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
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 17 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 17 The investigation of Complaints #99891-C and #103754-C and the recertification visit conducted to determine compliance with certification for an Assisted Living Program were completed and the following regulatory insufficiencies were cited:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the policy and procedure related to medication administration for 1 of 1 tenants reviewed who received staff administration of over the counter (OTC) medications (Tenant #2). Findings follow: Review of Tenant #2's file on 6-8-22 revealed a Comprehensive Health Assessment dated 1-18-22 reflecting Tenant #2 had a stroke that affected her right side and she did not have use of the right arm. The assessment also indicated she had numbness in her left hand. The most current service plan (undated) indicated medications were set up weekly by staff. Tenant #2 was independent with taking her medications	A 150	The Plan of Correction is attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 150	Continued From page 1	A 150		

without reminders.

When interviewed on 6-7-22 at 1:22 p.m. Staff A said staff assisted Tenant #2 with a nasal spray, lip balm and eye drops every night at bedtime.

When interviewed on 6-9-22 at 2:56 p.m. AL Nurse #2 said staff applied OTC eye drops, a topical cream for her knees and a nasal spray. Tenant #2 self-administered her prescription medication. She did not set up medications for Tenant #2.

A review of Staff Communication Report documents indicated the following:
- On 12-23-21 Tenant #2 asked staff to give her medication
- On 12-24-21 (x2) Tenant #2 asked staff to give her medication
- On 2-24-22 it was noted Tenant #2 needed staff to put on her "lotion on her face every night now."

Nurse's/Care Notes indicated on 5-27-22 Tenant #2 requested assistance to a seated position on the toilet. She reported burning pain to her bilateral knees. Tenant #2 had been less active and needed to use her wheelchair more. Tenant #2 self-administered her medications but staff were to start giving her reminders to take her PRN (as needed) Tylenol at breakfast and mid-afternoon if necessary.

A Medication List dated 4-14-22 indicated three oral medications were prescribed. The list did include any OTC medications including eye drops, nasal spray or topical cream. The February 2022 medication administration record (MAR) reflected on 2-1-22 Systane drops (1 drop per eye) was instilled and lip balm was applied by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 150	Continued From page 2	A 150		

staff. March, April, May and June 2022 MARs did not reflect the OTC medications staff administered or documentation of the administration of the OTC medications including eye drops, nasal spray and topical cream.

Review of the program's policy and procedure regarding medications revealed the service plan would indicate the responsibility of medication administration by either the tenant or the program. Tenants kept their medications in their own possession unless partial or complete administration of medications was delegated. Medications stored or administered by the program was to be documented in the tenant's record. All medications would be labeled in compliance with label instructions. Medications would be administered as prescribed.

The Medication Management Agreement indicated nurses could direct staff to use OTC medications available for tenants "at their discretion." Medications not signed off but given to the tenant constituted a medication error.

When interviewed on 6-9-22 at 2:56 p.m. AL Nurse #2 said she thought Tenant #2 was only tenant staff assisted with OTC medications.

When interviewed on 6-13-22 at 12:52 p.m. the AL Manager said Tenant #2's eye drops, nasal spray and topical cream were kept at a bedside table. He said they should have a physician's order for medications administered by staff.

