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
	S0317	A. BUILDING: _____ B. WING _____	C 09/27/2023

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

(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 impairment: 0 Number of tenants with cognitive impairment: 15 Total census: 15 The following regulatory insufficiencies were cited during the investigation of Complaint #109278-C.	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 established policies and procedures for incident reports and head injuries. This pertained to 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review of the Program's policies and procedures revealed the following: a. The Suspected Head Injury policy noted if a resident suffered a possible head injury the nurse must evaluate and document the status of the resident on the Head Injury Report. If there was any injuries or altered mental/physical status observed the resident must be sent to the ER for further evaluation. Upon return the resident would be observed for 3 days and the physician notified	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	A 150		

of any changes in their baseline.

b. The Resident Incident/Accident Reporting policy included a report must be completed whenever there is a new to explain/investigate an unwitnessed injury or unexplainable events and included bruises. Staff were to complete the report prior to the end of their shift and report the incident to the supervisor on duty and forwarded to the Wellness Director. The Wellness Director would review the report and follow up as indicated and log the incident on the Resident Incident/Accident log. It was then to be forwarded to the Executive Director for review and follow up.

1. Review on 9/26/23 revealed Tenant #1's medical provider records documented the following office visits:
a. 8/29/22 for skin breakdown on buttock and noted bruises on left arm. The provider contacted the Program's Registered Nurse (RN) to discuss ongoing concerns related to skin breakdown and refusals to eat, take medications, and participate in activities.
b. 9/13/22 a family member contacted the provider about a fall and the provider told the family member to take Tenant #1 to the emergency room (ER) for evaluation and was diagnosed with a urinary tract infection (UTI). Photos taken revealed dark purple bruising to her left ear and a light purple bruise below the earlobe.
c. 9/28/22 for her annual appointment and documented weight was a little better and noted bruising to the back of the left arm. Additional photos revealed the bruise covered her entire left ear and extended to her neck that could have been caused by a falling into the edge of some type of furniture.
d. 11/29/22 noted a weight loss of 36 pounds

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A 150	Continued From page 2 from December of 2021, bruising on her left cheek, and skin breakdown on her buttock. e. 1/6/23 for open wound on buttock and bruising on back of both arms and family reported the staff could not explain how it happened. The Provider noted Tenant #1 was prone to bruising and felt this pattern of bruising was unusual. No Resident Incident/Accident Reports for the falls and bruising could be located. No Head Injury Report or documented three day observations could be located. The RN and direct care staff working at the time of these incidents were not available for an interview as they were no longer employed. The Wellness Director confirmed these findings be email on 8/31/23.	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: Based on interview and record review the program failed to provide adequate and appropriate care to tenants. This pertained to 1 of 3 tenants reviewed (Tenant #1). Finding follows:	A 160		

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A 160	Continued From page 3 Record review of the Program's policies and procedures revealed the following: a. The Suspected Head Injury policy noted if a resident suffered a possible head injury the nurse must evaluate and document the status of the resident on the Head Injury Report. If there was any injuries or altered mental/physical status observed the resident must be sent to the ER for further evaluation. Upon return the resident would be observed for 3 days and the physician notified of any changes in their baseline. b. The Resident Incident/Accident Reporting policy included a report must be completed whenever there is a need to explain/investigate an unwitnessed injury or unexplainable events and included bruises. Staff were to complete the report prior to the end of their shift and report the incident to the supervisor on duty and forwarded to the Wellness Director. The Wellness Director would review the report and follow up as indicated and log the incident on the Resident Incident/Accident log. It was then to be forwarded to the Executive Director for review and follow up. Review on 9/26/23 revealed Tenant #1's medical provider records documented the following office visits: a. 8/29/22 for skin breakdown on buttock and noted bruises on left arm. The provider contacted the Program's Registered Nurse (RN) to discuss ongoing concerns related to skin breakdown and refusals to eat, take medications, and participate in activities. b. 9/13/22 a family member contacted the provider about a fall and the provider told the family member to take Tenant #1 to the emergency room (ER) for evaluation and was diagnosed with a urinary tract infection (UTI).	A 160		

