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
	770354	A. BUILDING: _____ B. WING _____	C 04/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE - ANKENY	4102 NW 2ND COURT ANKENY, IA 50023

(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
T 000	Initial Comments There were no deficiencies cited during the onsite infection control survey completed on 4/20/21. The following deficiencies were cited during the investigation into Complaint #92917-C.	T 000		
T 615	481-63.9(1)h General Policies 63.9(1) Facility operation. The licensee shall establish written policies for the operation of the facility, including but not limited to the following: (III) h. Medication management, including self-administration of medications and chemical restraints (III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow medication policies for 3 of 3 discharged residents reviewed (Resident C1, Resident C2 and Resident C3). Findings follow: 1) Record review on 4/13/21 revealed Resident C1 moved into the facility on 2/10/20. Resident C1 saw her psychiatrist on 7/21/20 and had her evening dose of Seroquel increased from 50mg. to 100mg. Instead of discontinuing the 50mg. and giving only the newly obtained 100mg. tablet, the facility administered both resulting in the resident receiving 150mg. of Seroquel each evening. The facility did not correct this error until 8/1/20. On 8/17/20, Resident C1 was seen in the behavioral health urgent care clinic. The doctor she saw discontinued her Wellbutrin XL and started her on chlorpromazine, 25mg. to be taken	T 615	Plan of Correction is attached 6/14/21	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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T 615	Continued From page 1 up to three times daily as needed for anxiety. The facility discontinued the Wellbutrin but never started the chlorpromazine. 2) Resident C2 was admitted to the facility on 11/27/19. Resident C2 had an undated Medical Appointment Form filled out by his primary care provider (PCP) in which the PCP ordered the facility to start applying barrier cream along his bottom and peri-area at least twice daily, with bathroom usage and as needed. The form also ordered the facility to have Resident C2 start taking Metamucil daily and changed his use of docusate sodium to PRN (as needed) instead of routine. A review of the February 2020 MAR revealed a handwritten entry of Boudreaux's ointment 40%, to be used nightly as needed to protect skin. There were no entries on the February MAR for the application of the Boudreaux's ointment to Resident C2's skin. There was also a handwritten entry for Resident C2 to start taking Polyeth. Glycol Powder (a medication similar to Metamucil) daily. It was not documented Resident C2 took this medication in February. The first administration of Polyeth Glycol Powder was on 3/1/20. The March MAR noted both the Boudreaux's ointment and Polyeth. Glycol Powder were ordered on 2/21/20, so the undated appointment medical appointment form was likely filled out on that date. On 4/23/20, Resident C2 saw his psychiatrist. The psychiatrist changed the time Resident C2 was to receive his dose of 20mg. Olanzapine from noon to bedtime. The facility did not change the time the pill was given until 5/7/20. Resident C2 saw a provider at the mental health clinic on 10/19/20 and was directed to stop taking 10 mg. of hydroxyzine PRN. Staff at the facility	T 615		

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T 615	Continued From page 2 continued to give Resident C2 the medication on 10/20/20, 10/26/20, 10/27/20, 10/28/20, twice on 10/29/20 and on 10/30/20. 3) Resident C3 moved into the facility on 3/2/20. Resident C3's MAR noted he was to receive 2 tablets of acetaminophen 325mg. four times daily per day due to acute pain. Resident C3 was not administered this medication from the time he was admitted until 3/6/20. Resident C3 was not administered his Genteal tear ointment, which was to be applied into both eyes every evening until 3/16/20. Resident C3 saw his PCP on 3/9/20 and was directed to stop taking tramadol until seizures were ruled out. The facility did not immediately discontinue this medication and it was administered to him on 3/10/20 and 3/11/20. The March 2020 MAR contained a handwritten note indicating Calmoseptine ointment was to be applied topically to his bottom with each change and at bedtime. The Calmoseptine was not documented as being applied. Resident C3 received services from a physical therapist. On 3/19/21, the physical therapist tilted his wheelchair as Resident C2 was reporting pain while seated. The physical therapist stated Resident C3 needed barrier cream used on his gluteal fold areas. Staff at the facility completed Weekly Participant Assessment Forms for Resident C3. He identified issues with his bottom on the following dates: 3/22/20, 4/15/20, 4/27/20, 5/3/20, 5/11/20, 5/18/20, 5/26/20, 6/25/20, 6/30/20, 7/6/20 and 8/10/20. On 4/14/21 at 4:30 PM, Staff B reported she had applied the ointment to Resident C2's bottom. She could not recall any issues with Resident C2's skin, such as	T 615		

