

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2024
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NAME OF PROVIDER OR SUPPLIER STIRLINGSHIRE OF CORALVILLE MC	STREET ADDRESS, CITY, STATE, ZIP CODE 1140 KENNEDY PARKWAY CORALVILLE, IA 52241
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A 000	<p>Initial Comments</p> <p>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.</p> <p>Number of tenants without cognitive impairment: 3 Number of tenants with cognitive impairment: 16 Total census: 19</p> <p>The following regulatory insufficiencies were cited related the investigation of Complaint #121004-C.</p>	A 000		
A 160	<p>481-67.3(2) Tenant Rights</p> <p>481-67.3 Tenant rights. All tenants have the following rights:</p> <p>67.3(2) To receive care, treatment and services which are adequate and appropriate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate. This pertained to 1 of 4 former tenants reviewed (Tenant C1) and 7 of 7 current tenants reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). Findings follow:</p> <p>1. Review of Tenant C1's file on 10/9/24 revealed an Incident Investigation Report dated 3/29/24 indicating during lunch, staff observed Tenant C1</p>	A 160	The Plan of Correction is attached	

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

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A 160	<p>Continued From page 1</p> <p>appear to struggle with eating and turn blue. Staff performed the Heimlich maneuver and called 911. Hospice and Tenant C1's legal representative were notified. Tenant C1 was transferred to the emergency department (ED). The staff involved were B, G, H and I.</p> <p>An internal investigation revealed staff attempted the Heimlich maneuver until she went unresponsive, then started cardiopulmonary resuscitation (CPR) per 911 directive. Tenant C1 was on hospice but staff said they were not able to find her Do Not Resuscitate (DNR) paperwork. The DNR forms were located by the Director of Nursing (DON). The internal investigation indicated corrective action was required and all tenant charts were re-organized with code status forms in a consistent location in all charts. Direct care staff were re-educated on where to locate code status paperwork. A typed statement with the report indicated on 3/29/24 at approximately 12:43 p.m. the DON was notified Tenant C1 was unresponsive during lunch. Staff reported they were overseeing the tenants during lunch and noticed Tenant C1 turn blue in the face and thought she was choking. Staff started the Heimlich maneuver, notified 911 and hospice. Per 911 dispatch, staff continued the Heimlich maneuver and were to start CPR if she went unresponsive. Staff told the 911 dispatch Tenant C1 was on DNR status and on hospice. The 911 dispatch instructed them to perform CPR nonetheless. Tenant C1 became unresponsive and two staff started CPR. Medics arrived and took over compressions. The DON arrived back as Tenant C1 was being loaded into the ambulance. The DON told the medic the tenant had a DNR status and located the DNR paperwork. Emergency medical technicians (EMTs) said she had a pulse and they were</p>	A 160		

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A 160	<p>Continued From page 2</p> <p>leaving to go to the hospital.</p> <p>Staff G no longer worked at the Program and an attempt for an interview was unsuccessful. Staff G's written statement dated 3/29/24 indicated around 12:30 p.m. in the dining room, she was clearing dishes when she noticed Tenant C1's face was purple. She told Staff H and Staff I she believed Tenant C1 was choking. They checked for a pulse. Staff H called the DON and Staff I called 911. Staff B arrived and helped with the Heimlich maneuver. Staff B and Staff H switched off doing the Heimlich maneuver. Tenant C1 became unresponsive and 911 directed staff to start compressions whether Tenant C1 was a DNR or not. EMTs came and continued compressions.</p> <p>When interviewed on 10/23/24 at 10:00 a.m. Staff H said she was passing medications and came to the dining room. Staff G told her Tenant C1 did not look good. She thought the tenant's skin appeared to be purple. Staff H called the tenant's name but got no response. She was at the table in her wheelchair. Staff H immediately started the Heimlich maneuver as she believed Tenant C1 was choking. It did not dislodge anything. The tenant then became completely unconscious. Staff called 911 and hospice. The 911 dispatch told Staff I to do chest compressions so she did. Staff H called hospice and the DON. She confirmed brussels sprouts were served that day. It was her belief everyone in the memory care unit should have their food chopped or cut up, but stated there were no mechanical or special diets at the Program. She confirmed the EMTs asked for the tenant's IPOST (Iowa Physician Orders For Scope Of Treatment) or DNR form but they could not be located by any of the staff.</p>	A 160		

