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
	S0326	A. BUILDING: _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF ANKENY MC	1275 SW STATE STREET ANKENY, IA 50023

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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: 7 Number of tenants with cognitive impairment: 8 Total census: 15 The following regulatory insufficiencies were cited during the investigation of Complaint #114056-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 consistently follow established policy/procedure for incident reports. This pertained to 3 of 6 reviewed (Tenants #1, #2 and #4). Findings follow: During an interview on 7/12/23 at 11:15 a.m. the interviewee mentioned a concern regarding Tenant #1 and #2. According to the interviewee staff found Tenant #1 unclothed and Tenant wore only a brief. The interviewee claimed the tenants had sexual intercourse and the Program had not notified the responsible parties for either tenant. Record review on the Program's	A 150		

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A 150	Continued From page 1	A 150		

Incident/Accident Reporting Policy revealed the staff person who witnessed the incident should have completed an IR.

When interviewed on 7/18/23 at 1:26 p.m. the nurse said she had contacted the responsible parties for the tenants involved. She also confirmed the Program failed to complete an incident report and/or document the incident in progress notes.

Review of Incident Reports (IR) during the visit revealed lack of follow up from the Wellness Director and/or Executive Director. Examples included, but were not limited to:

On 7/10/23 staff documented staff found Tenant #1 on the floor. The IR provided no follow up from Wellness Director and/or the Executive Director.

On 5/8/23 staff documented Tenant #2 fell to the ground. The IR provided not follow up from Wellness Director and/or the Executive Director.

On 4/19/23 staff documented staff heard Tenant #4 calling for help and staff found her crawling on the floor. The IR provided no follow up from Wellness Director and/or the Executive Director.

On 5/10/23 staff documented Tenant #4 found on the floor. The IR provided no follow up from Wellness Director and/or the Executive Director.

On 4/18/23 staff documented Tenant #4 tripped and fell. On 4/8/23 staff documented tenant slowly fell to the floor. The IR provided no follow up from Wellness Director and/or the Executive Director.

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A 150	Continued From page 2 During the exit on 7/25/23 the administrative team acknowledged the Program failed to follow IR policy.	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 consistently ensure tenants received care, treatment and services which were adequate and appropriate. This pertained to 5 of 6 tenants reviewed (Tenants #1 - #6). Finding follows: Record review on 7/25/23 revealed Tenant #4's Progress Notes. According to notes on 5/30/23 and 6/23/23 Tenant #4's Carbidopa-Levodopa 25-100 mg take 1 tablet by mouth three times a day not available. Further review revealed Tenant #4's Progress notes dated 5/31/23 and 6/17/23 for Rivastigmine dis 4.6 mg/24 apply once daily not available. Record review on 7/25/23 revealed Tenant #5's Progress Notes dated 7/23/23 staff noted the "blood sugar machine' not working three times. Record review on 7/25/23 revealed Tenant #5's Progress Notes noted rocdantan drop instill one drop in both eyes at bedtime was not	A 160		

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A 160	Continued From page 3 administered on 3/16-27/23 and 1/24 -1/31/23. Additionally, program staff noted Lisinopril 5 mg not available on 5/23/23, Caltrate Gummy bites on 5/15/23 and 5/26/23 and Trazadone 50 mg 1/4 tablet every evening on 2/28/23 not available. Record review on 7/24/23 revealed Tenants #1 -#4 and #6's service plans included under home management the following - housekeeping provided on scheduled days. During the on-site visit staff confirmed the Program had not had a housekeeper for many months and cleaning had been completed by them. They said they did not have time to complete cleaning therefore it went undone. During an interview on 7/12/23 at 11:15 a.m. the interviewee expressed concerns regarding the cleanliness of the memory care unit. On 7/20/23 a family member approached the surveyor to point out the Program failed to complete weekly cleaning as they had promised during their tour of the Program. During the exit on 7/25/23 the administrative team acknowledged the Program failed to complete housekeeping as agreed.	A 160		
A 275	481-67.5(2)f(2) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.	A 275		