In summary, Tenant #2's service plan reflected she was independent with medication administration. The service plan did not reflect staff routinely assisted with OTC medications. It also did not reflect the routine medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 150	Continued From page 3 reminders of the as needed Tylenol. Staff assisted with the OTC medications nightly but there was no documentation of the administration of these medications. Additionally, there was no order from a medical provider to administer Tenant #2's nasal spray, eye drops or topical cream.	A 150		
A 180	481-67.3(6) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(6) To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program did not ensure a tenant could communicate privately and without restrictions. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: Review of Tenant C1's file on 6-8-22 and 6-9-22 revealed Tenant C1 was admitted on 7-5-16 and discharged on 7-2-20. The Tenant Application and Information Sheet dated 7-1-16 indicated to contact Individuals #1 or #2 in case of emergency. The persons listed were noted as friends. Individual #1 was indicated as the power of attorney (POA) and durable	A 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 180	Continued From page 4 power of attorney (DPOA). The Tenant Application and Information Sheet was updated (with no date provided) to reflect to send all bills to Tenant C1. It also reflected not to contact Individual #1. A new name was listed to notify in case of emergency, Individual #3, who was also Tenant C1's legal representative. Individual #3 was indicated as the POA/DPOA. Continued record review revealed indicated Power of Attorney and Durable Power of Attorney for Health Care Decisions documented were dated 4-2-19 and reflected Individual #3 as the POA/DPOA for health care. Further review revealed Tenant C1's service plan did not reflect any preferences for restrictions related to communication or visitors made per Tenant C1's request. When interviewed on 6-7-22 at 1:22 p.m. Staff A said during COVID-19 families were restricted from coming. They had video calls, telephone calls, outside visits with masks on and window visits. Tenant C1's legal representative (Individual #3) was told there were no visitors when in actuality window visits were available. Tenants were taken to into the dining area for those visits. The Former AL Nurse #1 told staff to tell Tenant C1's legal representative (Individual #3) when he called that Tenant C1 was sleeping and to transfer the call to the her. She said the Former AL Nurse #1 disconnected Tenant C1's cell phone. Tenant C1's legal representative (Individual #3) called four to five times a month or more during March/April 2020 (approximate timeframe). Tenant C1 had a couple (Individuals #1 and #2) who visited her prior to Individual #3 becoming POA/DPOA.	A 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 180	Continued From page 5 When interviewed on 6-7-22 at 2:46 p.m. Staff C said Tenant C1's landline phone was off for months. There was a few times she had allowed the tenant to use her phone. When interviewed on 6-8-22 at 8:14 a.m. Tenant C1's legal representative (Individual #3) indicated he called weekly to visit with Tenant C1. For an extended period of time he was not able to talk to her and was told by staff she was sleeping. He said her cell phone was closed out and landline phone did not work. He also wanted to come and visit and was told he was not able to visit due to COVID-19. He found out later they allowed visitors via other means, including window visits, and had a family day celebration in the gazebo. He said Tenant C1 had long term family friends, 20 plus years, who used to visit her weekly and were the POA prior to him. Staff stopped allowing them to visit her. When interviewed on 6-8-22 at 8:52 a.m. Individual #1 and Individual #2 reported Individual #1 became POA for healthcare for Tenant C1 and they had visited her twice weekly at the program. Just before COVID-19 hit, it was noted Tenant C1 was more distant and was not the same. Individual #2 said Tenant C1's attorney called and said Tenant C1 did not want them as POA for healthcare. Due to COVID-19 they could not talk to her in person. When interviewed on 6-13-22 at 12:52 p.m. the AL Manager confirmed no current tenants had restrictions related to communications or visitors. In summary per interviews Tenant C1's legal representative was not able to contact or visit her. She was not able to be interviewed prior to her	A 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 180	Continued From page 6 death; however she service plan lacked any directives regarding restrictions for communication or visitors per her choice.	A 180		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to administer medications as ordered to 1 of 3 tenants reviewed who received medications administered by the program (Tenant #3). Findings follow: Review of Tenant #3's file on 6-8-22 and 6-9-22 revealed diagnoses included alcohol abuse, hypertension, fatty liver, COPD (chronic obstructive pulmonary disease), syncope and pulmonary nodule. The service plan reflected staff administered his medications. A Staff Communication Report dated 11-24-21 indicated staff went to give Tenant #3 a breathing treatment and he said he was not feeling well. He was nauseated and felt "flushed." Tenant #3 had a garbage can at his side. The Former Director of Nursing at the affiliated skilled nursing facility was	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 7	A 285		

made aware as Tenant #3 had been without medications for seven days and staff was not sure if it was related.

A Staff Communication Report dated 11-25-21 indicated Tenant #3 vomited three times between 6:00 a.m. and 11:00 a.m. The reported indicated Tenant #3 was nauseated, vomited, had discomfort or pain, decreased appetite and refused a meal. At 11:00 a.m. Tenant #3's vitals indicated his blood pressure was 119/94 and his oxygen saturation was 94%.

A review of hospital documents indicated the following:
- A Progress Note (hospital record) indicated the tenant was admitted to the hospital on 10-12-21 for chest pain with wheezing. Tenant #3 was "in COPD exacerbation with non-STEMI type 2." He was placed on steroids, breathing treatments and antibiotics. A cardiac catheterization was completed and stent was placed to the right coronary artery (RCA). The Assessment and Plan indicated "Acute hypoxemic respiratory failure secondary to acute chronic obstructive pulmonary disease exacerbation." It also indicated "Non-ST segment elevation myocardial infarction type 2" and "Coronary artery disease with ejection fraction of 40% and moderate to severe septal hypokinesis, status post catheterization and stent to the RCA."
- A History and Physical (hospital record) document indicated the date of service was 11-26-21. The document reflected Tenant #3 had been previously admitted on 10-9-21 with an "acute NSTEMI." He had a left heart catheterization on 10-12-21 and a stent was placed in the RCA. Tenant #3 was discharged with orders for Plavix and aspirin. On 11-26-21 when taking a shower Tenant #3 lost

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 8	A 285		

consciousness and did not remember anything after that. When he opened his eyes he was on the floor. 911 was called and the initial electrocardiogram showed an "inferior STEMI with complete AV block."

Resident Care Notes located in the file from the SNF indicated the following:
- On 10-15-21 Tenant #3 was admitted to the skilled nursing facility (SNF) level of care from the hospital.
- On 11-9-21 Tenant #3 returned to the assisted living program (ALP).
- On 12-2-21 Tenant #3 was admitted to the SNF level of care status post "acute inferior MI with stenting of 100% occlusion of RCA" and "3rd degree heart block with temporary pacemaker."
- On 12-23-21 Tenant #3 returned to his apartment in the ALP.