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A 160	<p>Continued From page 3</p> <p>When interviewed on 10/29/24 at 4:30 p.m. Staff I said during lunch one of the aides noticed a blue tint to Tenant C1's mouth and it was realized she was choking. She told the medication aide on the other side of the building and EMTs were called. She looked for the DNR form in Tenant C1's file but could not find it. The EMTs revived the tenant and took her to the hospital. Staff I remembered brussels sprouts were served and said Tenant C1 did not have a special diet. She said in general, the staff walked around and cut up food in memory care but there was not an ordered diet for Tenant C1. She did not remember if her food was cut up that day.</p> <p>On 10/23/24 at 10:21 a.m. Staff B said she was working on the other side of the building and Staff I came over and asked her to come to the memory care unit. It was lunch time. When she got there, Tenant C1 was standing up with staff behind her. When staff put her on the floor, the tenant's lips were purple/blue in color. She and Staff I alternated completing chest compressions. Staff called 911 and were told to keep doing CPR until EMS arrived. She said Tenant C1 did not have a pulse until EMS got one back. Tenant C1 was not on a special diet.</p> <p>When interviewed on 10/24/24 at 9:50 a.m. Staff J said she was cook that day and prepared the lunch meal. She did not recall the entire menu but said brussels sprouts were served. Tenant C1 was not on a special diet. After lunch, one of the staff said paramedics were called because a tenant was choking on brussels sprouts in memory care. She said the brussels sprouts were not cut for the tenant. Staff J said she had stressed to the Dining Director on the day of the incident before the meal was served that the brussels sprouts should be cut in half for those</p>	A 160		

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A 160	<p>Continued From page 4</p> <p>tenants in the memory care unit. She was told those tenants could eat what the assisted living tenants ate. Staff J stated there was not a registered dietician involved to go over food preparations and techniques. Since that incident she chopped up food for the folks in the memory care unit before it was plated.</p> <p>During interviews on 10/22/24 at 9:46 a.m. and 10/31/24 at 2:27 p.m. the Dining Director said there was no special diet order for Tenant C1 that had been provided to him. He said they did not offer special diets. They served brussels sprouts, a hamburger and potatoes for lunch that day. He did not cook that day but said if it was a bigger vegetable it would have been cut up. He had heard in passing that someone choked on brussels sprouts. He had not seen the food that day and no concerns were brought to him prior to the serving of the meal regarding the brussels sprouts.</p> <p>When interviewed on 10/24/24 at 11:10 a.m. the DON said she had been out to lunch when she was called by staff to come back to the building. She was told staff did the Heimlich maneuver until she was unconscious, then CPR was started. When the DON arrived Tenant C1 was getting CPR from EMS and was being loaded into the ambulance. The DON reported the tenant's diet order at the time of the incident was for cut-up food. She said in general, the kitchen plated the food and put a cover on it. The cart was transported to the memory care unit and direct care staff took it to the tables and uncovered it. Direct care staff cut up her food. She did not know if dietary staff or direct care staff cut up Tenant C1's food that day. She said direct care staff were aware of her order and they generally cut up her food. She believed she had</p>	A 160		

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A 160	<p>Continued From page 5</p> <p>either told the Dining Director or one of the chefs of Tenant C1's diet order for cut up food, but could not recall exactly who she had told. The meals served were all regular diets. They had never had a special diet or a pureed diet at the Program. She explained that not only Tenant C1 needed her food cut up but almost all other tenants in memory care had their food cut up as well. She did not recall how long Tenant C1 had swallowing issues. Regarding life saving measures, the DON stated staff were not required to be CPR certified. The staff working that day were following the 911 dispatcher's directive. When staff first started at the Program, she demonstrated how to do the Heimlich maneuver and it was also shown during the skills fair.</p> <p>When interviewed on 10/23/24 at 1:07 p.m. the Executive Director said she was not involved with the incident but was called about it. She said staff were told by the 911 dispatch to start CPR. She did not know Tenant C1's diet orders and did not know what was served to her that day. She said Tenant C1 was DNR, and staff followed the direction given by 911 dispatch and provided CPR. She believed staff handled it to the best of their ability. She said it was a combination of direct care and dietary staff regarding who was responsible to ensure diet orders were followed. Diet orders were given to the Dining Director who would tell the dietary staff. She said sometimes chefs would go ahead and cut foods and other times staff in memory care would do it. It was a combined effort. She did not know if dietary staff or direct care staff confirmed Tenant C1's food was served per her diet.</p> <p>A review of ambulance records revealed on 3/29/24 at 12:30 p.m. Tenant C1 was choking on</p>	A 160		

