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
	S0351	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY PLACE	901 SOUTH MENTZER ROAD ROBINS, IA 52328

(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: 32 Number of tenants with cognitive impairment: 16 Total census: 48 The following regulatory insufficiencies were cited related to the investigation of Complaints #117848-C and #122653-C, the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program and the revisit of FC 10179: 231C.5 Written occupancy agreement required. 2. An assisted living program occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the program. The occupancy agreement shall also include but is not limited to inclusion of all of the following information in the body of the agreement or in the supporting documents and attachments: b. (2) The occupancy agreement shall specifically include a statement regarding each of the following: h. Occupancy, involuntary transfer, and transfer criteria and procedures, which ensure a safe and orderly transfer. i. The internal appeals process provided relative to an involuntary transfer	A 000	The POC is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director — (X6) DATE: 11/18/24

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A 000	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure all required information regarding the involuntary transfer procedures and the internal appeals process was included in the occupancy agreement. This pertained to 1 of 1 discharged tenants reviewed who received a 30 day written notice for transfer (Tenant C1). Findings follow: 1. Review of Tenant C1's file on 9/24/24 and 9/30/24 revealed a letter dated 12/11/23 to Tenant C1's legal representative indicating it was a 30 day discharge notice as the tenant needed a higher level of care. The letter referenced the Occupancy Agreement signed on 7/24/23 and indicated the tenant exceeded level of care due to the need for routine two-person assistance with transfers. Tenant C1 had needs that were beyond the scope of the Program. The letter indicated alternative placement would need to be made on or before 1/11/24 and under Iowa law, the decision could be disputed. The contact information for the State Ombudsman was provided. The letter indicted it was sent to Tenant C1's legal representative and the Long Term Care Ombudsman. 2. A Progress Notes dated 1/11/24 (discharge summary) indicated Tenant C1 moved out due to needing a higher level of care. 3. Further review revealed the Occupancy Agreement dated 7/24/24 was signed by Tenant C1's spouse and a Program representative. The Occupancy Agreement did not include information related to involuntary transfer procedures or the internal appeals process related to involuntary transfers.	A 000		

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A 000	Continued From page 2 4. When interviewed on 10/1/24 at 1:38 p.m. and 4:00 p.m. the Executive Director confirmed Tenant C1 received a 30 day notice for transfer. She said there was nothing specific in the occupancy agreement related to involuntary transfer procdures or internal appeals.	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 policy and procedures related to medications and incident reports. This pertained 5 of 9 current tenants reviewed (Tenants #1, #4, #7, #8 and #9). Findings follow: 1. Review of a Counseling Documentation Form on 10/1/24 indicated on 8/9/24 Staff A received a written warning for falsification of documentation. On 8/9/24 Staff A charted that morning's medications were administered. On 8/10/24 morning medications (from 8/9/24) for Tenants #4, #7, #8 and #9 were found locked in their medication cabinets. The form indicated that documenting giving medications when they were not administered was falsification of documentation. Staff A, the Healthcare Coordinator, and the Executive Director signed the document. On 9/30/24 review of Tenant #4's August 2024	A 150		

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A 150	Continued From page 3	A 150		

medication administration records (MARs) revealed the following:
- Divalproex 250 milligram (mg) tablet, one tablet twice daily at 9:00 a.m. and 8:00 p.m. On 8/9/24 at 9:00 a.m. it was charted as refused by Staff A.
- Fiber-lax tablet 625 mg, one tablet twice daily at 8:00 a.m. and 8:00 p.m. On 8/9/24 at 8:00 a.m. it was charted as refused by Staff A.

On 10/1/24 review of Tenant #7's August 2024 MARs revealed Tenant #7 had acetaminophen 500 mg tablet, two tablets at 8:00 a.m. and 8:00 p.m. On 8/9/24 at 8:00 a.m. it was charted as refused by Staff A.

Review of Tenant #8's August 2024 MARs on 10/1/24 revealed the following:
- Buspirone 10 mg tablet, one tablet twice daily at 8:00 a.m. and 8:00 p.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A.
- Levothyroxin tablet 125 microgram (mcg), one tablet every morning before breakfast at 7:00 a.m. On 8/9/24 at 7:00 a.m. it was charted as administered by Staff A.
- Memantine 10 mg tablet, one tablet twice daily at 8:00 a.m. and 8:00 p.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A.
- Omerprazole 20 mg capsule, one capsule daily at 8:00 a.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A.
- Ropinirole 1 mg tablet, one tablet twice daily at 8:00 a.m. and 8:00 p.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A.
- Sentry women 50+ vitamin, one tablet every morning at 8:00 a.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A.
- Vitamin D3 (400 unit) two tablets daily at 8:00 a.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A.
- Escitalopram 20 mg tablet, one tablet at 8:00

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A 150	Continued From page 4 a.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A. On 10/1/24 review of Tenant #9's August 2024 MARs revealed the following: - Acetaminophen 325 mg tablet, two tablets three times daily at 8:00 a.m., 1:00 p.m. and 8:00 p.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A. - Bumetanide 2 mg, one tablet twice daily at 8:00 a.m. and 12:00 p.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A. - Escitalopram 10 mg, one tablet once daily at 8:00 a.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A. - Vitamin D tablet 25 mcg, one tablet by mouth daily at 8:00 a.m. On 8/9/24 at 8:00 a.m. it was charted as administered by Staff A. Review of the Program's Medication and Medication Administration policy and procedure revealed any violation of the "Six Rights" or medication administration (correct medication, dose, time, person, route and documentation) would constitute a medication error. It should be reported to the nurse and a medication error report form would be completed and submitted to the nurse on-call. Continued record review revealed incident reports could not be located related to the medication errors for Tenant #4, #7, #8 and #9 on 8/9/24 related to medications not administered as ordered. 2. Review of Tenant #1's file on 9/25/24 revealed a handwritten Incident Report related to a medication error. On 6/5/24 at 7:00 p.m. Tenant #1 was administered an extra dose of Xarelto 20 mg. His a.m. dose was held on 6/6/24 related to	A 150		

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A 150	Continued From page 5 the error. The Program's policy and procedure related to Incident Report indicated an incident report would be completed and submitted to the nurse or designee. The nurse was responsible to follow up with a review of reportable incidents and to enter it into the electronic health system. An electronic incident report could not be located related to Tenant #1's medication error as required in the incident report policy and procedure. 3. When interviewed on 10/1/24 at the Executive Director confirmed all incident reports were provided for the tenants reviewed.	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 provided cares, services and treatment that were adequate and appropriate. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6). Findings follow:	A 160		

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A 160	Continued From page 6 1. When interviewed on 9/24/24 at 10:31 a.m. Staff B said some days they were short staffed and were not able to get all of the bathing done. It was typically done on the next shift or the next day. It occurred a couple times per week. On 9/24/24 at 10:53 a.m. Staff C said they had someone quit and were short staffed. She thought Tenant #2 went without a shower. When interviewed on 9/24/24 at 11:16 a.m. Staff D said they were now back on routine but there had been complaints regarding not getting bathed or not getting it on scheduled days. 2. Review of Tenant #1's file on 9/24/24 and 9/25/24 revealed the following: - June 2024 Monthly Task Logs reflected Tenant #1 had bathing daily. It was charted on 6/6/24 as "other," 6/8/24 as refused, and on 6/11/24 as "other." The charting indicated on 6/6/24 staff ran out of time to give a shower and would tell second shift, on 6/11/24 it was charted as he had a shower yesterday (he was scheduled for daily bathing) and on 6/20/24 that he had a shower yesterday (he was scheduled for daily bathing). He had hourly visual checks per the task log. There were numerous entries related to the check being done late, documentation of the check done later, and staff forgot to chart and it was late. - July 2024 Monthly Tasks Logs reflected Tenant #1 had bathing daily. On 7/12/24 it was charted as "other" and indicated staff could not get three showers done in one day. There were also two refusals on 7/13/24 and 7/21/24. He had hourly visual checks per the task log. There were numerous entries related to the check being done late, documentation of the check done later, and	A 160		