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A 160	Continued From page 4 Photos taken revealed dark purple bruising to her left ear and a light purple bruise below the earlobe. c. 9/28/22 for her annual appointment and documented weight was a little better and noted bruising to the back of the left arm. Additional photos revealed the bruise covered her entire left ear and extended to her neck that could have been caused by a falling into the edge of some type of furniture. d. 11/29/22 noted a weight loss of 36 pounds from December of 2021, bruising on her left cheek, and skin breakdown on her buttock. e. 1/6/23 for open wound on buttock and bruising on back of both arms and family reported the staff could not explain how it happened. The Provider noted Tenant #1 was prone to bruising and felt this pattern of bruising was unusual. No Resident Incident/Accident Reports for the falls and bruising could be located. No Head Injury Report or documented three day observations could be located. The RN and direct care staff working at the time of these incidents were not available for an interview as they were no longer employed. The Program failed to ensure Tenant #1 received appropriate care related to these ongoing concerns. The Wellness Director confirmed these findings via email on 8/31/23.	A 160		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A	A 135		

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A 135	Continued From page 5 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 (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 evaluate the functional, cognitive, and health status prior to moving in to determine eligibility. This pertained to 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review of Tenant #1's file on 8/31/23 revealed the following: Tenant #1's Face Sheet indicated a move in date of 8/1/22. No functional, cognitive, and health assessments completed prior to moving in could be located. The Wellness Director confirmed these findings via email on 8/31/23.	A 135		
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	A 145		

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A 145	Continued From page 6 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 evaluate the functional, cognitive, and health status as warranted. This pertained to 1 of 3 tenants reviewed (Tenant #1). Finding follows: Review on 9/26/23 revealed Tenant #1's medical provider records documented the following office visits: a. 8/29/22 for skin breakdown on buttock and noted bruises on left arm. The provider contacted the Program's Registered Nurse (RN) to discuss ongoing concerns related to skin breakdown and refusals to eat, take medications, and participate in activities. b. 9/13/22 a family member contacted the provider about a fall and the provider told the family member to take Tenant #1 to the emergency room (ER) for evaluation and was diagnosed with a urinary tract infection (UTI). Photos taken revealed dark purple bruising to her left ear and a light purple bruise below the	A 145		

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A 145	Continued From page 7 earlobe. c. 9/28/22 for her annual appointment and documented weight was a little better and noted bruising to the back of the left arm. Additional photos revealed the bruise covered her entire left ear and extended to her neck that could have been caused by a falling into the edge of some type of furniture. d. 11/29/22 noted a weight loss of 36 pounds from December of 2021, bruising on her left cheek, and skin breakdown on her buttock. e. 1/6/23 for open wound on buttock and bruising on back of both arms and family reported the staff could not explain how it happened. The Provider noted Tenant #1 was prone to bruising and felt this pattern of bruising was unusual. Record review of Tenant #1's file on 8/31/23 revealed no functional, cognitive, and health assessments for these changes in health status to determine continued eligibility were completed. The RN was not available for an interview as she was no longer employed. The Wellness Director confirmed these findings via email on 8/31/23.	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	A 290		

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A 290	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 1 of 3 tenants reviewed (Tenant #1). Finding follows: Review of medical provider records on 9/26/23 revealed the following fax communications from the Registered Nurse (RN): a. 12/6/22 requested an order for urinalysis for increased confusion/agitation and was returned by the physician on 1/4/23. b. 9/12/22 asked for an increase in fluoxetine for increased crying and secluding herself in her apartment and was returned on 9/13/22. Review on 9/26/23 revealed Tenant #1's medical provider records documented the following office visits: a. 8/29/22 for skin breakdown on buttock and noted bruises on left arm. The provider contacted the Program's RN to discuss ongoing concerns related to skin breakdown and refusals to eat, take medications, and participate in activities. b. 9/13/22 a family member contacted the provider about a fall and the provider told the family member to take Tenant #1 to the emergency room (ER) for evaluation and was diagnosed with a urinary tract infection (UTI). Photos taken revealed dark purple bruising to her left ear and a light purple bruise below the earlobe. c. 9/28/22 for her annual appointment and documented weight was a little better and noted bruising to the back of the left arm. Additional photos revealed the bruise covered her entire left ear and extended to her neck that could have	A 290		

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A 290	Continued From page 9 been caused by a falling into the edge of some type of furniture. d. 11/29/22 noted a weight loss of 36 pounds from December of 2021, bruising on her left cheek, and skin breakdown on her buttock. e. 1/6/23 for open wound on buttock and bruising on back of both arms and family reported the staff could not explain how it happened. The Provider noted Tenant #1 was prone to bruising and felt this pattern of bruising was unusual. Record review of Tenant #1's Progress Notes on 8/31/23 revealed no ongoing notes completed by a nurse documenting communication with the physician for orders and treatments, falls, bruises, and skin breakdown. The RN was not available for an interview as she was no longer employed. The Wellness Director confirmed these findings via email on 8/31/23.	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	A 350		