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A 160	<p>Continued From page 6</p> <p>food and was in cardiac arrest. Tenant C1 had an airway obstruction, was unresponsive, and her skin was cold and pale. The ambulance was dispatched related to a tenant choking. She was found in the memory care dining room receiving CPR by staff. Staff reported she started choking on her lunch but they were not sure what was stuck. Abdominal thrusts were attempted without success. Tenant C1 went into cardiac arrest so they started CPR. Staff reported Tenant C1 was a DNR but staff could not produce the form and said they did not have access until the nurse returned from lunch. Resuscitation was continued as no IPOST or DNR was provided. A paramedic attempted to visualize the airway and was able to remove some food with suction and forceps. A scene survey was completed and there were brussels sprouts present. Removal was not successful. Cricoid pressure was applied and the brussels sprout was moved to a position where it could be removed. At a later pulse check, a pulse was found so CPR was stopped but ventilations continued. Tenant C1 was placed on a stretcher. The ambulance arrived at the hospital and Tenant C1's care was turned over to the Emergency Department (ED) staff.</p> <p>Hospital records indicated Tenant C1 was admitted on 3/29/24 and discharged (death) on 3/30/24. Tenant C1, who had a history of dysphagia, went into cardiac arrest after choking on brussels sprouts. Due to an unclear code status, CPR was started and return of spontaneous circulation (ROSC) was obtained. It was noted she received two rounds of epinephrine with ROSC. CPR was performed for an estimated 20 minutes. Tenant C1 was brought to the ED where she was unresponsive. The plan was for comfort measures and to hold all non-essential medications. A transition would</p>	A 160		

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A 160	<p>Continued From page 7</p> <p>occur to acute hospice care for end of life treatment after a discussion with Tenant C1's family. The Death Record documented Tenant C1 died on 3/30/24 at 10:03 a.m. The primary cause of death was acute asphyxiation.</p> <p>On 10/9/24 further review of the tenant's file revealed Tenant C1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Service plans dated 2/5/24 and 3/18/24 reflected she had a regular diet, meals were provided three times per day and she needed her food cut up into small bite sized pieces. Tenant C1 had a code status form dated 10/4/23 that indicated DNR which was signed by the attending physician. She also had an IPOST that indicated the DNR was signed by the provider on 3/18/24. Tenant C1 had a signed diet order for small bite sized pieces cut up. It indicated the program could accommodate when meals were served. It also stated the tenant did have access to food and made her own decisions. The order was signed 10/10/23.</p> <p>Progress Notes revealed the following:</p> <ul style="list-style-type: none"> - On 1/5/24 a call was made to Tenant C1's legal representative regarding a decline, difficulty swallowing and poor intake. - On 3/12/24 staff reported Tenant C1 was not eating much solid food and preferred soft foods. Family and the provider were notified. - On 3/14/24 Tenant C1 was admitted to hospice. - On 3/29/24 at 12:30 p.m. Tenant C1 had a choking episode that led to her being unconscious. Staff completed the Heimlich Maneuver but were not successful. Staff were instructed by 911 to begin CPR after she lost consciousness. She was transported to the hospital. 	A 160		

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A 160	<p>Continued From page 8</p> <ul style="list-style-type: none"> - On 3/30/24 staff reported Tenant C1 had died at the hospital. <p>Staff Communications Reports indicated the following:</p> <ul style="list-style-type: none"> - On 1/4/24 Tenant C1 had difficulty swallowing and was coughing. It sounded like she had fluid in her lungs that could be from swallowing wrong. - On 1/5/24 Tenant C1 had decreased appetite and difficulty swallowing. Two reports were made: one at 8:30 a.m. and one at 12:14 p.m. - On 3/11/24 Tenant C1 had decreased appetite and difficulty swallowing. It was noted she was not eating as many solid foods and went towards soft foods like applesauce and jello. <p>In summary, Tenant C1 had a diet order for foods to be cut up into small pieces that was in place since October 2023 and included in her service plans. She had a history of swallowing difficulties and decreased appetite per nurse's notes and staff communication documents that was noted in January 2024. She was admitted to hospice on 3/14/24 for weight loss and dysphagia. None of the direct care staff or dietary staff interviewed had knowledge of Tenant C1's diet order to have foods cut up in small bite sized pieces even though it was in her service plan. On 3/29/24 she was served a meal that included brussels sprouts. Per interview with the staff who cooked the meal that day the brussels sprouts were not cut up for her. At lunch, staff noted Tenant C1 appeared to be choking and turning blue/purple in color. Tenant C1 choked and went into cardiac arrest. Staff started the Heimlich maneuver and, at the direction of 911, started CPR. While at the Program EMTs were able to remove some food from Tenant C1 which was identified as a brussels sprout. She was transported to the hospital. Per interview, family withdrew care and</p>	A 160		