Continued record review revealed the October 2021 medication administration records (MARs) reflected Tenant #3 had previously taken one oral medication prior to his hospitalization which was lisinopril 20 milligram (mg) daily. Post hospitalization and SNF stay (October/November), new medications were ordered and were listed on the Home Discharge Instructions dated 11-12-21. Those orders included aspirin 81 mg daily at breakfast, Plavix 75 mg daily at breakfast, lisinopril 5 mg daily at breakfast, metoprolol succinate 25 mg daily at breakfast, pantoprozole 40 mg daily at breakfast, atorvastatin 40 mg at bedtime and budesonide 1 (vial) twice daily at breakfast and bedtime and duoneb (1 vial) four times daily.

November 2021 MARs reflected 14 entries charted as medications not available from 11-12-21 to 11-25-21. The entries on 11-12-21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 9	A 285		

11-20-21, 11-21-21, 11-22-21, 11-23-21 and 11-25-21 indicated there were no a.m. medications available. The medication at bedtime, atorvastatin was charted as not available on 11-19-21, 11-20-21 and 11-21-21.

Review of the Nurse's/Care Notes did not reflect any documented entries related to the medication availability issue in November 2021. The Home Discharge instructions dated 11-12-21 were not noted with time, date or signature when the orders were received. A medication error report was not completed related to medications not being available to administer to Tenant #3 during November 2021.

When interviewed on 6-13-22 at 12:52 p.m. the AL Manager said the medication (atorvastatin) could not be filled until Tenant #3 was seen by his cardiologist in the office. He said he could not speak to the a.m. medications and why they were not administered.

Program documents revealed there was no program nurse from September 2021 to December 2021.

When interviewed on 6-29-22 at 1:48 p.m. Tenant #3's primary care provider could not recall if he had been notified of the medications not administered but if he had it should have been documented in the program's records. When asked about Tenant#3's medications not administered for greater than five days and any possible correlation to his hospitalization (November 2021) he would not provide a comment or opinion but said it was "not ideal."

In summary, Tenant #3 was prescribed one oral medication in October 2021 and staff assisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 10 with medication administration. On 10-9-21 Tenant #3 went to the hospital, was admitted and went to SNF before he returned to the program on 11-9-21. There were new orders for medications upon discharge from SNF and return to the program. Tenant #3 did not receive the medications as prescribed and the medications were documented as not available. There were multiple entries regarding medications not available from 11-12-21 to 11-25-21, including all of his morning medications. Per staff communication records Tenant #3 was nauseated, vomiting and did not feel well on 11-24-21 and 11-25-21. Tenant #3 was sent out to the hospital on 11-26-21 after he lost consciousness. Tenant #3 was admitted to the hospital again on 11-26-21 and then was discharged to SNF s/p "acute inferior MI with stenting of 100% occlusion of RCA." Tenant #3 returned to the Program on 12-23-21. Tenant #3 did not received the medications as prescribed in November 2021.	A 285		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete cognitive, health and functional evaluations within 30 days of taking	A 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 140	Continued From page 11 occupancy for 1 of 1 tenants reviewed admitted since November 2021 (Tenant #2). Findings follow: Review of Tenant #2's file on 6-8-22 revealed an admission date of 11-1-21. Cognitive, health and functional evaluations were completed on 10-19-21. The next documented cognitive, health and functional evaluations were dated 1-18-22, which was more than 30 days after taking occupancy. When interviewed on 6-13-22 at 12:52 p.m. the AL Manager confirmed the above finding.	A 140		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete evaluations as needed for 1 of 1 current tenants reviewed who had been hospitalized (Tenant #3). Findings follow:	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 145	Continued From page 12 1. Review of Tenant #3's file on 6-8-22 and 6-9-22 revealed diagnoses including alcohol abuse, hypertension, fatty liver and pulmonary nodule. Hospital records indicated the following: - A Progress Note (hospital record) indicated the tenant was admitted to the hospital on 10-12-21 for chest pain with wheezing. Tenant #3 was "in COPD exacerbation with non-STEMI type 2." He was placed on steroids, breathing treatments and antibiotics. A cardiac catheterization was completed and stent was placed to the right coronary artery (RCA). The Assessment and Plan indicated "Acute hypoxemic respiratory failure secondary to acute chronic obstructive pulmonary disease exacerbation." It also indicated "Non-ST segment elevation myocardial infarction type 2" and "Coronary artery disease with ejection fraction of 40% and moderate to severe septal hypokinesis, status post catheterization and stent to the RCA." - A History and Physical (hospital record) document indicated the date of service was 11-26-21. The document reflected Tenant #3 had been previously admitted on 10-9-21 with an "acute NSTEMI." He had a left heart catheterization on 10-12-21 and a stent was placed in the RCA. Tenant #3 was discharged with orders for Plavix and aspirin. On 11-26-21 when taking a shower Tenant #3 lost consciousness and did not remember anything after that. When he opened his eyes he was on the floor. 911 was called and the initial electrocardiogram showed an "inferior STEMI with complete AV block." Resident Care Notes located in the file from the SNF indicated the following: - On 10-15-21 Tenant #3 was admitted to the skilled nursing facility (SNF) level of care from the	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 145	Continued From page 13 hospital. - On 11-9-21 Tenant #3 returned to the assisted living program (ALP). - On 12-2-21 Tenant #3 was admitted to the SNF level of care status post "acute inferior MI with stenting of 100% occlusion of RCA" and "3rd degree heart block with temporary pacemaker." - On 12-23-21 Tenant #3 returned to his apartment in the ALP. The tenant's Comprehensive Health Assessments (cognitive, health and functional) were completed on 3-3-21 and 2-1-22. Evaluations were not completed when Tenant #3 was admitted to the hospital in October 2021, then went to SNF and returned to the Program in November 2021 or when Tenant #3 was admitted to hospital in November and then went to SNF and returned in December 2021. When interviewed on 6-13-22 at 12:52 p.m. the AL Manager confirmed there were no additional evaluations for Tenant #3.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by:	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 14	A 290		