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A 350	Continued From page 10 Program failed to update service plans based on the required evaluations. This pertained to 1 of 3 tenants reviewed (Tenant #1). Findings follow: Record review of Tenant #1's Face Sheet indicated a move in date of 8/1/22. No functional, cognitive, and health assessments completed prior to moving in could be located. Review on 9/26/23 revealed Tenant #1's medical provider records documented the following office visits: a. 8/29/22 for skin breakdown on buttock and noted bruises on left arm. The provider contacted the Program's Registered Nurse (RN) to discuss ongoing concerns related to skin breakdown and refusals to eat, take medications, and participate in activities. b. 9/13/22 a family member contacted the provider about a fall and the provider told the family member to take Tenant #1 to the emergency room (ER) for evaluation and was diagnosed with a urinary tract infection (UTI). Photos taken revealed dark purple bruising to her left ear and a light purple bruise below the earlobe. c. 9/28/22 for her annual appointment and documented weight was a little better and noted bruising to the back of the left arm. Additional photos revealed the bruise covered her entire left ear and extended to her neck that could have been caused by a falling into the edge of some type of furniture. d. 11/29/22 noted a weight loss of 36 pounds from December of 2021, bruising on her left cheek, and skin breakdown on her buttock. e. 1/6/23 for open wound on buttock and bruising on back of both arms and family reported the staff could not explain how it happened. The Provider noted Tenant #1 was prone to bruising and felt	A 350		

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A 350	Continued From page 11 this pattern of bruising was unusual. Record review of Tenant #1's file on 8/31/23 revealed no functional, cognitive, and health assessments for these changes in health status to determine continued eligibility were completed. The service plans failed to be updated based on the required assessments and individualized to include frequent refusals, bruising, and skin breakdown. The RN could not be interviewed as she was no longer employed. The Wellness Director confirmed these findings via email on 8/31/23.	A 350		
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 assess and document the health status of each tenant that received	A 430		

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A 430	Continued From page 12	A 430		

personal or health-related care at least every 90 days. This pertained to 1 of 3 tenants reviewed (Tenant #1). Finding follows:

Record review on 8/31/23 revealed Tenant #1's Service Plan dated 9/6/22, indicated she required assistance with medication management, bathing, and putting in her TED hose.

Review of medical provider records on 9/26/23 revealed the following fax communications from the Registered Nurse (RN):
a. 12/6/22 requested an order for urinalysis for increased confusion/agitation and was returned by the physician on 1/4/23.
b. 9/12/22 asked for an increase in fluoxetine for increased crying and secluding herself in her apartment and was returned on 9/13/22.

Review on 9/26/23 revealed Tenant #1's medical provider records documented the following office visits:
a. 8/29/22 for skin breakdown on buttock and noted bruises on left arm. The provider contacted the Program's RN to discuss ongoing concerns related to skin breakdown and refusals to eat, take medications, and participate in activities.
b. 9/13/22 a family member contacted the provider about a fall and the provider told the family member to take Tenant #1 to the emergency room (ER) for evaluation and was diagnosed with a urinary tract infection (UTI). Photos taken revealed dark purple bruising to her left ear and a light purple bruise below the earlobe.
c. 9/28/22 for her annual appointment and documented weight was a little better and noted bruising to the back of the left arm. Additional photos revealed the bruise covered her entire left ear and extended to her neck that could have

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A 430	Continued From page 13 been caused by a falling into the edge of some type of furniture. d. 11/29/22 noted a weight loss of 36 pounds from December of 2021, bruising on her left cheek, and skin breakdown on her buttock. e. 1/6/23 for open wound on buttock and bruising on back of both arms and family reported the staff could not explain how it happened. The Provider noted Tenant #1 was prone to bruising and felt this pattern of bruising was unusual. No nurse review to monitor progress and assess the health status related to the falls, bruising, and skin breakdown at least every 90 days could be located. A Major Nurse reviewed completed 3/9/23 failed to include review the concerns noted from the office visit on 1/6/23. The RN was not available for an interview as she was no longer employed. The Wellness Director confirmed these findings via email on 8/31/23.	A 430		