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A 160	Continued From page 7 staff forgot to chart and it was late. - August 2024 Monthly Tasks Logs reflected Tenant #1 had bathing daily. On 8/17/24 it was charted as "other" and staff indicated she did not have time to get it completed. On 8/4/24 it was charted as task not completed. There were also three refusals charted. He had hourly visual checks per the task log. There were numerous entries related to the check being done late, documentation of the check done later, and staff forgot to chart and it was late. - September 2024 Monthly Tasks Logs reflected Tenant #1 had bathing daily. On 9/10/24 it was charted as other and staff indicated there were not enough staff to complete. There were also five refusals. He had hourly visual checks per the task log. There were numerous entries related to the check being done late, documentation of the check done later, and staff forgot to chart and it was late. 3. Review of Tenant #2's file on 9/25/24 revealed the following: - July 2024 Monthly Task Log reflected Tenant #2 received bathing twice weekly. On 7/8/24, 7/15/24, 7/22/24 and 7/25/24 it was not documented as completed and reflected "other." It was charted as not done by staff or would be completed on third shift. Tenant #2 refused on 7/1/24 and 7/29/24. - August 2024 Monthly Task Log reflected Tenant #2 had bathing twice weekly. It was charted as "other" and not done on 8/29/24 and refused on 8/12/24, 8/15/24 and 8/22/24. - September 2024 Monthly Task Log reflected Tenant #2 had bathing twice weekly. It was charted as "other" on 9/9/24 and indicated there was one staff (regarding why it was not done). On 9/19/24 it was charted as "other" and documented as not able to completed as there	A 160		

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A 160	Continued From page 8 was one staff on the floor. 4. Review of Tenant #3's file on 9/30/24 revealed Staff Documentation/Communication to Nurse documents indicated the following: - On 9/6/24 it was noted upon arrival staff found Tenant #3 covered in feces and urine. The apartment, bathroom and recliner were covered in feces. The laundry in the laundry basket also had feces and it was all very dry. Tenant #3 was eager and compliant to get staff assistance to get cleaned up. - On 9/19/24 it was noted it was Tenant #3's scheduled shower day was unknown but he really needed one. The skin on and around his groin was very red, painful and had lots of open sores. A & D ointment was applied after his shower and after each time he was changed today. Tenant #3's September 2024 Monthly Task Log indicated hands on assistance with toileting every two hours. Staff A had charted Tenant #3 was assisted with toileting at 7:00 a.m., 9:00 a.m., 11:00 a.m. and 1:00 p.m. on 9/6/24 on first shift. When second shift staff arrived Tenant #3 was covered in feces and urine, the apartment, bathroom and recliner were covered in feces and there was laundry that was soiled with feces. The Monthly Task Log also reflected Tenant #3 received hands on assistance with bathing twice per week. Showers were documented as completed last on 9/11/24. They were charted as refused on 9/14/24 and 9/18/24. It was documented on 9/19/24 that Tenant #3 really needed a shower and his shower day was unknown. In addition, visual checks were to be completed hourly. There were numerous entries related to documentation of the visual check being done late.	A 160		

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A 160	Continued From page 9 5. Review of Tenant #4's file on 9/30/24 and 10/1/24 revealed a primary care provider (PCP) note dated 7/13/24 indicated she was poorly kept and was in need of a shower. Continued review revealed the following: - July 2024 Monthly Task Log reflected Tenant #4 received bathing twice per week. On 7/20/24 it was charted as not completed as it was not her shower day. Six refusals were documented. Tenant #4 had two documented showers/bathing in July. - August 2024 Monthly Task Log reflected #4 received bathing twice per week. There were six refusals and one shower task not completed on 8/20/24. Tenant #4 had two documented showers/bathing assist in August. - September 2024 Monthly Task Log reflected Tenant #4 received bathing twice per week. There were four refusals charted and one entry that indicated it was not completed. 6. Review of Tenant #5's file on 9/30/24 and 10/1/24 revealed the following: - August 2024 Monthly Task Log reflected Tenant #5 had bathing twice per week. It was not completed on 8/27/24 and 8/30/24 and was charted as "other." The log indicated he was to have visual checks hourly and there were numerous entries regarding the charting of the checks being done late. - September 2024 Monthly Task Log indicated Tenant #5 had bathing twice per week. It was charted on 9/17/24 as "other" and indicated there was not enough people to help. The log indicated he was to have visual checks hourly and there were numerous entries regarding the charting of the checks being done late. 7. Review of Tenant #6's file on 9/30/24 and	A 160		

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A 160	Continued From page 10 10/1/24 revealed a Staff Documentation/Communication to Nurse document dated 7/19/24 indicating Tenant #6's catheter needed to be emptied every shift and third shift was not doing it. The tenant's July 2024 Monthly Task Log indicated staff assisted with emptying the catheter bag three times per day, once on each shift from 7/10/24 to 7/22/24. It was documented as completed on third shift. The September 2024 Monthly Task Log indicated staff assisted with emptying the catheter bag every shift. On 9/28/24 it was charted as task not completed. On 9/26/24 at 12:55 a.m. and 9/26/24 at 5:28 a.m. it was charted as "NA." 8. When interviewed on 10/1/24 at 2:08 p.m. the Healthcare Coordinator confirmed all task logs were provided for the tenants reviewed. She said staff received training that the visual checks were to be completed within the hour scheduled.	A 160		
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:	A 285		

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A 285	Continued From page 11 Based on interview and record review the Program failed to administer medications and treatments as ordered. This pertained to 2 of 6 current tenants reviewed (Tenant #2 and Tenant #6) and 2 of 3 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review of Tenant #2's file on 9/25/24 revealed a Progress Note document dated 3/25/24 from Tenant #2's primary care provider (PCP) indicating Tenant #2 was seen for a regulatory visit regarding a continuous glucose monitor. The tenant was anxious to get a monitor. Orders were received for blood glucose diagnostic miscellaneous route four times per day, before meals and at bedtime. Staff were to call the provider if the blood glucose readings were less than 60 or greater than 400. The orders also included a blood glucose meter, sensor device, transmitter and blood glucose diagnostic strips (90). A Physician Order Review noted on 7/2/24 indicated the following orders for insulin: Novolog 100 units/milliliters (ml), inject 10 units under the skin three times daily with meals and hold if blood sugars were less than 150. Staff were to call the provider if the blood glucose readings were less than 60 or greater than 400. There was also an order Lantus 100 unit/ml, inject 30 units under the skin at bedtime. Tenant #2's June, July, August and September 2024 medication administration records (MARs) did not reflect the order for blood glucose monitoring three times daily with meals and at bedtime as ordered. Staff recorded blood glucose readings in the Vitals section of the MAR; however, the blood glucose readings were not recorded as ordered four times daily. For	A 285		