Based on interview and record review the Program failed to document nurse's notes by exception for 2 of 4 tenants reviewed (Tenants #2 and #4). Findings follow:

1. Review of Tenant #2's file on 6-8-22 reveled an admission date of 11-1-21. An Occupational Therapy (OT) Discharge Summary indicated the dates of service were from 12-21-21 to 4-13-22.

A review of Nurse's/Care Notes indicated the first entry in the nurse's notes was dated 1-11-22. A nurse's note was not completed when Tenant #2 was admitted. Nurse's notes were not completed when OT services started on 12-21-21 or when OT services were discontinued.

2. Review of Tenant #3's file on 6-8-22 and 6-9-22 revealed diagnoses including alcohol abuse, hypertension, fatty liver, pulmonary nodule and chronic obstructive pulmonary disease.

Hospital records indicated the following:
- A Progress Note (hospital record) indicated the tenant was admitted to the hospital on 10-12-21 for chest pain with wheezing. Tenant #3 was "in COPD exacerbation with non-STEMI type 2." He was placed on steroids, breathing treatments and antibiotics. A cardiac catheterization was completed and stent was placed to the right coronary artery (RCA). The Assessment and Plan indicated "Acute hypoxemic respiratory failure secondary to acute chronic obstructive pulmonary disease exacerbation." It also indicated "Non-ST segment elevation myocardial infarction type 2" and "Coronary artery disease with ejection fraction of 40% and moderate to severe septal hypokinesis, status post catheterization and stent to the RCA."
- A History and Physical (hospital record)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 15	A 290		

document indicated the date of service was 11-26-21. The document reflected Tenant #3 had been previously admitted on 10-9-21 with an "acute NSTEMI." He had a left heart catheterization on 10-12-21 and a stent was placed in the RCA. Tenant #3 was discharged with orders for Plavix and aspirin. On 11-26-21 when taking a shower Tenant #3 lost consciousness and did not remember anything after that. When he opened his eyes he was on the floor. 911 was called and the initial electrocardiogram showed an "inferior STEMI with complete AV block."

Resident Care Notes located in the file from the SNF indicated the following:
- On 10-15-21 Tenant #3 was admitted to the skilled nursing facility (SNF) level of care from the hospital.
- On 11-9-21 Tenant #3 returned to the assisted living program (ALP).
- On 12-2-21 Tenant #3 was admitted to the SNF level of care status post "acute inferior MI with stenting of 100% occlusion of RCA" and "3rd degree heart block with temporary pacemaker."
- On 12-23-21 Tenant #3 returned to his apartment in the ALP.

Further record review revealed Nurse's/Care Notes indicated an entry was completed on 9-1-21 with the next entry dated 1-11-22. Nurse's notes were not documented related to when Tenant #3 left the Program, was admitted to the hospital, went to SNF and returned in October 2021/November 2021 and when Tenant #3 left the Program, was admitted to the hospital, went to SNF and returned in November 2021/December 2021.

3. When interviewed on 6-13-22 at 12:52 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 16 the AL Manager confirmed all nurse's notes were provided for the tenants listed above.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed, and failed to ensure service plans were based on evaluations for 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file on 6-7-22 and 6-8-22 revealed the most recent Comprehensive Health Assessment dated 4-7-22 indicated Tenant #1 ate meals in her apartment. When interviewed on 6-7-22 at 1:22 p.m. Staff A Tenant #1 chose to stay in her apartment. She did not come out for meals or activities. When interviewed on 6-7-22 at 2:03 p.m. Staff B said Tenant #1 ate in her apartment. She did come out of her apartment to get her hair done. Tenant #1 liked to sleep. She said Tenant #1 occasionally refused her morning medication (Fosamax). When interviewed on 6-7-22 at 2:46 p.m. Staff C	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 17	A 350		

said Tenant #1 did not come out for meals or activities. Staff took meals to her.

When interviewed on 6-7-22 at 3:01 p.m. Staff D said Tenant #1 did not come out of her apartment per her choice. She did not come out for meals or activities.

