 moderate cognitive decline (mild dementia). Tenant #6's service plan with an activation date of 12/12/23 included the Program's responsibility for medication administration. 5. During the exit on 7/29/24 at 2:45 p.m. the administrative staff acknowledged these findings.	A 285		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and	A 350		

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 07/29/2024

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 350	Continued From page 15 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were based on evaluations, updated as needed and reflect current service needs of the tenants. This pertained to 1 of 1 tenants who injured another tenant (Tenant #1). Findings follow: Observations on 7/15/24 at 11:45 a.m. revealed Tenant #1 carried clothing items down the hallway. When questioned staff said the items were other tenants but if they tried to retrieve them from Tenant #1 he would hit them. Record review on 7/24/24 revealed Tenant #1's service plans (SP) activation dates, 4/30/24 and 7/8/24, addressed Tenant #1's history of wandering. SP (activation date 4/30/24) noted Tenant #1 had a history of wandering within the residence. SP (activation date 7/8/24) noted Tenant #1's aggression towards Tenant C2 on 7/6/24 but failed to include interventions to prevent interactions amongst tenants when he took their belongings. Further review revealed the Program failed to address Tenant #1's known behavior of taking other tenants' possessions. Record review on 7/24/25 revealed Tenant #1's diagnosis included unspecified dementia without	A 350		

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 07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 350	Continued From page 16 behavioral disturbance, chronic kidney disease, major depressive disorder, recurrent and generalized anxiety disorder. His Global Deterioration Scale indicated Stage 6 severe cognitive decline (moderately severe dementia). During the exit on 7/29/24 the administrative team confirmed the Program failed to address and/or include strategies to address Tenant #1's aggressive behavior when staff attempted to take items he had taken from other tenants.	A 350		

Holly Smith 10/4/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0300	DATE SURVEY COMPLETED: 7/29/2024

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Regulation and Reg Number** 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 established medication policy affecting 3 of 5 tenants reviewed (Tenants #1, #4 and #6).	**Tag # A150**	**What initial correction was made?** 1. Medication Training 8/20/24 in person for 9/ 15 employees. 2. Medication Cabinet/Locked Room Review 3. Employees to complete medication manager by 10/15/24, if not complete. Delegations will be completed for all staff not delegated by 10/20/24.	**How will we ensure and maintain compliance going forward?** 1. RN will do weekly audits for med managed residents. 2. Continued medication administration and appropriate documentation education provided to staff monthly, quarterly or as needed, as determined by the director or designee.	**Implementation Date: 08/20/24** **Completion Date:** 10/20/24 **Responsible Party: Director/RN/ Designee**
Tag #2	**Regulation and Reg Number** Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on observations,	**Tag # A160**	**What initial correction was made?** 1. RN will complete a reset of all resident's service plans to ensure resident receives care, treatment services which are adequate and appropriate.	**How will we ensure and maintain compliance going forward?** 1. RN will complete assessment at admission, 30 days after admission, annually and with any change in condition.	**Implementation Date:** 08/20/24 **Completion Date:** Ongoing

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

	interview and record review the Program failed to consistently ensure tenants received cares and services that were adequate and appropriate. This specifically pertained to 1 of 1 current tenants (Tenant #1) and 1 of 1 former tenants (Tenant C2) reviewed. It potentially affected all other 17 tenants residing in the memory care unit.				**Responsible Party:** Director/ RN/ Designee
Tag#3	**Regulation and Reg Number** Medication Manager Training 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: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be	**Tag # A270**	**What initial correction was made?** 1. Medication Training 8/20/24 in person for 9/ 15 employees. 2. Medication Cabinet/Locked Room Review 3. Employees to complete medication manager by 10/15/24, if not complete. Delegations will be completed for all staff not delegated by 10/20/24.	**How will we ensure and maintain compliance going forward?** 1. RN will do weekly audits for med managed residents. 2. Continued medication administration and appropriate documentation education provided to staff monthly, quarterly or as needed.	**Implementation Date:** 08/20/24 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or Designee

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	administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure medications were administered by staff who had successfully completed a department-approved medication aide or medication manager course. This pertained to 2 of 2 former staff reviewed (Staff C and D).				
Tag#4	**Regulation and Reg Number** Medication Errors and Missing Documentation 481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.	**Tag# A285**	**What initial correction was made?** 1. Medication Training 8/20/24 in person on 9/ 15 employees. 2. Medication Cabinet/Locked Room Review 3. Employees to complete medication manager by 10/15/24, if not complete. Delegations will be completed for all staff not delegated by 10/20/24.	**How will we ensure and maintain compliance going forward?** 1. RN will do weekly audits for med managed residents. 2. Continued medication administration and appropriate documentation education provided to staff monthly, quarterly or as needed. 3. Director/RN will run medication administration audits weekly.	**Implementation Date**: 08/20/24 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee

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	This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to consistently ensure tenants received medications and treatments as ordered. This pertained to 4 of 5 tenants reviewed (Tenants #1, #4, #5, #6).				
Tag #5	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 9.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were based on evaluations, updated as needed and reflect current service needs of the tenants. This pertained to 1 of 1 tenants who injured another tenant (Tenant #1).	**Tag # A350**	**What initial correction was made?** 1. RN will complete a reset of all resident's service plans to ensure resident receives care, treatment services which are adequate and appropriate.	**How will we ensure and maintain compliance going forward?** 1. RN will complete assessment at admission, 30 days after admission, annually and with any change in condition.	**Implementation Date:** 08/20/24 **Completion Date:** Ongoing **Responsible Party:** Director, RN or designee

Compliance Date: 10/20/24

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