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T 615	Continued From page 3 wounds or skin break down but knew she applied Calmoseptine ointment when he used the bathroom. She stated she applied the cream and had reordered it when it ran out. She did not document it on the MAR. A review of Resident C3's March and April 2020 MARs revealed he was not administered Gabapentin, 300mg. which was to be taken three times daily from 3/27/20 to 5/8/20. A friend of Resident C3 sent an email to the Residential Supervisor on 4/30/20 asking why he wasn't receiving the medication and the Residential Supervisor reported the error was made by the pharmacy who did not send out the medication and had not listed it on the MAR. On 11/3/20, Resident C3 saw a doctor and was prescribed cholecalciferol 2000 units per day due to a Vitamin D deficiency. The facility did not administer this medication to him. 4) A review of the facility's Medication Management - Medication Change policy revealed all medications administered to residents required a written order. When the Medical Manager or designee received the order from a treating physician or psychiatrist, changes were to be implemented as soon as possible (within 24 hours). Discontinued medication, if any, were to be removed. Medication or treatment changes were reported on change of shift reports and where applicable in the communication log. A review of the Medication Management - Direct Care Staff policy revealed Medication Managers were to document all medications administered on the participants' individualized MARs.	T 615		

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T 615	Continued From page 4 On 4/20/21 at 3:45 PM, the Residential Supervisor and Program Director confirmed these polices had not been followed.	T 615		
T1420	481-63.16(2)l Drugs 63.16(2) Drug safeguards. l. No medications or prescription drugs shall be administered to a resident without a written order signed by the primary care provider. (II) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure written order were obtained prior to administering medication to 3 of 3 discharged residents reviewed (Resident C1, Resident C2 and Resident C3). Findings follow: 1) Record review on 4/13/21 revealed Resident C1 moved into the facility on 2/10/20. Resident C1 did not see her new primary care provider (PCP) until 2/14/20. An interview conducted with the Residential Supervisor on 4/13/21 at 1:30 revealed Resident C1 arrived at the facility with medication from her previous placement. The orders for these medications were not obtained from the previous placement. The facility administered these medications until she was able to get in to see the prescribing PCP. The facility had no orders for the medication they administered to Resident C1 until 2/14/20. 2) Record review of weekly participant assessment forms for Resident C2 revealed he had complained of a sore or itchy ear beginning on 2/10/20 and lasting until 10/12/20. The area was noted to be extremely dry, red and patchy on	T1420		

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T1420	Continued From page 5 6/15/20. Resident C2 was taken to his PCP for the condition on 8/18/20 and prescribed Bacitracin to be applied to the open area behind his left ear. The Residential Supervisor reported on 4/15/21 at 12:00 PM staff attempted to keep Resident C2's ear clean. If it became sore, they applied ointment to his ear out of the first aid kit. This was done prior to him seeing the doctor on 8/18/20. Resident C2's mother also brought in an ointment for him to apply to his ear which was kept in his room. This ointment was not ordered by the doctor. 3) Resident C3 moved into the facility on 3/3/20 from a long-term facility. The Residential Supervisor reported on 4/19/21 the facility and the long-term facility where Resident C3 had been residing used the same pharmacy, so transferring the resident's medication was not an issue. No orders for these medications were obtained from the previous placement. Orders were not obtained until the resident saw a new PCP on 3/9/20. 4) The Residential Supervisor and Program Director confirmed these findings on 4/20/21 at 3:45 PM.	T1420		
T1545	481-63.18(2)a Dietary 63.18(2) Nutrition and menu planning. a. Menus shall be planned and followed to meet the nutritional needs of residents in accordance with the primary care provider's orders. Diet orders should be reviewed as necessary, but at least quarterly, by the primary care provider. (II,	T1545		