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A 275	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to consistently ensure medications were locked and only accessible to persons responsible for administration/storage of the medications. This pertained to 6 of 6 sample tenants (Tenants #1 -#5) and Tenant #6 who had narcotics prescribed (Tenant #6). Findings follow: Observations on 7/12/23 at 2:20 p.m. revealed an unlocked refrigerator below the work area in the nurse/staff station. Further observations revealed Tenant #6's Lorazepam concentrate 2mg/ml and Morphine Sulfate Oral Solution 100 mg per 5 ml. Interviews with staff on 7/12/23, 7/17/23, 7/18/23 and 7/20/23 revealed the lock on the medication cart had been broken in June exact dates unknown. Staff said the amount of time the medication cart could not be locked ranged from one week to two weeks. Further review revealed an invoice dated 6/19, 20 and 23/2023 for a locksmith. During the exit on 7/25/23 the Regional Wellness Director acknowledged the medication cart lock was broken.	A 275		
A 340	481-67.9(4)a 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: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a	A 340		

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A 340	Continued From page 5 review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the delegating nurse failed to consistently ensure staff were sufficiently trained within 60 days of her employment. This pertained to 1 of 4 staff reviewed (Staff D). Finding follows: Record review on 7/24/23 revealed the delegating nurse failed to complete a review to ensure Staff D had been sufficiently trained and competent in all tasks. According to documentation Staff D had been delegated on 8/30/21. According to the Program Entrance form the interim delegating nurses were hired on 9/21 and 10/22. When interviewed on 7/24/23 at 12:05 p.m. the Regional Wellness Director confirmed the Program had provided all training documentation for staff.	A 340		
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).	A 345		

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A 345	Continued From page 6 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 1 of 4 staff reviewed (Staff A). Finding follows: Record review on 7/19/23 revealed the Program hired Staff A on 4/3/23. Further review revealed no documentation of nurse delegation. When interviewed on 7/24/23 at 12:05 p.m. the Regional Wellness Coordinator confirmed the Program had provided all employee training documents.	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 pertained to 3 of 4 staff reviewed (Staff A and D). Finding follows:	A 380		

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A 380	Continued From page 7 Record review on 7/19/23 revealed no certificate of Dependent Adult Abuse (DAA) training for Staff A. Further review revealed the Program hired Staff D on 5/7/21 and she completed DAA training on 1/3/22 (not within six months). When interviewed on 7/24/23 at 12:05 p.m. the Regional Wellness Director confirmed the Program had provided all documentation of staff DAA training.	A 380		
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 (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 to 6 of 6 tenants reviewed (Tenants #1- #6). Findings follow:	A 135		

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A 135	Continued From page 8 Record review on 7/24/23 revealed St. Louis University Mental Status (SLUMS) and Brief Cognitive Rating Scale (BCRS) evaluations for Tenants #1, #3-#6. Further review revealed a BCRS for Tenant #2. Tenants #1, #3-#6 all scored as having moderate cognitive decline on the SLUMS. The Program provided BCRS as the cognitive evaluation tool for Tenants #1 - #6. During the exit on 7/25/23 the administrative team acknowledged the Program utilized the BCRS instead of the Global Deterioration Scale tool as required.	A 135		
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 consistently complete evaluations within 30 days of occupancy. This pertained to 2 of 6 tenants reviewed (Tenants #1 and #6). Finding follows: Record review on 7/24/23 revealed the Program failed to complete 30-day evaluations for Tenant #1 and #6. Further review revealed the Program completed initial health and functional evaluations for Tenant #1 on 2/24/23 and Tenant #6 on	A 140		

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A 140	Continued From page 9 1/25/23. During the exit on 7/25/23 the administrative team acknowledged the Program failed to complete 30-day evaluations or could not produce documentation to support the evaluation was done.	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 consistently complete evaluations as needed but not less than annually. This pertained to 2 of 4 tenants reviewed (Tenant #3 and #4). Findings follow: Record review on 7/24/23 revealed Tenant #4's Progress note dated 6/27/23 noted Tenant #4's admission to hospice. Further review revealed no evaluations completed for this significant change	A 145		