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A 285	Continued From page 12 example in June there was only one day (6/20/24) where Tenant #2's blood glucose readings were completed and documented four times daily. On 6/22/24, there were no recorded blood glucose readings. In July there were three dates blood glucose readings were completed and recorded four times daily (7/9/24, 7/10/24, 7/14/24, 7/15/24). On 7/5/24, 7/6/24, 7/12/24, 7/19/24, 7/20/24, 7/22/24 and 7/26/24 there were no recorded blood glucose readings. In August there were four dates Tenant #2's blood glucose readings were completed and documented four times daily (8/11/24, 8/20/24, 8/21/24, 8/22/24, 7/26/24). On 8/3/24, 8/14/24, 8/23/24 and 8/31/24 there were no recorded blood glucose readings. In September there were no dates that had recorded blood glucose readings four times per day as ordered. On 9/1/24, 9/6/24, 9/7/24, 9/10/24, 9/11/24, 9/20/24 there were no recorded blood glucose readings. Additionally, the July MAR reflected an order for the Dexcom, change every 10 days. It was not documented as changed from 7/1/24 to 7/15/24, which was greater than 10 days. It was documented as completed on 7/15/24 and then was documented as not competed on 7/25/24. In August it was scheduled to be changed per the MAR on 8/4/24 and was charted as not completed. It was scheduled to be changed on 8/14/24 and was charted as not completed. On 8/24/24 it was documented as changed. Tenant #2's PCP ordered treatments were not completed as ordered including for blood glucose monitoring and Dexcom sensor changes. 2. Review of Tenant #6's file on 10/1/24 revealed June, July, August and September 2024 MARs reflected an order for anti-embolism stockings to	A 285		

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A 285	Continued From page 13 be applied in the morning and removed at bedtime. The MARs reflected an entry for the application of the hose at 8:00 a.m. however, the MARs did not reflect the removal of the anti-embolism hose in those months as ordered. Continued record review revealed the June, July and August 2024 MARs reflected an order for a dry dressing one time daily ordered on 4/24/24 (skin tag tear). The MAR did not specify the location of the dressing or what materials to be used for the dressing change. It was documented as not completed six times in June, six times in July, nine times in August and once as "other." Tenant #6 did not receive his anti-embolism hose and dry dressing as ordered. 3. Review of Tenant C1's file on 9/30/24 revealed he moved out on 1/11/24. The November 2023 MAR reflected an order to change Dexcom every 10 days and as needed. It was started on 11/26/23. It was reflected to be completed on 11/26/23; however, not documented as completed. The December 2023 MARs reflected the following orders: - Change Dexcom every 10 days and as needed. It was started on 12/6/23 and stopped on 12/20/23. It was documented as changed on 12/6/23; however, was not documented on as completed after 12/6/23 until the order was discontinued. - Dexcom G7 Sensor, apply one applicator transdermal in the morning every 10 days was ordered on 12/21/23 and discontinued on 1/1/24. It was charted as not completed on 12/21/23. It was documented as changed once on 12/28/23	A 285		

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A 285	Continued From page 14 (as needed). Tenant C1's Dexcom was not changed as ordered. 4. Review of Tenant C2's file on 9/30/24 revealed the January 2024 MARs reflected the order to apply betadine external solution to the left leg incision for wound care, remove the shrinker and re-apply in the morning. It was not documented as completed 11 times. Progress Notes reflected various entries including, it had a wrap on it, supplies were not available and were on order, she had a stocking on and refused to remove the stocking. Tenant C2's treatment related to the lower leg leg was not completed as ordered. 5. When interviewed on 10/1/24 at 2:08 p.m. the Healthcare Coordinator confirmed all orders and MARs for the tenants reviewed were provided.	A 285		
A 355	481-67.9(4)d 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: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.	A 355		

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A 355	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide training on service plan tasks including Dexcom blood glucose meter and Dexcom sensor application. This pertained to 4 of 4 staff reviewed who administered medications (Staff, F, G, H and I). Findings follow: 1. When interviewed on 10/1/24 at 2:08 p.m. the Healthcare Coordinator said there were three tenants with a continuous glucometer. One tenant had a Libre and two tenants had a Dexcom. Tenant #2 was one of the tenants who had a Dexcom. 2. Review of Tenant #2's file on 9/25/24 revealed a service plan dated 9/24/24 reflecting orders for a Dexcom sensor and transmitter. A Staff Documentation/Communication to Nurse form dated 9/12/24 indicated Tenant #2 needed his Dexcom replaced. Staff was not sure how it worked and asked for the nurse to assist him. 3. Review of nurse delegation forms for Staff F, G, H and I who administered medications were reviewed. They all had documented training on the traditional glucometer, Libre sensor application and Libre blood glucose. The nurse delegation training did not include training on the Dexcom blood glucose and Dexcom sensor application. 4. When interviewed on 10/1/24 at 2:08 p.m. the Healthcare Coordinator said the direct care staff had received training on changing the sensor. For the the Dexcom, there was a video on the screen if a staff member was confused.	A 355		

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A 145	Continued From page 16	A 145		
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 with significant change. This pertained to 2 of 6 current tenants reviewed (Tenant #1 and Tenant #3) and 1 of 3 discharged tenants reviewed (Tenant C2). Findings follow: 1. Review of Tenant #1's file on 9/24/24 and 9/25/24 revealed Progress Notes documented the following: - On 8/7/24 staff noticed Tenant #1 was not acting like himself. Tenant #1 was shaking and said he was cold. Emergency medical services (EMS) was called and he was transported to the hospital. - On 8/7/24 staff at the hospital reported Tenant #1 had elevated white blood cell counts.	A 145		

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A 145	Continued From page 17 - On 8/7/24 a nurse from the hospital called and reported Tenant #1 was admitted (observation). He showed signs of sepsis but it was caught early. - On 8/8/24 a social worker from the hospital called and said Tenant #1 was on intravenous (IV) antibiotics and they had concerns it was diverticulitis. - On 8/11/24 Tenant #1 arrived back to the Program. An After Visit Summary indicated he was hospitalized from 8/7/24 to 8/11/24 for acute metabolic encephalopathy. He was prescribed Levaquin 750 milligram (mg) tablet, one tablet daily for three days for diverticulitis and Flagyl, 500 mg, one tablet every 12 hours for diverticulitis. Hospital records indicated a history of clostridium difficile colitis and history of bacteremia. Evaluations were not completed as needed with Tenant #1's hospitalization and diagnoses history of bacteremia and diverticulitis. Tenant #1's prior diagnoses did not include diverticulitis as a known diagnoses until 8/11/24. Tenant #1 was sent to the hospital on 8/7/24 and returned on 8/11/24. He was discharged with two new medications orders for Levaquin (antibiotic) and Flagyl (nitroimidazole antimicrobials) and received a new diagnosis. 2. Review of Tenant #3's file on 9/30/24 revealed diagnoses including type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, type 2 diabetes mellitus with diabetic nephropathy, and a local infection of the skin and subcutaneous tissue. Progress Notes indicated the following: - On 7/21/24 Tenant #3 was sent to the	A 145		