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T1545	Continued From page 6 III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure diet orders were reviewed by a primary care physician on a quarterly basis for 3 of 3 discharged residents reviewed (Resident C1, C2 and C3). Findings follow: Record Review on 4/13/21 revealed Resident C1 was admitted to the facility on 2/10/20. Resident C1 had a signed diet order from her primary care provider for a general diet dated 5/14/20. She discharged from the facility on 1/23/21. There were no other diet orders in her record. Resident C2 moved into the facility on 11/27/19. Resident C2 had a signed diet order from his primary care provider for a general diet with bite size pieces dated 5/14/20. The order also added Resident C2 was to receive supervision while eating. Staff were to prompt Resident C2 to put his fork down, clean his mouth/sweep his mouth with his tongue and then take a drink before the next bite. Resident C2 was to be in an upright position when eating. The order was not renewed prior to Resident C2's discharge on 10/30/20. Resident C3 admitted to the facility on 3/2/20. There was an order for thickened liquids daily on 3/9/20, but it did not address how the rest of his diet should be served. Resident C3 had a diet order for a general diet, bite size pieces with mildly thick liquids signed by his primary care provider on 5/15/20. Resident C3 discharged from the facility on 2/27/21. There were no other diet orders in his record. The Residential Supervisor and Program Director	T1545		

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T1545	Continued From page 7 confirmed these findings on 4/20/21 at 3:45 PM.	T1545		
T1630	481-63.19(3) Orientation and Service Plan 63.19(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident and the resident's interdisciplinary team, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete a service plan within 30 days of admission for 1 of 3 discharged residents reviewed (Resident C2). Findings follow: Record review on 4/13/21 revealed Resident C2 was admitted to the facility on 11/27/19. His service plan was not written until 1/29/20, more than 30 days after admission. The Residential Supervisor and Program Director confirmed these findings on 4/20/21 at 3:45 PM.	T1630		
T1645	481-63.19(3)c Orientation and Service Plan 63.19(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident and the resident's interdisciplinary team, shall develop a written, individualized, and	T1645		

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T1645	Continued From page 8 integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to modify service plans as needs changed for of 2 of 3 discharged residents reviewed (Residents C1 and C3). Findings follow: 1) Record review on 4/13/21 revealed Resident C1 was admitted to the facility on 2/10/20. According to the Background Information section on Resident C1's Individual Service Plan, her diagnoses included traumatic brain injury, major depressive disorder, generalized anxiety disorder, other specified personality disorder with obsessive compulsive and cluster B traits and PTSD (post-traumatic stress disorder). As a result, Resident C1 exhibited significant psychologic and behavioral challenges including suicidal ideation, theft and probation violations and poor insight into her condition. Resident C1's plan for discharge included better understanding of her medical and mental health diagnosis.	T1645		

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T1645	Continued From page 9 A review of Resident C1's Incident Details revealed on 5/22/20 she cut her wrist. On 6/17/20, she self-harmed by cutting herself with the edge of a book on her right forearm. Resident C1 told staff she was not okay and checked herself into the hospital. On 9/3/20, Resident C1 was having a hard time mentally and asked staff for a razor. They declined to give her one. She later pulled staff aside and handed them razors she had been hiding and showed them cuts she had made to herself. She was taken to the behavioral health urgent care. On 9/4/20, Resident C1 was upset she couldn't go to the library and left the house as staff watched her leave. They were able to talk her into returning. Resident C1 experienced one of her episodes on 11/17/20, acting very confused, talking to herself, slurring words and talking to inanimate objects. She was taken to the behavioral health urgent care. There were no goals addressing mental health issues on Resident C1's Individual Service Plan. 2) Resident C3 was admitted to the facility on 3/2/20. According to the Background Information section on the Individual Service Plan, Resident C3 sustained a traumatic brain injury in 2019. Resident C3 was noted to have a history of being aggressive towards staff and others. The aggression was verbal and physical in nature, characterized as kicking, hitting, spitting, yelling and swearing at family and staff. A review of Monthly Progress Reports revealed on 6/13/20 at 7:40 AM, Resident C3 asked for some Tylenol. Staff C reminded Resident C3 he already received his dose of morning Tylenol. Resident C3 called her a name and a racial slur.	T1645		

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T1645	Continued From page 10 Staff D went into Resident C3's room at 8:30 AM to see if he wanted to get dressed and have some breakfast. Two staff were required to help transfer the resident, so Staff C re-entered the room. Resident C3 started yelling the racial slur again. Resident C3 chose to stay in bed rather than have Staff C assist him. At 4:45 PM that afternoon, Resident C3 called another staff a racial slur. Resident C3 made racial slurs toward a staff on 7/2/20. On 7/3/20, Resident C3 asked Staff D, "Why do pregnant women work here?" He then let her know he had a gun at home (not at the facility) and could shoot her and her baby. Staff B intervened and asked him to stop. Resident C3 used a racial slur and said he would shoot Staff D in the gut. Resident C3 then went to the kitchen and then the medication cart looking for a weapon while insulting Staff D and making racial slurs. Resident C3 punched and kicked staff while they were attempting to transfer him on 7/5/20. Resident C3 came out of his room and instead of going around another resident's wheelchair, he rammed his wheelchair into the first wheelchair. The resident in the first wheelchair tried to fight Resident C3 and then called the police on Resident C3. The July progress report noted this was becoming a pattern of behavior anger management was being pursued for Resident C3. Resident C3 received speech therapy and occupational therapy. On 3/19/20, the physical therapist noted Resident C3 was having skin redness on his bottom and pain while seated, so he tilted the power wheelchair. The physical therapist directed staff to tilt the wheelchair every hour to decrease the pressure on his bottom and to reposition Resident C3 in his bed every two hours. On 7/7/20, Staff B was trained in putting on Resident C3's left elbow splint by the	T1645		