When interviewed on 6-9-22 at 2:56 p.m. the AL Nurse #2 said Tenant #1 came out of her apartment to get her hair done. She spent the majority of her time in the apartment per her choice. She ate meals in her apartment and did not attend activities.

Continued record review revealed a Staff Communication Report dated 6-4-22 indicated Tenant #1 refused all food and medication until 1:45 p.m.

Medication administration records (MARs from January 2022 to May 2022 reflected the following dates of refusals of medications:
- On 1-24-22 a.m. medications were documented as refused
- On 3-3-322 a.m. medications were documented as refused
- On 4-11-22 Fosamax (a.m.) was documented as refused
- On 4-25-22 Fosamax was documented as refused.
- On 5-6-22 a.m. medications were documented as refused (feeling sick)
- On 5-8-22 a.m. medications were documented as refused (wanted to sleep)
- On 5-10-22 a.m. medications were documented as refused (wanted to sleep)

The most recent service plan dated 4-7-22 reflected Tenant #1 wanted reminders for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 18	A 350		

activities and would participate in activities of her choice. It also reflected Tenant #1 requested reminders at meal times and was independent with eating. The service plan reflected staff administered her medications. The service plan did not reflect Tenant #1 stayed in her apartment per her choice and did not eat meals in the dining room or attend activities. The service plan also did not reflect at times Tenant #1 refused her medication, including Fosamax.

2. Review of Tenant #2's file on 6-8-22 revealed a Comprehensive Health Assessment dated 1-18-22 reflecting Tenant #2 had a stroke that affected her right side and she did not have use of the right arm. The assessment also indicated she had numbness in her left hand.

When observed on 6-7-22 at the time of the noon meal Tenant #2 ate independently with an adaptive plate, cup and clothing protector. Tenant #2 used her left arm during the meal.

Nurse's/Care Notes indicated the following:
- On 2-17-22 it was noted Tenant #2 required more assistance with activities of daily living (ADLs) from staff.
- On 5-27-22 Tenant #2 requested assistance to a seated position on the toilet. She reported burning pain to her bilateral knees. Tenant #2 had been less active and needed to use her wheelchair more. Tenant #2 self-administered her medications and staff would start giving her reminders to start taking her as needed Tylenol at breakfast and mid-afternoon if needed.
- On 6-7-22 it was noted Tenant #2 needed assistance from the sitting position to standing from her recliner. Tenant #2's recliner was low and a pillow was added. Tenant #2 had been "increasingly worried about falling."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 19 Staff Communication Report documents indicated the following: - On 12-23-21 Tenant #2 asked staff to give her medication - On 12-24-21 (x2) it was noted Tenant #2 asked staff to give her medication - On 2-24-22 it was noted Tenant #2 needed staff to put on her "lotion on her face every night now." Continued record review revealed an Occupational Therapy (OT) Discharge Summary indicated the dates of service were from 12-21-21 to 4-13-22. Tenant #2's February 2022 medication administration records (MARs) reflected on 2-1-22 Systane eye drops were instilled and lip balm was applied by staff. When interviewed on 6-7-22 at 1:22 p.m. Staff A said staff assisted Tenant #2 with nasal spray, lip balm and eye drops every night at bedtime. When interviewed on 6-9-22 at 2:56 p.m. AL Nurse #2 said staff applied over the counter (OTC) eye drops, a topical cream for her knees and a nasal spray. Tenant #2 self-administered her own prescription medication. She did not set up medications for Tenant #2. Tenant #2's service plans dated 1-19-22 and 2-25-22 did not reflect OT services. The most current service plan (undated) indicated Tenant #2 ate independently, however staff might cut up foods into smaller pieces. On 4-14-22 it was added to put a clothing protector under her plate. The service plan did not reflect the adaptive plate and cup used. It also did not reflect Tenant #2's	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 20	A 350		

affected side and the non-use of her right arm. The service plan indicated Tenant #2 was independent with mobility and did not use an assistive device. The service plan did not reflect the use a wheelchair when needed. The service also reflected medications were set up weekly by staff. Tenant #2 was independent with taking her medications without reminders. The service plan did not reflect the reminders given for as needed Tylenol, the OTC medications administered by staff or who set up her medications.

3. Review of Tenant #3's file on 6-8-22 and 6-9-22 revealed diagnoses including alcohol abuse, hypertension, fatty liver and pulmonary nodule.