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A 145	Continued From page 18 emergency department (ED) due to family request related to lethargy. - On 7/23/24 Tenant #3 was admitted for a urinary tract infection (UTI) and was dehydrated and it appeared that his wound might be causing some issues. - On 7/26/24 the nurse went to assess Tenant #3 at the hospital. He refused to get up and ambulate three times and became very agitated. The nurse assessed his foot wound and the surrounding skin was red and warm to touch. The nurse was concerned the cellulitis was not resolved and had issues about him returning to the Program. - On 7/30/24 it was noted Tenant #3 would be going to skilled care post hospitalization. - On 8/9/24 it was noted Tenant #3 returned to the Program - On 8/9/24 at 7:30 p.m. staff reported Tenant #3's blood glucose was 430. A one time dose of Novolog 20 units was received. Tenant #3 then had low oxygen saturation at 83% and it dipped into the 70s. Tenant #3 was taken to the ED. - On 8/10/24 Tenant #3 was admitted to the hospital with pneumonia. - On 8/13/24 the nurse went to assess Tenant #3 at the hospital and he would not respond and would not ambulate. - On 8/15/24 Tenant #3 returned to the Program. - On 8/20/24 Tenant #3's blood glucose was 97. He was given a glass of orange juice. - On 8/24/24 Tenant #3's blood glucose was 419. - On 8/24/24 blood glucose parameters were provided to call if less than 60 or greater than 450. - On 9/1/24 Tenant #3 refused his scheduled insulin and refused to eat. His blood glucose was 244. - On 9/13/24 while being toileted Tenant #3 got	A 145		

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A 145	Continued From page 19 upset when he was wiped and staff asked him to stand still. Staff turned to get wipes and he started to walk away with his pants at his knees. He turned, fell backwards and hit his head on the floor. - On 9/16/24 Tenant #3 fell and hit his head. He complained about leg pain. - On 9/19/24 it was noted Tenant #3 fell. - On 9/21/24 Tenant #3's blood glucose was 472. Staff Documentation/Communication to Nurse documents indicated the following: - On 7/21/24 Tenant #3 refused all cares and medications. - On 9/6/24 upon arrival staff found Tenant #3 covered in feces and urine. The apartment, bathroom and recliner were covered in feces. The laundry in the laundry basket also had feces and it was all very dry. Tenant #3 was eager and compliant for staff assistance to get cleaned up. - On 9/19/24 it was noted it was Tenant #3's scheduled shower day was unknown but he really needed one. The skin on and around his groin was very red, painful and had lots of open sores. A & D ointment was applied after his shower and after each time he was changed today. When interviewed on 9/24/24 at 10:31 a.m. Staff B said Tenant #3 refused cares a lot, including changing his protective undergarment. She said he refused and had open areas on his buttocks. She had noticed them the day before but there was no treatment. On 9/24/24 at 10:53 a.m. Staff C said Tenant #3 had refused medications and cares. He displayed verbal behaviors, including profanity and gross language, almost daily. He had gotten very mad and tried to hit. He had grabbed her before. She	A 145		

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A 145	Continued From page 20 believed she had been informed that morning he had a few open areas on his bottom and was incontinent of bladder and bowel. When interviewed on 9/24/24 at 11:16 a.m. Staff D said some days were good with Tenant #3 so it was hard to tell if he needed a higher level of care. When he had bad days, it could last four to five days. He could get verbal and physical. For verbal behaviors he used profanity, racial slurs and was loud. He had been physical with one staff and grabbed her. He had refused medications, including insulin. He had fallen several times lately. She felt the bad days outweighed the good days lately. On 10/1/24 at 2:08 p.m. the Healthcare Coordinator said Tenant #3 was sometimes resistant to cares. He had reddened areas that were not scabbed and A & D ointment was ordered. She said she had not heard of Tenant #3 being physically aggressive but said at times he used profanity. He did not always want to let staff change him. Tenant #3's evaluations were dated 7/16/24 (initial) 8/8/24 (post hospitalization and skilled care), 8/15/24 and 9/12/24. Evaluations were not completed with the open areas on Tenant #3's buttocks and treatment or refusals related to toileting. Evaluations were also not completed with Tenant #3's behaviors, including verbal and physical behaviors. 3. Review of Tenant C2's file on 9/30/24 revealed diagnoses included complication of vascular prosthetic devices, implants and grafts and acquired absence of left leg below the knee. Tenant C2 moved in on 12/12/23 and moved out on 2/14/24. Progress Notes indicated the	A 145		

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A 145	Continued From page 21 following: - On 12/21/23 a new order was received to remove shrinker at bedtime, paint the incision with betadine and allow to dry. Then replace the shrinker in the morning. - On 12/22/23 staff reported Tenant C2 had right foot discoloration and family had concerns. The foot was assessed and was warm to touch and pink in color. There was no discoloration noted. - On 12/29/23 the home health nurse was there see Tenant C2 for physical therapy (PT)/occupational therapy (OT). The nurse reported redness on his bottom but no open area. - On 1/2/24 Tenant C2 pushed her pendant over six time to go to the bathroom. The last time she said she was feeling weak. - On 1/11/24 a new order was received for Nystatin 100,000 unit/ml, 4 milliters (ml) by mouth four times daily for seven days for oral thrush. Tenant C2 was independent with medication. - On 1/16/24 it was noted OT would be discharged on 1/17/24 and home health on 1/18/24. PT would continue once weekly until the end of the certification period. Tenant C2's evaluations were dated 12/6/23 (initial evaluations) and 1/11/24 (30 day evaluations). Evaluations were not completed as needed when the changes occurred including the orders to remove the shrinker, paint incision with betadine and replace the shrinker in the morning, the diagnosis of oral thrush and treatment for the reddened area. 4. When interviewed on 10/1/24 at 1:38 p.m. the Executive Director confirmed all evaluations were provided for the tenants reviewed.	A 145		

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A 220	Continued From page 22	A 220		
A 220	481-69.24(1)b Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: b. The program shall immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify a tenant's primary care provider (PCP) of the involuntary transfer. This pertained to 1 of 1 discharged tenants reviewed who received a 30 day notice of transfer (Tenant C1). Findings follow: 1. Review of Tenant C1's file on 9/24/24 and 9/30/24 revealed a letter dated 12/11/23 to Tenant C1's legal representative indicating it was a 30 day discharge notice as the tenant needed a higher level of care. The letter referenced the Occupancy Agreement signed on 7/24/23 and indicated the tenant exceeded level of care due to the need for routine two-person assistance with transfers. Tenant C1 had needs that were beyond the scope of the Program. The letter was carbon copied to the tenant's legal representative and the State of Iowa Ombudsman. 2. A Progress Note dated 1/11/24 (discharge	A 220		

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A 220	Continued From page 23 summary) indicated Tenant C1 moved out due to needing a higher level of care. The note indicated the PCP was made aware. 3. The discharge summary indicated Tenant C1's PCP had been notified on 1/11/24 of his move out; however, nothing was documented prior to that indicating the PCP was notified of the Program initiated transfer on 12/11/23. 4. When interviewed on 10/1/24 at 1:38 p.m. and 4:00 p.m. the Executive Director confirmed Tenant C1 received a 30 day notice for transfer. She also confirmed Tenant C1's legal representative and the Ombudsman received the notice.	A 220		
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: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 3 of 3 current tenants reviewed (Tenants #3, #4 and #6) and 1 of 3 discharged tenants reviewed (Tenant C2). Findings follow:	A 290		