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A 145	Continued From page 10 in condition. Record review on 7/25/23 revealed Tenant #3's Progress Note dated 6/28/23 for hospice evaluation. No evaluations could be located for this significant change in condition. During the exit on 7/25/23 the administrative team acknowledged the Program failed to complete evaluations or they could not locate the documents.	A 145		
A 420	481-69.27(1)a 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: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently complete 90-day nurse reviews as required. This pertained to 5 of 6 tenants reviewed (Tenant #1, #2, #3, #4, and #5). Findings follow:	A 420		

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A 420	Continued From page 11 Record review on 7/24/23 revealed the following examples (including but not limited too) regarding nurse reviews: Tenant #1's initial evaluations were completed on 2/24/23 with no 90-day evaluations completed. Tenant #2's most recent nurse review dated 3/10/23 and the most recent prior to this review dated 9/28/22. Further review revealed the Program failed to complete 90-day nurse reviews for Tenant #2 in 12/22. Tenant #3's most recent nurse review dated 4/13/23. The Program failed to complete 90 nurse reviews for Tenant #3 in 6/22, 9/22 and 1/23. Tenant #4's most recent nurse review dated 3/11/23. The Program failed to complete 90-day reviews for Tenant #4 in 12/22. Tenant #5's most recent nurse review dated 9/23/22. The Program failed to complete 90-day reviews for Tenant #5 in 12/22, 3/23 and 6/23. During the exit on 7/25/23 the administrative team acknowledged the Program failed to complete 90-day nurse reviews as required or could not produce documentation to support the evaluation was done.	A 420		
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	A 520		

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A 520	Continued From page 12 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 addressing the emergency needs of tenants. This pertained to 6 of 6 tenants reviewed (Tenants #1 - #6) reviewed and potentially the remaining 9 of 9 tenants. Finding follows: Record review on 7/19/23 revealed a policy provided entitled Secured Door Verification revised 7/27/22. The policy's purpose was to ensure safety and security of the tenants by checking and monitoring the secured doors to ensure they worked properly. The Program provided secured verification sign off sheet. Review of the sheets revealed the staff noted a head count only. On 7/19/23 at 2:19 p.m. The Clinical Operations Nurse confirmed the Program utilized this policy to address the emergency needs of tenants. She acknowledged this policy seemed directed more towards door security and not all tenant safety needs.	A 520		
A 525	481-69.29(3) Staffing 69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population.	A 525		

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A 525	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to consistently ensure all personnel including agency/contract staff were appropriately trained to meet the tenant needs. This pertained to 3 of 4 program staff and 2 of 2 agency/contract staff reviewed (Staff A, B, C and AS E and AS F). Finding follows: Record review Record review on 7/20/23 revealed no training documentation for 3 of 4 staff and 2 of 2 Agency Staff (AS) AS D and E. When interviewed on 7/20 -21/23 the Clinical Operations Nurse confirmed the Program failed to ensure all staff including agency staff were trained to meet the tenants needs.	A 525		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure staff received eight hours of dementia- specific training within 30 days of employment. This pertained to 3 of 4 staff and 2 of 2 agency staff (Staff A, B and C and Agency Staff (AS) E and AS F). Findings	A 545		

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A 545	Continued From page 14 follow: Record review on 7/24/23 revealed the Program hired Staff A on 4/3/23, Staff B on 4/11/23 and Staff C on 4/5/23 and AS E and F on 12/22/22. Review of dementia-specific training documentation revealed Staff A, B, C, AS E and AS F had completed some hours but failed to complete the required eight hours of training within 30 days of employment. When interviewed on 7/24/23 at 12:05 p.m. the Regional Wellness Director confirmed the Program provided all training documents.	A 545		