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T1645	Continued From page 11 occupational therapist. Resident C3's service plan did not have a goal which addressed his verbal and physical aggression or racial comments. Resident C3's service plan did not address the specific recommendations made by his therapists. 4) The Residential Supervisor and Program Director confirmed these findings on 4/20/21 at 3:45 PM.	T1645		

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Plan of Correction

Deficiency cited: 481-63.9(1) h General Policies

63.9(1) Facility operation. The licensee shall establish written policies for the operation of the facility, including but not limited to the following:

h. Medication management, including self-administration of medications and chemical restraints (III)

Corrective Action Plan: Going forward we will comply with code 63.9(1) ensuring that we are following our established policies for medication management. We will follow our policy of administering medications as ordered and documenting each administration in the eMAR, in addition we will ensure medications are discontinued as ordered by the physician the day the order is received. The Program Director will oversee that Medication Management Policy re-training is completed within the program. The Director of Nursing will oversee the quality assurance of our eMAR system to ensure medications are being administered as prescribed.

Deficiency cited: 481-63.16(2)l Drugs
63.16(2) Drug safeguards.
l. No medications or prescription drugs shall be administered to a resident without a written order signed by the primary care provider. (II)

Corrective Action Plan: Going forward we will comply with code 63.16(2) ensuring all admissions have current orders from their physician prior to medications being administered. We will ensure that we follow our medication management policies specific to where medications are stored. The Program Director will oversee that Medication Management Policy re-training is completed within the program. The Director of Nursing and the Program Director will work collectively to oversee that physician orders are received prior to a member admitting.

Deficiency cited: 481-63.18(2)a Dietary
63.18(2) Nutrition and menu planning. a. Menus shall be planned and followed to meet the nutritional needs of residents in accordance with the primary care provider's orders. Diet orders should be reviewed as necessary, but at least quarterly, by the primary care provider. (II, III)

Corrective Action Plan: Going forward we will comply with code 481-63.18(2) ensuring we follow diet orders as written and obtain new orders at least quarterly. The Director of Nursing and the Program Director will work collectively to oversee that diet orders are received prior to a member admitting and that they are reviewed at least quarterly by the primary care provider.

Deficiency cited: 481-63.19(3) Orientation and Service Plan
63.19(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident and the resident's interdisciplinary team, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III)

6/10/21

6/10/21

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4102 NW 2nd Ct
Ankeny, IA 50023

Corrective Action Plan: Going forward we will comply with code 481-63.19(3) ensuring that all new residents or transfers have a new Service plan within 30 days of admission or transfer. The Social Worker will ensure that a new member or member transitioning from another internal program will have an individualized service plan developed within 30 days of their admission/transfer. The Residential Supervisor and Program Director will work closely with the Social Worker to provide the necessary information to develop a thorough and individualized plan for the member.

Deficiency Cited: 481-63.19(3)c Orientation and Service Plan
63.19(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident and the resident's interdisciplinary team, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III)

c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III)

Corrective Action Plan: Going forward we will comply with code 481-63.19(3)C ensuring that the resident service plan will be modified to add or delete goals and objectives as the resident's needs change. The Residential Supervisor and/or Program Director will ensure the Social Worker is notified promptly when the resident's needs change. The Social Worker will ensure that the resident's plan is updated reflecting the change in their needs within 5 working days and shared with the resident's team.

These corrective action plans will be in addressed by the Administrator/Regional Program Director and will be implemented by 6/9/2021. This compliance will be monitored by the State Director of Iowa to ensure future compliance.

Please feel free to contact Ashley Smith at 563-321-5706 or Ashley.smith@neurorestorative.com with any additional questions.

Sincerely,

Ashley Smith, MSM

State Director- Iowa