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A 290	Continued From page 24 1. Record review on 9/30/24 revealed Tenant #3 was admitted on 7/19/24. Continued record review revealed Progress Notes indicated the following: - On 7/18/24 the pharmacy was contacted to ensure Tenant #3's medications would be sent over before move in the next day - On 7/20/24 Tenant #3 fell and was sent to the hospital. Further record review revealed a nurse's note was not completed when Tenant #3 was admitted and moved in. 2. Review of Tenant #4's file on 9/30/24 revealed a note to the primary care provider (PCP)dated 7/13/24 indicating they wanted the PCP to tell Tenant #4 she would be placed in memory care on 8/1/24. Progress Notes reviewed revealed no entry completed regarding Tenant #4's move from the general population to the memory care unit on 8/1/24. 3. On 10/1/24 review of Tenant #6's file revealed Progress Notes indicating the following: - On 7/2/24 Tenant #6 had an abscessed tooth that was removed and a new order was received for amoxcillion 500 mg, one tablet, every six hours until gone (dispense 12 tablets). - On 7/27/24 staff responded to the apartment and observed Tenant #6 on the ground bleeding from his head. Emergency medical services (EMS) was notified. - On 7/27/24 the nurse called the hospital to follow up on Tenant #6 and learned he had been discharged back to the Program at 6:55 a.m. The nurse called the Program but was not able to reach anyone for an update.	A 290		

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(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 25 - On 7/29/24 Tenant #6 returned from the emergency department (ED) with a new medication cephalexin 500 milligram (mg), four times per day for a possible urinary tract infection (UTI). Nurse's notes were not completed related to the completion of the antibiotic related to the abscessed tooth or the antibiotic related to the possible UTI. 4. Review of Tenant C2's file on 9/30/24 revealed Tenant C2 was admitted on 12/12/23. Continued record review revealed Progress Notes indicated the first entry in notes was dated 12/17/23 (late entry) related to fall. A nurse's note was not completed when Tenant C2 was admitted and moved in. 5. When interviewed on 10/1/24 at 1:38 p.m. the Executive Director confirmed all nurses notes were provided for the tenants reviewed.	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	A 350		

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	S0351	A. BUILDING: _____ B. WING _____	C 10/01/2024

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A 350	Continued From page 26 by: Based on interview and record review the Program failed to update service plans as needed. This pertained to 6 of 6 current tenants reviewed (Tenant #1, #2, #3, #4, #5 and #6) and 2 of 3 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review of Tenant #1's file on 9/24/24 and 9/25/24 revealed Progress Notes revealed the following: - On 4/29/24 it was noted Tenant #1 was shaking and was very agitated. He said he did not feel well and was very cold. His oxygen saturation was at 79% on room air. Emergency medical services (EMS) was called to transport Tenant #1 to the hospital. - On 4/30/24 Tenant #1's spouse called and said he was diagnosed with pneumonia. - On 5/3/24 Tenant #1's spouse reported they were still running tests on him and it was thought he had a blood infection. - On 5/6/24 Tenant #1 was changed to oral antibiotics for blood infections. On 5/6/24 he returned to the Program. - On 5/8/24 physical therapy (PT)/occupational therapy (OT) was going to start back up. Orders were sent on 5/6/24. - On 8/7/24 staff noticed Tenant #1 was not acting like himself. He was shaking and said he was cold. EMS was called and he was transported to the hospital. - On 8/7/24 staff at the hospital reported Tenant #1 had elevated white blood cell counts. - On 8/7/24 a nurse from the hospital called and reported Tenant #1 was admitted (observation). He showed signs of sepsis but it was caught early. - On 8/8/24 a social worker from the hospital called and said Tenant #1 was on intravenous	A 350		

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A 350	Continued From page 27 antibiotics and they had concerns it was diverticulitis. - On 8/11/24 Tenant #1 arrived back to the Program. Hospital records (hospital summary) reviewed indicated he was admitted on 4/29/24 and discharged on 5/6/24. An active problem list included pseudomonas aeruginosa bacteremia (5/2/24) and clostridioides difficile carrier (5/2/24) and acute metabolic encephalopathy secondary to bacteremia (4/30/24). It indicated Patient Infection Status, C.difficile was added 5/2/24. On 5/1/24 the toxin was negative and isolation was only required with active infection. An After Visit Summary indicated he was hospitalized from 8/7/24 to 8/11/24 for acute metabolic encephalopathy. He was prescribed Levaquin 750 milligram (mg) tablet, one tablet daily for three days for diverticulitis and Flagyl, 500 mg, one tablet every 12 hours (5 doses) for diverticulitis. Hospital records indicated a history of clostridium difficile colitis and history of bacteremia. Further review revealed the April to September medication administration records (MARs) reflected Tenant #1 was prescribed Xarelto 20 mg, one tablet by mouth daily at 8:00 a.m. Tenant #1's most recent service plan was dated 4/18/24. The service plan was not updated as needed post hospitalization and did not reflect Tenant #1's carrier status of clostridioides difficile, PT/OT services, history of bacteremia and diverticulitis. The service plan also did not reflect Tenant #1 was prescribed an anticoagulant medication what to monitor for related to the medication.	A 350		

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A 350	Continued From page 28 2. On 9/25/24 review of Tenant #2's file revealed Progress Notes indicating the following: - On 3/19/24 Tenant #2's family inquired when the Dexcom would be started. The primary care provider (PCP) would be able to see Tenant #2 on 3/25/24 for face to face notes (regarding required documentation) and a verbal order was received for an A1C drawn. - On 3/27/24 a face to face visit was completed with the PCP on 3/25/24. The notes were faxed requesting a Dexcom sensor. - On 5/23/24 Tenant #2 had difficulty moving his right leg and foot. Tenant #1 requested PT/OT. - On 5/29/24 the PCP was informed of the odor in the apartment as if he had an infection. A verbal order was received for a urinalysis. - On 7/2/24 an order was received for the Ventolin inhaler to be kept at bedside as he administered independently. - On 7/18/24 it was noted Tenant #2 was currently working with PT three times per week. When interviewed on 9/24/24 at 11:16 a.m. Staff D said Tenant #2 was not calling when he needed assistance to change his protective undergarment. She said his apartment had an odor. He was incontinent of bladder and been soaking through his clothes. She said there were also flies in the apartment and it had been brought up to management. On 10/1/24 at 2:08 p.m. the Healthcare Coordinator said Tenant #2's apartment had an odor. She said he slept in his chair. They were going to talk to him and his family about adding extra housekeeping. She said Tenant #2 could do a lot more for himself but he wanted staff to touch him.	A 350		

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A 350	Continued From page 29 Tenant #2's service plans were dated 1/26/24 (activation date) and 9/24/24 (after tenant file was requested). The service plan with an activation date of 1/26/24 reflected all of Tenant #2's orders including blood glucose checks four times per day, Dexcom sensor and transmitter and Novolog insulin. The service plan reflected staff administered Tenant #2's medications. The service plan did not reflect staff administered his insulin and took his blood glucose readings, including via Dexcom device. The service plan was also not updated when an order was received to keep the inhaler at bedside to administer independently. It also did not reflect PT/OT services. The service plan dated 9/24/24 (after tenant file was requested) reflected the Dexcom and inhaler at bedside. The current service plan still did not reflect the odor noted in Tenant #2's apartment and the level of incontinence. Tenant #2's service plan reflected he had occasional behaviors and had a history of yelling and using profanity towards staff. The service plan did not reflect the behavior as identified in the Healthcare Coordinator's interview. 3. Review of Tenant #3's file on 9/30/24 revealed diagnoses including type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, type 2 diabetes mellitus with diabetic nephropathy, and a local infection of the skin and subcutaneous tissue. Progress Notes indicated the following: - On 7/21/24 Tenant #3 was sent to the emergency department (ED) due to family request related to lethargy. - On 7/23/24 Tenant #3 was admitted for a urinary tract infection (UTI) and was dehydrated and it appeared that his wound might be causing some issues.	A 350		