Hospital records indicated the following:
- A Progress Note (hospital record) indicated the tenant was admitted to the hospital on 10-12-21 for chest pain with wheezing. Tenant #3 was "in COPD exacerbation with non-STEMI type 2." Tenant #3 was placed on steroids, breathing treatments and antibiotics. A cardiac catheterization was completed and stent was placed to the right coronary artery (RCA). The Assessment and Plan indicated "Acute hypoxemic respiratory failure secondary to acute chronic obstructive pulmonary disease exacerbation." it also indicated "Non-ST segment elevation myocardial infarction type 2" and "Coronary artery disease with ejection fraction of 40% and moderate to severe septal hypokinesis, status post catheterization and stent to the RCA."
- A History and Physical (hospital record) document indicated the date of service was 11-26-21. The document reflected Tenant #3 had been previously admitted on 10-9-21 with an "acute NSTEMI." He had a left heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 21	A 350		

catheterization on 10-12-21 and a stent was placed to in the RCA. Tenant #3 was discharged with orders for Plavix and aspirin. On 11-26-21 when taking a shower Tenant #3 lost consciousness and did not remember anything after that. When he opened his eyes he was on the floor, 911 was called and the initial electrocardiogram was completed it showed an "inferior STEMI with complete AV block."

Resident Care Notes located in the file from the affiliated skilled nursing facility (SNF) indicated the following:
- On 10-15-21 Tenant #3 was admitted to the SNF level of care from the hospital.
- On 11-9-21 Tenant #3 returned to the assisted living program (ALP).
- On 12-2-21 Tenant #3 was admitted to the SNF level of care status post "acute inferior MI with stenting of 100% occlusion of RCA" and "3rd degree heart block with temporary pacemaker."
- On 12-23-21 Tenant #3 returned to his apartment in the ALP.

Further review revealed service plans were not developed or updated related to Tenant #3's hospitalizations, SNF stays or returns to the program in October/November 2021 and November/December 2021. The service plan in place at the time of the hospitalizations was dated 3-3-21. It was not updated post hospitalization, post SNF stay and return the Program.

When interviewed on 6-7-22 at 1:22 p.m. Staff A said Tenant #3 was incontinent of bowel at least weekly. She said there was pad on his recliner and he was not wiping himself clean.

When interviewed on 6-7-22 at 2:46 p.m. Staff C said Tenant #3 had bowel incontinence and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 22	A 350		

needed reminders to change. It occurred one time per week and staff assisted.

When interviewed on 6-9-22 at 2:56 p.m. the AL Nurse #2 said staff communicated with her regarding Tenant #3's incontinence. She said it has been addressed with him the past. There had been no issues with bedding or furniture being soiled but it had been observed in the shower. Tenant #3 did not clean up the floor or toilet. It was mostly incontinence related to bowel.

Tenant #3's May 2022 MARs reflected orders for Eliquis 5 milligram (mg), twice daily and nitroglycerin 0.4 mg, take every five minutes and repeat three times.

Tenant #3's current service plan dated 6-1-22 reflected Tenant #3 was continent of bowel and bladder. He chose to wear protective undergarments at his discretion and managed them independently. The service plan did not reflect Tenant #3's incontinence issues and interventions. The service plan reflected staff administered his medications; however, did not reflect the anticoagulant medication or nitroglycerin.

4. Review of Tenant #4's file on 6-8-22 revealed Nurse's/Care Notes indicated the following:
- On 4-19-22 it was noted staff had been concerned about her sleeping and eating habits and her mood has changed recently.
- On 4-21-22 Tenant #4's bupropion was discontinued and escitalopram was started.
- On 4-29-22 it was noted Tenant #4 had improved since the bupropion was discontinued on 4-21-22. A fax was received to discontinue escitalopram.
- On 5-4-22 weekly and as needed blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 23	A 350		

glucose checks were ordered.
- On 5-11-22 Tenant #4 sustained a fall on 5-10-22 and had a "goose egg" on her forehead. A script was sent to the pharmacy for escitalopram.
- On 5-17-22 Tenant #4 refused dinner on 5-14-22 and said she was not hungry.
- On 5-20-22 Tenant #4 mentioned to a provider that she wanted to discontinue a lot of medication. Two medications were discontinued.
- On 5-24-22 it was noted Tenant #4 fell on 5-22-22 and did not sustain an injury. The note indicated Tenant #4 was "hardly active at all."
- On 6-2-22 blood glucose checks were ordered as needed only.

When interviewed on 6-7-22 at 1:22 p.m. Staff A said Tenant #4 ate meals in her apartment and every once in awhile came out for activities. Tenant #4 said she was ready to see her husband (deceased). She had not made any self-harm statements. Tenant #4 lost her eyesight, was hard of hearing and did not want to get a new hearing aide.

When interviewed on 6-7-22 at 2:03 p.m. Staff B said Tenant #4 came out for certain activities. She said Tenant #4 was depressed and had said she lived a good life and was ready to die. Tenant #4 had not made any self-harm statements.

When interviewed on 6-7-22 at 3:01 p.m. Staff D said Tenant #4 came out for activities at times. She appeared depressed but did not voice a plan for self-harm.

On 6-9-22 at 2:56 p.m. AL Nurse #2 said Tenant #4 sometimes came out in the afternoon. Tenant #4 had voiced that she was ready to go (die). She had not voiced any self-harm statements. Tenant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 24	A 350		

#4 ate all of her meals in the apartment.

