DEPARTMENT OF INSPECTIONS AND APPEALS ok

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0328	A. BUILDING: _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF SHENANDOAH	**601 HARRISON STREET SHENANDOAH, IA 51601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 6 Number of tenants with cognitive impairment: 32 Total census: 38 The following regulatory insufficiencies were cited during the investigation of Mandatory Abuse 112176-M & 112446-C. No regulatory insufficiencies were cited during the investigation of Incident #113323-I.	A 000	See Attached POC 6/8/23	
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 ensure hourly checks were completed as required by the Program's policy. This pertained 2 of 2 tenants reviewed. Findings follow: 1. Record review on 6/8/23 revealed documentation survey reports for March for Tenants #1. Further reavealed Program staff failed to document/complete hourly checks for Tenant #1 on the following dates (examples include but are not limited too):	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. 3/18/23 at 1100, 1200 and 1300 hours and 0800, 0900 and 1000 hours b. 3/23/23 at 0200 hours, 0300 hours, 0400 hours and 0500 hours. c. 3/25/23 at 1300 2. Record review on 6/8/23 revealed documentation survey reports for April for Tenant C3. Further review reavealed Program staff failed to document/complete hourly checks for Tenant C3 on the following dates (examples included, but were not limited to): a. 4/10/23 at 0000, 0100, 0200 and 0300 hours and 1200 and 1300 hours b. 4/18/23 at 0000 hours, 0100 hours, 0200 hours, 0300 hours, 0400 hours and 0500 hours. c. 4/28/23 at 0000 hours, 0100 hours, 0200 hours, 0300 hours, 0400 hours and 0500 hours. 3. Further record review revealed the Program's policy Global Deterioration Scale (GDS), no date. The policy included the following statement, when a tenant scores a five on the GDS scale, the nurse will initiate hourly safety checks on the tenant. This will provide additional coverage should the tenant not know how or when to use their emergency pendant. Documentation will be kept of the hourly checks. 4. During the exit on 6/7/23 at 12:30 p.m. the Director acknowledged staff may have failed to document or complete the checks it was unclear what situation applied.	A 150		

08/02/23

A 150 481-67.2 (3) Program Policies and Procedures, Hourly Checks:

1. Hourly checks will be completed for residents who have a score of 5 or more on the GDS.

2. Routine audits of the documentation will be completed by the ED, RCC or nurse to ensure compliance.

3. Staff have been reeducated in this process.

Date Corrected was 6/8/23.