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A 350	Continued From page 30 - On 7/26/24 the nurse went to assess Tenant #3 at the hospital. He refused to get up and ambulate three times and became very agitated. The nurse assessed his foot wound and the surrounding skin was red and warm to touch. The nurse was concerned the cellulitis was not resolved and had issues about him returning to the Program. - On 7/30/24 it was noted Tenant #3 would be going to skilled care post hospitalization. - On 8/9/24 it was noted Tenant #3 returned to the Program - On 8/9/24 at 7:30 p.m. staff reported Tenant #3's blood glucose was 430. A one time dose of Novolog 20 units was received. Tenant #3 then had low oxygen saturation at 83% and it dipped into the 70s. Tenant #3 was taken to the ED. - On 8/10/24 Tenant #3 was admitted to the hospital with pneumonia. - On 8/13/24 the nurse went to assess Tenant #3 at the hospital and he would not respond and would not ambulate. - On 8/15/24 Tenant #3 returned to the Program. - On 8/20/24 Tenant #3's blood glucose was 97. He was given a glass of orange juice. - On 8/24/24 Tenant #3's blood glucose was 419. - On 8/24/24 blood glucose parameters were provided to call if less than 60 or greater than 450. - On 9/1/24 Tenant #3 refused his scheduled insulin and refused to eat. His blood glucose was 244. - On 9/13/24 while being toileted Tenant #3 got upset when he was wiped and staff asked him to stand still. Staff turned to get wipes and he started to walk away with his pants at his knees. He turned, fell backwards and hit his head on the floor. - On 9/16/24 Tenant #3 fell and hit his head. He	A 350		

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A 350	Continued From page 31 complained about leg pain. - On 9/19/24 it was noted Tenant #3 fell. - On 9/21/24 Tenant #3's blood glucose was 472. Staff Documentation/Communication to Nurse documents indicated the following: - On 7/21/24 Tenant #3 refused all cares and medications. - On 9/6/24 upon arrival staff found Tenant #3 covered in feces and urine. The apartment, bathroom and recliner were covered in feces. The laundry in the laundry basket also had feces and it was all very dry. Tenant #3 was eager and compliant for staff assistance to get cleaned up. - On 9/19/24 it was noted it was Tenant #3's scheduled shower day was unknown but he really needed one. The skin on and around his groin was very red, painful and had lots of open sores. A & D ointment was applied after his shower and after each time he was changed today. When interviewed on 9/24/24 at 10:31 a.m. Staff B said Tenant #3 refused cares a lot, including changing his protective undergarment. She said he refused and had open areas on his buttocks. She had noticed them the day before but there was no treatment. On 9/24/24 at 10:53 a.m. Staff C said Tenant #3 had refused medications and cares. He displayed verbal behaviors, including profanity and gross language, almost daily. He had gotten very mad and tried to hit. He had grabbed her before. She believed she had been informed that morning he had a few open areas on his bottom and was incontinent of bladder and bowel. When interviewed on 9/24/24 at 11:16 a.m. Staff D said some days were good with Tenant #3 so it	A 350		

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A 350	Continued From page 32 was hard to tell if he needed a higher level of care. When he had bad days, it could last four to five days. He could get verbal and physical. For verbal behaviors he used profanity, racial slurs and was loud. He had been physical with one staff and grabbed her. He had refused medications, including insulin. He had fallen several times lately. She felt the bad days outweighed the good days lately. On 10/1/24 at 2:08 p.m. the Healthcare Coordinator said Tenant #3 was sometimes resistant to cares. He had reddened areas that were not scabbed and A & D ointment was ordered. She said she had not heard of Tenant #3 being physically aggressive but said at times he used profanity. He did not always want to let staff change him. Tenant #3's service plans were dated 7/16/24 (initial) 8/9/24 (post hospitalization and skilled care), 8/23/24 and 9/12/24 (activation date of 9/24/24). The most current service plan reflected staff administered his medications, however, did not indicate staff took his blood glucose readings and administered insulin, the parameters and high blood glucose readings at times and his refusals of medications. The service plan also did not reflect the open areas on Tenant #3's buttocks and treatment or refusals related to toileting. The service plan documented he had frequent behavior issues; however, did not address the behaviors reported or interventions. The service plan also did not reflect Tenant #3's foot wound and history of cellulitis. It documented at times he would not eat or drink; however, did not provide directives related to this. 4. Review of Tenant #4's file on 9/30/24 and 10/1/24 revealed the June 2024 Monthly Task Log	A 350		

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A 350	Continued From page 33 reflected bathing assistance weekly starting on 6/25/24. There was one refusal and one charted as it was not her shower day. July Monthly Task Log reflected bathing was scheduled weekly and was charted as refused three times and other (not her shower day). The July 2024 MAR reflected frequent refusals of medications, including 1 tablet of divalproex 250 mg twice daily, which was refused 10 times. Further record review revealed a PCP note dated 7/13/24 indicated she was poorly kept and was in need of a shower. The tenant's service plans were dated 6/24/24 and 8/2/24. The 6/24/24 service plan was not updated to reflect bathing and medication refusals until the service plan dated 8/2/24 (with a move to memory care). 5. On 9/30/24 review of Tenant #5's file revealed June to September 2024 MARs reflected Tenant #5 was prescribed warfarin (anticoagulant medication). The doses and frequency varied and staff administered the medication. The service plan dated 6/7/24 reflected staff administered Tenant #5's medications. The service plan listed clinical orders for all medications including warfarin. The service plan did include things to monitor for related to the medication. 6. Review of Tenant #6's file on 10/1/24 revealed Progress Notes indicated on 9/22/24 it was reported Tenant #6 had chest pain. Staff was instructed to take vital signs. When they went back into the apartment, Tenant #6's spouse was administering Nitroglycerin. Tenant #6 refused to	A 350		

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A 350	Continued From page 34 go to the ED at that time. The tenant's September 2024 Monthly Task Log indicated staff provided medication reminders four times daily. Staff Documentation/Communication to Nurse documents indicated the following: - On 8/19/24 Tenant #6 could not get up from the toilet and could not empty his catheter bag or wipe himself. Staff assisted him with walking. He needed a lot of time and cares when staff were in the apartment. He could not open his cup to put water in it. - On 8/26/24 Tenant #6 said he could not stand and walk to the bathroom. He had to sit down on the bed due to being tired from walking. He kept saying he was going to fall as his legs would give out. - On 9/1/24 Tenant #6 could not get up without help. He felt weak before he made it to the bathroom and staff had to get him to the bed to rest. - On 9/2/24 Tenant #6 complained he could not walk to and from the bathroom without feeling like he was going to fall. When interviewed on 9/24/24 at 11:53 a.m. Staff E said Tenant #6 stayed in his apartment and did not come out for meals. He called for help with his catheter bag. She said he had trouble walking and yesterday he called and she walked with him. Tenant #6's service plans were dated 8/6/24 and 9/25/24. The service plans reflected Tenant #6 preferred hands on assistance when ambulating due to poor balance. He might require hands on assistance as needed. Minimal assistance was needed for transfers. The service plans did not reflect the assistance as indicated in staff to	A 350		