Continued record review revealed State University of Iowa College of Nursing documents indicated the following:
- A visit form dated 4-21-22 indicated it was an acute visit for depression. Tenant #4 took bupropion 150 mg daily ordered in November. Staff noted increased tearfulness, not wanting to go out for lunch, not coming out into the common areas as much and statements of being ready to die. Tenant #4 had poor vision and she reported it was "hard on her." Tenant #4 said she was ready to die but denied any suicidal ideation. Bupropion was discontinued and escitalopram 5 mg daily was prescribed.
- A visit form dated 5-19-22 indicated it was an acute visit for depression and left ear pain. Tenant #4 was prescribed escitalopram 5 mg daily. Staff noted an increase in depression symptoms including not wanting to eat, not drinking as much or coming out of her apartment and saying she was ready to die. Tenant #4's appetite and fluid intake were poor and she reported she had more headaches throughout the day and slept more.

A fax to the provider dated 5-5-22 indicated Tenant #4 had "reverted back to her old habits." Tenant #4 was staying in bed and did not want to participate in activities. An order was received to start escitalopram 5 mg, daily.

Tenant #4's service plan dated 4-19-22 reflected she ambulated independently with a wheeled walker. A wheelchair was used for long distances. The service plan reflected Tenant #4 ate independently in the dining room and that staff administered her medications. The service plan did not reflect Tenant #4 ate meals in her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 25 apartment. It also did not include her vision impairment, that she was hard of hearing, had depression symptoms as indicated above or expressions of wanting to die. The service plan also did not reflect falls and interventions or staff assistance with blood glucose monitoring. 5. When interviewed on 6-13-22 at 12:52 p.m. the AL Manager confirmed all service plans were provided for the tenants reviewed.	A 350		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans within 30 days of taking occupancy for 1 of 1 tenants reviewed admitted since November 2021 (Tenant #2). Findings follow: Review of Tenant #2's file on 6-8-22 revealed an admission date of 11-1-21. A service plan was dated and signed on 10-19-21, prior to taking occupancy. The next service plan signed by a nurse and Tenant #2 was dated 1-19-22. The service plan was not updated within 30 days of taking occupancy. When interviewed on 6-13-22 at 12:52 p.m. the AL Manager confirmed the above finding.	A 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews every 90 days for 2 of 4 tenants reviewed (Tenants #3, #4). Findings follow: 1. Review of Tenant #3's file on 6-8-22 and 6-9-22 revealed he received personal and health-related care. Nurse's/Care Notes indicated the following: - On 8-30-21 a 90 day review was completed. - On 6-1-22 a 90 day review was completed. There were no documented 90 day reviews between those dates. 2. Review of Tenant #4's file on 6-8-22 revealed she received personal and health-related care. Nurse's/Care Notes indicated the following: - On 7-6-21 a 90 day review was completed. - On 4-19-22 a 90 day review was completed. There were no other documented 90 day reviews between those dates.	A 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0306	A. BUILDING: _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON ASSISTED LIVING VILLAGE	623 EAST 5TH STREET SOLON, IA 52333

(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 430	Continued From page 27 3. When interviewed on 6-13-22 at 12:52 p.m. the AL Manager confirmed these findings.	A 430		

Solon Assisted Living Village Plan of Correction for on-site visit

07/15/2022

This facility denies the alleged facts as set forth constitutes a deficiency under the interpretation of Federal and State law. The preparation of the following plan of correction for those deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusion set forth in statement of deficiencies. The plan of correction prepared for the deficiencies was executed solely because provisions of the State and Federal law.

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.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Regarding tenant #2 and tenants in a similar situation, it is the policy of Solon Retirement Village ALP follow the policies and procedures related to medication administration including Over the Counter medication. All over the counter medications for tenant #2 are stored securely.

The Following measures will be taken to ensure the problem does not recur:

- The Program Manager and Assisted Living Nurse Coordinator and/or designee will monitor Medication and Treatment Records and update Service and Medication Administration plans when changes occur.
- All staff education was conducted on this matter on 7/14/22

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator will monitor services plans over the next six months with documentation of random audits of service plans and Medication Administration Records to ensure that all tenants needs and preference for assistance are identified correctly.

Date deficiencies corrected by: 07/15/2022

A 180 – 481-67.(6) Tenant Rights

67.2(6) The program shall allow tenants the right to communicate privately and without restrictions with persons and groups per tenants' choice including the tenant advocate.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Solon Retirement Village ALP will allow all tenants to communicate privately and without restrictions.

The Following measures will be taken to ensure the problem does not recur:

ok 7/15/22

- The Program Manager and Assisted Living Nurse Coordinator and/or designee will monitor ease of access to communication with family and friends.
- All staff education was conducted on this matter on 7/14/22

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator will monitor communication accessibility through random individual audits with tenants for 6 months, including group tenant council meetings.

Date deficiencies corrected by: 07/15/2022

A285 481-67.5(2) Medications

67.5(2) Each Program shall follow its own written medication policy, which shall include the following:

Plan of Correction:

The insufficiencies will be corrected as follows:

- In regards to tenant #3, It is the policy of Solon Retirement Village ALP that all medications shall be administered as prescribed by the tenants physician, ARNP or PA.

