DEPARTMENT OF INSPECTIONS AND APPEALS

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0317	A. BUILDING: _____ B. WING _____	C 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF WAUKEE MC	1505 SE LAUREL STREET WAUKEE, IA 50263

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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 1 Number of tenants with cognitive impairment: 12 Total census: 13 No regulatory insufficiencies were cited during the investigation of Incident #111812-I. The following regulatory insufficiencies were cited during the investigation of Complaint 111084-C.	A 000	See Attached POC 6/1/23	
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 consistently follow incident reporting policy. This pertained to 1 of 2 tenants (Tenants #3) reviewed for falls. Finding follows: Record review on 4/10/23 revealed Tenant #3's Incident Report (IR) for a fall dated 10/17/22. According to the IR staff found Tenant #3 on the floor in the bathroom. The IR said no notes found. Further record review revealed the Program's Resident Incident/Accident Reporting-Iowa	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 implementation date 6/8/21. The policy directed staff to document in the tenant's chart a brief summary of the incident, including time, date, location, description of the incident and notifications of family and medical doctor. When interviewed on 4/11/23 at 8:16 a.m. the Wellness Coordinator confirmed the Program failed to make a note and therefore failed to follow policy.	A 150		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program's delegating nurse failed to consistently ensure staff were trained to meet the individual needs of the tenants. This pertained to 5 of 5 tenants (Tenants #1-#5) and potentially affected the remaining 8 of 8 tenants. Finding follows: Record review on 4/11/23 revealed the Program hired Staff B on 7/21/21, Staff C on 11/1/19 and the Wellness Coordinator (delegating nurse) on 6/20/22. Further record review revealed Nurse aide checklists completed for Staff B and C on 11/30/22. When interviewed on 4/11/23 at 3:30 p.m. the Wellness Coordinator confirmed the Program	A 345		

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A 345	Continued From page 2 hired her on 6/20/22 and she completed delegations on 11/30/22 therefore the delegations were not completed within 60 days of beginning employment.	A 345		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure staff received Dependent Adult Abuse training as required. Chapter 235B.16 requires that employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every three years thereafter. This potentially affected 13 of 13 tenants (Tenants #1 - #13). Finding follows: Record review on 4/11/23 of Staff C's documentation revealed she completed Dependent Adult Abuse (DAA) training on 3/11/16. When interviewed on 4/11/23 at 2:09 p.m. the Wellness Coordinator confirmed that was the last time Staff A completed DAA.	A 380		
A 415	481-67.19(3)c Record Checks 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being	A 415		

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A 415	Continued From page 3 considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently perform evaluations of criminal history prior to employment. This pertained to 1 of 3 staff (Staff A) and potentially affected 13 of 13 tenants (Tenants #1-#13). Finding follows: Based on record review on 4/11/23 the Program hired Staff A on 1/3/23. Further review revealed the record check evaluation completed 1/4/23. When interviewed on 4/11/23 at 12:53 p.m. the Regional Wellness Director confirmed the Program failed to ensure the evaluation was completed prior to employment of Staff A.	A 415		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale	A 135		

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A 135	Continued From page 4 (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to utilize the Global Deterioration Scale for tenants who had moderate cognitive decline. This pertained 5 of 5 tenants (Tenants #1 -#5) reviewed. Findings follow: Record review on 4/6/23 revealed St. Louis University Mental Status (SLUMS) and Brief Cognitive Rating Scale (BCRS) evaluations for Tenants #1 -#5. Tenants #1 - #5's all scored as having moderate cognitive decline on the SLUMS. The Program provided BCRS as the cognitive evaluation tool for Tenants #1 - #5. When interviewed on 4/6/23 at 4:11 p.m. the Wellness Director confirmed the Program utlizes the BCRS instead of the Global Deterioration Scale tool.	A 135		
A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs)	A 330		

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A 330	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently maintain accurate documentation on task sheets for routine personal and/or health related care. This pertained to 5 of 5 tenants reviewed (Tenants #1 - #5). Findings follow: When asked to provide task sheets on 4/5/23 at 10:06 a.m. for Tenants #1-#5, the Wellness Coordinator said the Program had not been keeping up with task sheets.	A 330		
A 520	481-69.29(2) Staffing 69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to implement/document the staff procedure for addresing the emergency needs of tenants. This pertained to 5 of 5 tenants (Tenants #1 - #5) reviewed and potentially the remaining 8 of 8 tenants. Finding follows: When asked to provide documentation of the two hour checks for sample tenants 4/5/23 at 10:06 a.m. for Tenants #1-#5, the Wellness Coordinator said the Program could not locate any	A 520		

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A 520	Continued From page 6 docmentation of that staff had done the two hour checks.	A 520		

VIOLATION	HOW COMPLIANCE WILL BE ACHIEVED, MEASURE(S) TO ENSURE THE PROBLEM DOES NOT RECUR, AND PLAN TO MONITOR PERFORMANCE. OUTLINE WHO IS RESPONSIBLE FOR EACH MEASURE.	TIMELINE
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. Regarding incident reports, medication errors, and staff presence.	**Achieve Compliance:** All incident reports will be documented on appropriate forms and filed in designated binders within the Wellness office. On-Call Wellness Staff in place 24/7, between on site presence and triage call number to ensure proper handling of above stated occurences. Shift task sheets implemented to ensure staff presence for all shifts. **Prevent Recurrence:** Review of all incident reports to ensure proper use and documentation to be completed no less than once weekly by lead care staff or RCS/WTS. Shift task sheets turned in to RCS/WTS daily for review. **Monitor:** Wellness Director or other staff nurse to complete monthly review of incident reports, medication error binders, and communicate with RCS/WTS in regards to shift staffing to ensure compliance.	24/7 Nurse Triage implemented and ongoing since 9/1/22. Incident report form usage is ongoing- binder put together and re-implemented 5/1/22. Shift task sheets re-implemented 5/21/23. Monthly review of incident reports and audit of incidents prior to begin 6/1/23.