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A 350	Continued From page 35 nurse notification forms as indicated above. The service plans also indicated family set up medications in a pill planner and Tenant #6 needed medication reminders. The service plan did not indicate who provided the reminders for the medications or the frequency. The service plans also reflected Tenant #6 had a history of chest pain but did not reflect he had Nitroglycerin to administer and who stored and administered the Nitroglycerin. 7. Review of Tenant C1's file on 9/30/24 revealed he received a 30 day notice for transfer dated 12/11/23 related to requiring the routine assistance of two people for transfers and being beyond the scope of the Program capabilities to serve. Tenant C1's December 2023 MAR reflected a Dexcom device to monitor his blood glucose readings. Insulin was administered by staff. The MAR indicated to check his blood glucose levels using the Dexcom reader before meals and at bedtime and to call the nurse if his blood glucose was under 70 or over 400. The MAR also indicated Tenant C1 had an order for glucose gel to be given as needed when blood glucose was below 70 and he was not responding. The tenant's most recent service plan indicated staff administered Tenant C1's medications. The service plan reflected Tenant C1 was independent with ambulation and transfers. The service plan did not reflect the routine two person assistance as indicated in Tenant C1's 30 day notice to transfer letter. It also did not reflect the Dexcom reader, parameters for blood glucose levels and administration of glucose gel as needed. At the time of the last visit exit date of 11/15/23, there was a service plan regulatory	A 350		

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A 350	Continued From page 36 insufficiency cited for service plans including that of Tenant C1, related to lack of Dexcom and blood glucose parameters pertaining to his 10/16/23 service plan. 8. Review of Tenant C2's file on 9/30/24 revealed diagnoses included complication of vascular prosthetic devices, implants and grafts and acquired absence of left leg below the knee. Tenant C2 moved in on 12/12/23 and moved out on 2/14/24. Progress Notes indicated the following: - On 12/21/23 a new order was received to remove shrinker at bedtime, paint the incision with betadine and allow to dry. Then replace the shrinker in the morning. - On 12/22/23 staff reported Tenant C2 had right foot discoloration and family had concerns. The foot was assessed and was warm to touch and pink in color. There was no discoloration noted. - On 12/29/23 the home health nurse was there see Tenant C2 for physical therapy (PT)/occupational therapy (OT). The nurse reported redness on his bottom but no open area. - On 1/2/24 Tenant C2 pushed her pendant over six time to go to the bathroom. The last time she said she was feeling weak. - On 1/11/24 a new order was received for Nystatin 100,000 unit/ml, 4 milliliters (ml) by mouth four times daily for seven days for oral thrush. Tenant C2 was independent with medication. - On 1/16/24 it was noted OT would be discharged on 1/17/24 and home health on 1/18/24. PT would continue once weekly until the end of the certification period. The tenant's service plans were dated 12/12/23 and 1/15/24. The 12/12/23 service plan was not updated to reflect the orders to remove the shrinker, to paint the incision with betadine and	A 350		

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A 350	Continued From page 37 replace the shrinker in the morning. The service plan was also not updated to reflect oral thrush and treatment or the reddened area or the absence of the left lower leg (below the knee). The service plan was updated on 1/15/24 (30 day review) and reflected the order; however, it was not updated when the change occurred. Additionally, when OT and home health were discontinued the service plan was not updated to reflect those changes. 9. When interviewed on 10/1/24 at 1:38 p.m. the Executive Director confirmed all service plans were provided for the tenants reviewed.	A 350		
A 385	481-69.26(3)d 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. d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtained a signed service plan within 30 days of taking occupancy. This pertained of 1 of 1 discharged tenants admitted from December 2023 to current (Tenant C2). Findings follow: On 9/30/24 review of Tenant C2's file revealed they moved in on 12/12/23 and moved out on	A 385		

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
	S0351	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY PLACE	**901 SOUTH MENTZER ROAD ROBINS, IA 52328**

(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 385	Continued From page 38 2/14/24. The service plan dated 1/15/24 (30 day) was not signed by the health or human service professional or Tenant C2. When interviewed on 10/1/24 at 1:38 p.m. the Executive Director confirmed all signed service plans were provided for the tenants reviewed.	A 385		

STATEMENT OF DEFICIENCIES **AND PLAN OF CORRECTIONS**	**PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER:** S0351	**DATE SURVEY COMPLETED:** **10/1/2024**

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Written occupancy agreement required.** **2. An assisted living program occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the program. The occupancy agreement shall also include but is not limited to inclusion of all of the following information in the body of the agreement or in the supporting documents and attachments:** **b. (2) The occupancy agreement shall specifically include a statement regarding each of the following:** **h. Occupancy, involuntary transfer, and transfer criteria and procedures, which ensure a safe and orderly transfer.** **i. The internal appeals process provided relative to an involuntary**	**231C.5**	Tenant C1 was discharged on 1/11/2024. The Occupancy Agreement will be updated accordingly to disclose the internal appeals process requirement. All current residents will have a new OA completed reflecting the involuntary transfer procedure and internal appeals process by 12/18/2024.	All new admissions will have the revised OA completed upon move in, reflecting the involuntary transfer procedure and internal appeals process. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date: 11/14/2024** **Completion Date: Ongoing** **Responsible Party: Director or designee**

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	transfer This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure all required information regarding the involuntary transfer procedures and the internal appeals process was included in the occupancy agreement. This pertained to 1 of 1 discharged tenant reviewed who received a 30-day written notice for transfer (Tenant C1).				
Tag #2	**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 policy and procedures related to medications and incident reports. This pertained to 5 of 9 current tenants reviewed (Tenants #1, #4, #7, #8 and #9).	**A150**	Nursing staff will be re-educated regarding completion of medication/incident reports per policy by 12/18/2024. Med error IR were completed for Tenants #1, #4, #7, #8 and #9 on 11/11/24. Tenant #7's acetaminophen 500 mg tablet, two tablets at 8:00 am and 9:00 pm have been discontinued on 10/07/2024 due to his refusals and non-use. All med certified staff will receive reeducation on Six Rights of Medication Administration by 12/18/2024.	All new hires will be trained regarding how and when to complete incident reports during new hire training. All new medication managers will be trained regarding medication policy to include 6 Rights of Medication Administration with medication delegations. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date: 10/17/2024** **Completion Date: Ongoing** **Responsible Party: Director or designee**

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			HCC will be reeducated on medication/incident report policy by 12/18/2024.		
Tag #3	**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 cares, services and treatment that were adequate and appropriate. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6).	**A160**	Nursing staff will be re-educated on task documentation expectations and visual check expectations by 12/18/2024. HCC will be re-educated on task documentation expectations, auditing, follow up expectations with staff and visual check expectations by 12/18/2024. Tenants # 1, #4 and #5's service plans were updated on 11/8/2024 to reflect history of refusals with bathing and interventions for staff to utilize. Tenant #3 was discharged on 11/1/2024.	All new hires will be trained regarding documentation expectations and visual check process/expectation during new hire training. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date: 10/17/2024** **Completion Date: Ongoing** **Responsible Party: Director or designee**
Tag #4	**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**	**A285**	Tenant #2's EMAR was updated on 10/3/24 to reflect order for staff to utilize glucometer if Dexcom not available. Blood sugar order was changed to TID with meals on 11/8/2024. Tenant #6's dry dressing order was discontinued on 10/2/24 due to the area being healed. Tenant #6's service plan was updated to reflect schedule to don (am) and doff (HS) ted hose on 11/8/2024.	All new hires will be trained regarding the use of staff to nurse communication form when medications and/or treatments are no longer needed for a resident during new hire training. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date:** 10/17/2024 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

