STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD352 HFD	A. BUILDING _____ B. WING _____	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ESTHERVILLE	2015 3RD AVENUE NORTH ESTHERVILLE, IA 51334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 22 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 22 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 11 Total Population of Program at time of on-site: 11 TOTAL census of Assisted Living Program: 33 The following regulatory insufficiencies were cited during the investigation of Incidents #107775-I and #107984-I.	A 000		
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 record review and interview the program failed to ensure staff followed established policy regarding controlled substance management. This affected 1 of 1 tenant identified as a result of self-reported incident #107775-I (Tenant #2). Findings include:	A 160		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 160	Continued From Page 1 On 9/06/22 the program self reported Tenant #2's 30 day supply of Ativan as missing from the medication room on Wednesday 8/31/22 at approximately 9:00 p.m. by Medication Manager (MM) F. The narcotics were reportedly left sitting out on the counter after being counted by MM D also a medication manager around 2:00 p.m. Tenant #2's Ativan had been left sitting out and accessible to several staff during this time as the medication room was also noted to be a staff lounge and staff also used this same room to punch in and out of the facility. On 10/03/22 at 1:45 p.m. review of the Controlled Substance Management policy revealed controlled substances were delivered to the facility nurses' station by the pharmacy driver. A licensed nurse must count and verify medications delivered while driver was still present. The nurse should sign the delivery record if no inaccuracy was found. The nurse should verify the Controlled Drug Record "count sheet" is present for all delivered controlled substances. All controlled substances would be counted by two (2) nurses at each shift change. The on-coming nurse will count the narcotics and the off-going nurse will verify the count from the individual Controlled Drug Record. Both nurses should visualize the narcotics and the count sheet, checking for accuracy. Both Nurses should sign the Controlled Substances Count Record in the appropriate spaces. On 10/03/22 at 1:56 p.m. the Administrator confirmed the Controlled Substance Management policy directed two (2) nurses at shift change and the facility does not have two nurses to do this. On 10/04/22 at 9:38 a.m. interview with Staff B/Resident Care Coordinator revealed Tenant #2's Ativan had been delivered to the facility on 8/29/22 and signed for by Staff B. Staff B said all of Tenant	A 160		

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A 160	Continued From Page 2 #2's Ativan was present. Staff B confirmed she made a Controlled Drug Record "count sheet" for all delivered controlled substances. Staff B confirmed the narcotics sheets had not been dated on the date of delivery and had not noted the actual count of the amount of the drug on hand and/or had a co-signature. Tenant #2's medication had set inside Staff B's office until 8/31/22 at 2:00p.m. without counts at shift change as required per facility policy. On 8/31/22 at 2:00 p.m. a count on Tenant #2's medication was started by Medication Manager Staff B. On 10/04/22 at 8:33 a.m. interview with Staff D revealed she counted all of Tenant #2's narcotics in and left them on the counter. On 8/31/22 MM D worked until 6:21p.m. and was relieved by MM F at that time. Per policy, a count of Tenant #2's Ativan at shift change had not been completed by MM F and MM D during this shift change. On 10/04/22 at 10:56 a.m. interview with MM F revealed when she started her shift at 6:00p.m. MM D had the narcotics laying scattered on the counter. MM F reported she left the medication room and went to do her work on the floor. At 9:00p.m. MM F reported she returned to the medication room and realized Tenant #2's Ativan had a narcotics sheet with a count of 30 pills on it but no Ativan. MM F said Tenant #2's bubble pack card of 30 pills was missing. MM F called her nurse to report the incident. MM F confirmed a shift count on Tenant #2's missing Ativan should have been done when she relieved MM D at 6:00p.m. On 10/04/22 at 2:19 p.m. the Administrator confirmed the program failed to follow the medication policy established by the Program	A 160		

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A 160	Continued From Page 3 concerning the need to maintain an accurate accounting of a tenant's narcotics that included staff were to count and record the total number of narcotics at the beginning/end of each shift and after the administration of any narcotic. The failure to maintain an accurate count of the Narcotic led to the inability to account for a Tenant #2's 30 pills of missing Ativan.	A 160		
A 710	481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This Requirement is not met as evidenced by: Based on record review and interview, the Program failed to ensure the enclosed Gardens area off of the dementia-specific memory care floor remained safe and secure at all times. This affected 1 of 1 tenant identified as a result of self-reported incident # 107984-I (Tenant #1). Findings include: On 9/21/22 the Program self reported an incident that involved Tenant #1's elopement from the Program on 9/21/22. There were no known injuries. Tenant #1 had walked to a neighbor's home next door to the facility. The Gardens area located outside of the main building and was used by tenants and their families for recreation. There was no system in place to check the lock on the gate prior to the incident. The staff person who unlocked the gate left at 2:00 p.m. and at shift change reported the gardeners had been there earlier in the day. The report was miscommunicated and the oncoming	A 710		

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A 710	Continued From Page 4 staff was not directly aware the gate had not been locked back up again and assumed it had been. The gate remained open until it was learned Tenant #1 left the memory care area through the unlocked gate at 1:20 p.m. as determined when the computer door alarm log alerted the door had been opened. Staff reported they thought they last saw Tenant #1 inside the Program at or around 1:25 p.m.. The actual time Tenant #1 left could not be determined. There was no video available for review. At 1:30 p.m. the next door neighbor called the facility to report Tenant #1 was at their home. Tenant #1 was returned to the facility without injury. Record review revealed Tenant #1 lived on a memory care floor with ten other adults. This area served 11 members with a GDS score of 4 or above. The GDS score of Tenant #1 was noted at a 6. The temperature in Estherville, Iowa on 9/21/22 at 1:30 p.m. was noted at 66.2F according to localconditions.com. On 9/29/22 at 1:30 p.m,. interview with the Administrator revealed on 9/21/22 the gate to the fence used to secure the gardens area had been left unlocked. Staff unlocked the gate days before on Sunday 9/18/22 before 2:00 p.m. to allow gardeners to mow the grassy areas. When the gardeners left, they failed to notify staff so the gate could be locked again. The paddle lock required a key to lock and unlock it.	A 710		