A 340 481-67.9(4)a STAFFING a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. **A 345 481-67.9(4)b STAFFING** b. Within 30 days of beginning employment, all program staff shall received straining by the program's registered nurse(s). **A 380 481-67.9(6) STAFFING** Dependent Adult Abuse Training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa	**Achieve Compliance:** Review of all current employee medication manager certificates, delegations and adult dependant abuse certificate. New Hire Orientation schedule implemented to ensure all new staff have completed medication manager certificates, delegations and adult dependant abuse certificate prior to working independently in the community. New Wellness Directior onboarding to include delegation of all staff within initial 60 days of employment. Community/ Recruiting level assurance check of background clearance and I-9 documents upon hire implemented and ongoing. **Prevent Recurrence:** Review of delegations and additional eMAR training provided to all medication managers as needed to maintain compliance. RCS/WTS/ Wellness Administrator review of new employee status prior to orientation completion and being scheduled to work independently within the community. Regoinal Wellness Director review Wellness Adminstrator delegations within initial 60 days of employment. Recruiter to review background clearance prior to forwarding new hires to community. **Monitor:** Quarterly reviews of all Wellness employee files by RCS/WTS, staff nurses, Wellness Director and/or Regional Wellness DIrector to ensure certifications/delegations are complete and up to date to maintain compliance. Wellness Director and RCS/WTS to review new hire documents forwarded by recruiting prior to new hire start date at community.	Current staff re-delegations to be completed in June 2023. New hire training and delegations are ongoing. New Hire training schedule and reviews implemented for all new hires after 6/1/23. PCC eMAR training made available via Relias and Smartsheet website as well. Current staff documentation/certificate audit completed to be completed June 2023. Recruiting/Community level checks of new hire clearance re-implemented 5/1/23 and ongoing.

A 135 481-69.22(1) EVALUATION OF TENANT **A 140 481-69.22(2) EVALUATION OF TENANT** **A 145 481-69.22(3) EVALUATION OF TENANT**	**Achieve Compliance:** Assessment of health, cognitive, and functional to be completed pre-move in, 30 day post admission, with significant change, and annually. Wellness Form 7 used for health and functional and SLUMS and BCRS used for cognitive. Evaluations will be completed and documented in Point Click Care and recurring schedules set. **Prevent Recurrence:** Pre-move in asessments completed and follow up communication is sent to community prior to resident taking occupancy. Upon occupancy, a 30 day assessment date is established. Annual schedule is initiated after 30 day is completed. Significant change are initiated and tracked by staff registered nurses. Community wellness team to hold weekly meeting regarding all residents and addressing concerns/significant changes that have occured. Level of Care tracking tool implemented to reflect current resident and evaluation dates. **Monitor:** Wellness Administrator/staff nurses to review and maintain evaluation schedule monthly to ensure compliance.	Level of care audit completed for all residents March 2023. Evaluation schedules updated for all residents at this time. Clarification of use of BCRS cognitive tool to calculate GDS score.
A 330 481-69.25 (1)q TENANT DOCUMENTS	**Achieve Compliance:** Audit of all residents level of care and service plans to be completed to reflect current needs/additionl outside services with signatures from resident/respresentative and community staff obtained. Prior to admission of all residents service plans will be reviewed and signed. All service plan changes to be documented within 72 hours of the change. Service plan binder to be kept in Wellness office for review and signatures from all Wellness staff. Resident task sheets to be re-implemented throughout community. Until transition to full EHR usage is complete. **Prevent Recurrence:** Community Wellness team to hold weekly meeting regarding all residents and addressing concerns/service plan changes. Level of care tracking tool to be reviewed monthly. Move in momentum tool used for all new move ins to ensure documentation is received and service plan is agreed upon/signed prior to admission. Resident task sheets to be reviewed no less than weekly by direct care staff and submitted for updates to ensure accuracy. **Monitor:** Wellness Director/Staff Nurse to review level of care tracking tool and service plan binder atleast monthly to ensure accuracy and compliance. Review of task sheet submissions to occur no less than weekly to ensure accuracy.	Level of care audit completed for all residents February 2023. Evaluation schedules updated for all residents. Care conferences and Service plans updated at this time as well. Updates to resident task sheets implemented 6/1/23 and ongoing.

A 520 481-69.29(2) **STAFFING**	**Achieve Compliance:** Training checklist implemented for all new and agency staff to be completed during their initial shift in the community. Procedure and document for completing safety checks implented for Memory Care re-trained to community staff. **Prevent Recurrence:** Safety check documentation to be reviewed no less than weekly with corrective action to employees not completing checks. Documentation of said safety checks will be submitted to RCS/WTS and/or Wellness Director or staff nurse daily. Completed training checklists to be stored in employee files. **Monitor:** Wellness Director or staff nurse to ensure weekly. In the event of of emergency pendant system not working Wellness Director or staff nurse to review safety check documentation daily. RCS/WTS/Wellness DIrector to review training checklist is completed for all new hires and staff.	Current staff training and delegations- with specific focus on safety checks to be completed June 2023. New hire training and delegations are ongoing. New Hire training schedule and reviews implemented for all new hires after 6/1/23. Current staff documentation/certificate audit to be completed in July 2023. Hourly check sheets and procedure re-trained to staff 6/1/23.