The Following measures will be taken to ensure the problem does not recur:

- The Program Manager and Assisted Living Nurse Coordinator will monitor medication administration and audit MARs 1x weekly. All Medication Managers completed training with ALP Nurse Coordinator.
- All staff education was conducted on this matter on 7/14/22

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator or designee will be responsible for ongoing compliance through weekly audits and quarterly in-services with staff.

Date deficiencies corrected by: 07/15/2022

A140 481-69.22(2) Evaluation of Tenant

69.22(2) Evaluation within 30 days of occupancy

Plan of Correction:

The insufficiencies will be corrected as follows:

- It is the policy of Solon Retirement Village to conduct tenant evaluations within 30 days by a healthcare professional, human services professional, or licensed practical nurse via nurse delegation regarding tenants, functional, health, and cognitive status

The Following measures will be taken to ensure the problem does not recur:

- Solon Retirement Village ALP Assisted Living Nurse Coordinator will monitor tenant evaluations. 100% compliance is expected.

- All staff education was conducted on this matter on 7/14/22

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator or designee will be responsible for ongoing compliance through weekly audits.

Date deficiencies corrected by: 07/15/2022

A145 481-69.22(3) Evaluation of tenant

69.22 (3) Evaluation annually and with significant change.

Plan of Correction:

The insufficiencies will be corrected as follows:

- It is the policy of Solon Retirement Village to conduct annual and significant change tenant evaluations by a healthcare professional, human services professional, or licensed practical nurse via nurse delegation regarding tenants, functional, health, and cognitive status.

The Following measures will be taken to ensure the problem does not recur:

- Solon Retirement Village ALP Assisted Living Nurse Coordinator will monitor tenant evaluations. 100% compliance is expected.
- All staff education was conducted on this matter on 7/14/22

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator or designee will be responsible for ongoing compliance through weekly audits.

Date deficiencies corrected by: 07/15/2022

A290 481-69.25(1) Tenant Documents

69.25(1) Documentation for each tenant shall be maintained by the program.

Plan of Correction:

The insufficiencies will be corrected as follows:

- It is the policy of Solon Retirement Village to obtain tenant medical information sheet; documentation of healthcare professionals such as orders, for treatment, therapy and medications as well as nurses notes written be exception.

The Following measures will be taken to ensure the problem does not recur:

- Solon Retirement Village ALP Assisted Living Nurse Coordinator and/or designee will monitor tenant documentation and orders from healthcare professionals.
- All staff education was conducted on this matter on 7/14/22

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator will be responsible for ongoing compliance through weekly audits.

Date deficiencies corrected by: 07/15/2022

A350 481-69.26(1) Service Plans

69.26(1) The service plan shall be developed for each tenant based on the evaluations conducted.

Plan of Correction:

The insufficiencies will be corrected as follows:

- It is the policy of Solon Retirement Village to develop a tenant-based service plan based on evaluations to meet the needs of the individual tenants, to be updated annually or whenever changes are needed.

The Following measures will be taken to ensure the problem does not recur:

- Solon Retirement Village ALP Assisted Living Nurse Coordinator and/or designee will monitor tenant services plans and update with changes as needed and annually.
- All staff education was conducted on this matter on 7/14/22

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator will be responsible for ongoing compliance through weekly audits.

Date deficiencies corrected by: 07/15/2022

A360 481-69.26(3) Service Plans

69.26(3) When tenant needs personal care of health-related care, the service plan shall be updated with 30 days of taking occupancy and as needed, annual and with significant change.

Plan of Correction:

The insufficiencies will be corrected as follows:

- It is the policy of Solon Retirement Village to develop a tenant-based service plan based on evaluations to meet the needs of the individual tenants within 30 days of tenant occupancy and as needed with significant change as well as annually.

The Following measures will be taken to ensure the problem does not recur:

- Solon Retirement Village ALP Assisted Living Nurse Coordinator will develop tenant service plans within 30 days of taking occupancy and update with changes as needed and annually.
- All staff education was conducted on this matter on 7/14/22

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator and/or designee will be responsible for ongoing compliance through weekly audits.

Date deficiencies corrected by: 07/15/2022

A430 481-69.27(1)c Nurse Review

69.27(1) If a tenant does not receive personal or health-related care, but shows a significant change in status, a nurse review shall be conducted.

Plan of Correction:

The insufficiencies will be corrected as follows:

- It is the policy of Solon Retirement Village to develop a tenant-based service plan based on evaluations to meet the needs of the individual tenants within 30 days of tenant occupancy and as needed with significant change as well as annually.

The Following measures will be taken to ensure the problem does not recur:

- Solon Retirement Village ALP Assisted Living Nurse Coordinator and/or designee will complete a 90 day nurse review schedule for individual tenants.

The program will monitor performance to ensure compliance as follows:

The Program Manager and Assisted Living Nurse Coordinator will be responsible for ongoing compliance through weekly audits.