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	or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications and treatments as ordered. This pertained to 2 of 6 current tenants reviewed (Tenant #2 and Tenant #6) and 2 of 3 discharged tenants reviewed (Tenant C1 and Tenant C2).		Tenant C1 was discharged on 1/11/2024. Tenant C2 was hospitalized on 1/23/24 and then discharged from the community on 2/13/24. An audit of all tenants who are med managed was completed on 11/12/2024 to ensure that all treatments and topical medications have affected areas identified in the order. All nursing staff will be re-educated on notification to the nurse when any treatment or medications are no longer needed by 12/18/2024. HCC will be re-educated on wound care management and documentation expectations by 12/18/2024.		
Tag#5	**481-67.9(4)d 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:** **d. Certified and noncertified staff shall receive training regarding**	**A355**	All current medication administration certified nursing staff will be delegated on Dexcom use/placement by 12/18/2024.	A Dexcom specific delegation will be completed with all new hire medication certified staff within 30 days of hire or during delegations if newly certified. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date**: 10/17/2024 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee

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	service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide training on service plan tasks including Dexcom blood glucose meter and Dexcom sensor application. This pertained to 4 of 4 staff reviewed who administered medications (Staff, F, G, H and I)**.**				

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Tag#6	**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 with significant change. This pertained to 2 of 6 current tenants reviewed (Tenant #1 and Tenant #3) and 1 of 3 discharged	**A145**	Tenant #1's diagnoses were updated to reflect the history of Diverticulitis, Bacteremia and C-Diff. Tenant #1 had a COC completed on 11/14/2024 for new diagnoses of Diverticulitis, Bacteremia and C-diff. Tenant #3 was assessed by HCC and PCP on 10/2/2024. PCP determined the area was open d/t resident scratching himself. Treatment order received. COC was completed on 10/02/24 for new skin areas and verbal and physical aggression. Tenant C2 was hospitalized on 1/23/24 and then discharged from the community on 2/13/24. All nursing staff will receive education on the use of Staff to Nurse Communication form and expectations to report resident changes to the nurse by 12/18/24. HCC will be re-educated on COC expectations and time points by 12/18/2024.	All new hires will be trained regarding the use of staff to nurse communication form during new hire training. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date**: 11/14/2024 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee

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	tenants reviewed (Tenant C2).				
Tag#7	**481-69.24(1)b Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply:** **b. The program shall immediately**	**A220**	Resident C1 was discharged on 1/11/2024. HCC and Director will receive education by 12/18/2024 regarding notification of PCP in a timely manner of discharge notices.	Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date**: 11/14/2024 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or designee

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	provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify a tenant's primary care provider (PCP) of the involuntary transfer. This pertained to 1 of 1 discharged tenants reviewed who received a 30-day notice of transfer (Tenant C1).				
Tag#8	**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: Based on interview and record review	**A290**	Tenant #3's move in note was completed on 11/14/2024. Tenant #3 was discharged on 11/1/2024. Tenant #4's note for moving back to memory care on 8/1/24 was completed on 11/14/2024. Tenant #6's notes for completion of antibiotics for tooth abscess tooth on 11/14/2024. Resident was independent with medications when ATB for UTI was prescribed on 7/29/2024 thus stop note is not required.	Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure compliance.	**Implementation Date:** 11/14/2024 **Completion Date:** Ongoing **Responsible Party:** Director, Nurse, or Designee

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	the Program failed to document nurse's notes by exception. This pertained to 3 of 3 current tenants reviewed (Tenants #3, #4 and #6) and 1 of 3 discharged tenants reviewed (Tenant C2).		Tenant C2's move in progress note was completed on 12/12/2023 in Point Click Care. Tenant C2 was hospitalized on 1/23/24 and then discharged from the community on 2/13/24. HCC will be reeducated on Documentation expectations/charting by exception by 12/18/2024. Communication was provided to residents/families on 9/26/2024 and again on 10/25/2024 regarding the importance of providing AVS and/or any communication when being seen outside of the community by a health care professional.		
Tag #9	**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.**	**A350**	Tenant #1 had a COC completed on 11/14/2024 for new diagnoses of Diverticulitis, Bacteremia, C-diff and service plan was updated to reflect new diagnosis, that resident is on Xarelto and was on PT/OT service after hospitalization on 8/11/2024. Tenant #2's carpet and recliner were professionally cleaned on 10/27/24 to help reduce the odor in his apartment.	All new care staff will be educated regarding what anti-coagulant medications are and what to watch for and will also be educated on Nitroglycerin use during new hire training. Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure	**Implementation Date: 9/26/2024** **Completion Date:** Ongoing **Responsible Party:** Director or designee

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed. This pertained to 6 of 6 current tenants reviewed (Tenant #1, #2, #3, #4, #5 and #6) and 2 of 3 discharged tenants reviewed (Tenant C1 and Tenant C2).		A COC was completed on 9/26/2024 to increase housekeeping services to assist with minimizing odor. Tenant's service plan was updated on 11/11/24 to reflect behaviors, level of incontinence, Dexcom/glucometer use, staff administration of insulin and use of Ventolin inhaler at bedside. Tenant #3 was discharged from the community on 11/1/2024. A COC was completed on 10/2/2024 for the wounds to his buttocks and the service plan was updated to reflect that staff are checking blood sugars, administering insulin, blood glucose parameters, medication/care refusals, left foot wound/hx of cellulitis and behaviors. Tenant #4's service plan was updated on 11/8/2024 to reflect medication and bathing refusals along with interventions for staff. Tenant #5's service plan was updated on 11/11/24 to reflect he is taking warfarin and what staff need to monitor for and report to the nurse.	compliance.	

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			Tenant #6 had a COC completed on 10/3/24 to stop medication reminders as tenant/POA preferred resident be independent with medications with spouses' assistance. Residents service plan was updated on 11/11/24 to reflect use of PRN Nitro, where stored and who administers. Resident C1 was discharged on 1/11/2024. Tenant C2 was hospitalized on 1/23/24 and then discharged from the community on 2/13/24. An audit of all current residents who are diabetic and on an anti-coagulant medication, other than routine aspirin, will be completed by 12/18/24 and service plans will be updated to include frequency of blood glucose monitoring, insulin administration, blood glucose call parameters, anti-coagulant medication and what staff should monitor for and report to the nurse.		

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			An audit of all current residents will be completed by 12/18/24 to ensure any medication managed resident that has orders for a medication to be kept at bedside and self-administered is reflected on the service plan. An audit of all current residents will be completed by 12/18/24 to ensure all med managed residents that have PRN Nitroglycerin ordered, have a history of chest pain and PRN Nitro use, where stored and who administers on their service plans. All care staff will be educated on what anti-coagulant medications are and what to watch for and report to the nurse by 12/18/24. All staff will be educated on Nitroglycerin use by 12/18/24. HCC will be re-educated on service plan requirements and timepoints when needing updated by 12/18/24.		
Tag #10	**481-69.26(3)d Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be**	**A290**	An audit of all current residents EHR was completed on 11/5/2024 to ensure all residents have current active signed care plans. All residents	Director or designee will complete audits daily, weekly, monthly, as needed, as determined by the Director or Designee to ensure	**Implementation Date**: 11/5/2024 **Completion Date:**

	updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. **d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties.** This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtained a signed service plan within 30 days of taking occupancy. This pertained of 1 of 1 discharged tenants admitted from December 2023 to current (Tenant C2**)**		will have signed service plans by 12/18/2024. HCC will be re-educated on service plan requirements and timepoints when needing updated by 12/18/24.	compliance.	11/15/2024 **Responsible Party:** Director, Nurse, or designee

Compliance Date: 12/18/2024

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