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A 160	<p>Continued From page 9</p> <p>she died on 3/30/24. Hospital records indicated the cause of death was acute asphyxiation.</p> <p>In addition, Tenant C1 began receiving hospice services on 3/12/24. She had a code status form dated 10/4/23 that indicated DNR which was signed by the attending physician. She also had an IPOST indicating the DNR was signed by the provider on 3/18/24. Tenant C1 was on hospice but staff were not able to find her DNR or IPOST form to provide to the EMTs when they arrived at the Program. time of this incident. The DNR forms were located by the DON. The internal investigation indicated corrective action was required and all tenant charts were re-organized with code status forms in a consistent location in all charts. Direct care staff were re-educated on where to locate code status paperwork.</p> <p>2. When interviewed on 10/8/24 at 10:35 a.m. Staff A said people came into work and did always not check laundry and shower schedules. She believed not everyone did their job correctly, especially on second shift. Showers were not always getting done and at times staff charted they completed a shower when they did not actually do it. It had been reported to management.</p> <p>When interviewed on 10/10/24 at approximately 9:50 a.m. Staff C said staff did not know the shower schedule and at times did not look at it until the end of their shift.</p> <p>Review of Tenant #1's file on 10/8/24 revealed Tenant #1 received staff assistance with bathing.</p> <ul style="list-style-type: none"> - the July 2024 Monthly Task Logs reflected the task of bathing twice weekly was charted as not being completed one time. - the August 2024 Monthly Task Logs reflected 	A 160		

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A 160	<p>Continued From page 10</p> <p>the task of bathing twice weekly was charted as not being completed one time.</p> <ul style="list-style-type: none"> - the September 2024 Monthly Task Logs reflected the task of bathing twice weekly was charted as not being completed one time. <p>Review of Tenant #2's file on 10/9/24 reflected Tenant #2 received staff assistance with bathing.</p> <ul style="list-style-type: none"> - the July 2024 Monthly Task Logs reflected the task of bathing twice weekly was charted as not being completed one time. - the August 2024 Monthly Task Logs reflected the task of bathing twice weekly was charted as not being completed one time. - the September 2024 Monthly Task Logs reflected the task of bathing twice weekly was charted as not being completed one time. <p>Review of Tenant #3's file on 10/9/24 reflected Tenant #3 received staff assistance with bathing.</p> <ul style="list-style-type: none"> - a Progress note indicated on 4/28/24 Tenant #3's family called and wanted to speak to the DON. The family member reported other family members were in the building and Tenant #3 was observed sitting in his chair in clothing with feces all over them. It was reported there was feces in the apartment, on his bed and in his bathroom. The DON called the building and was told staff were cleaning him up and the family member had requested to have a virtual visit on the phone with him. When she called the building she found out that he had a shower that morning and refused to get dressed. Staff had left the apartment due to inappropriate behaviors. Staff came back to the apartment and provided clean clothes and left the apartment. Tenant #3 changed back into dirty clothes from the prior day. There was no feces in the apartment at that time. Then family came to visit. Another nurse was in the building and family stopped her and told her about the feces. She 	A 160		

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A 160	<p>Continued From page 11</p> <p>immediately sent staff to clean him up. He had clothing on from the prior day and they and the sheets had feces on them. There was feces in his bathroom too. Staff cleaned him and attempted to shower him but he refused. Staff left the apartment and another staff returned to complete a virtual visit or video for family and the feces had been cleaned up but he had his dirty clothes on again. The family member received the video and was upset that he still had clothing with feces on it. Staff was educated to remove his previously worn clothing from his apartment so he would not put them back on. Second shift called and said there was more feces in his bathroom and they were cleaning it up but they did not want to be in the room alone with him due to sexual comments. Staff was educated to take two staff in the apartment. They changed his clothing and removed the clothing with feces on it. His bed was changed and clean sheets were put on the bed.</p> <ul style="list-style-type: none"> - the April 2024 Monthly Task Log reflected the task of bathing was scheduled twice weekly. Per the task record there were no baths documented as completed for April. There were 7 refusals and 1 entry documented as task not completed. - the August 2024 Monthly Task Log reflected the task of bathing scheduled twice weekly was charted as the task was not completed three times. - the September 2024 Monthly Task Log revealed the task of bathing scheduled twice weekly was charted as the task was not completed twice. <p>Review of Tenant #4's file on 10/9/24 revealed Tenant #4 received assistance with bathing.</p> <ul style="list-style-type: none"> - the July 2024 Monthly Task Log reflected the task of bathing scheduled twice weekly was charted as not being completed one time. 	A 160		

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A 160	<p>Continued From page 12</p> <ul style="list-style-type: none"> - the August 2024 Monthly Task Log reflected the task of bathing scheduled twice weekly was charted as the task was not completed twice. - the September 2024 Monthly Task Log revealed the task of bathing scheduled twice weekly was charted as the task was not completed twice. <p>Review of Tenant #5 file on 10/9/24 revealed Tenant #5 received assistance with bathing.</p> <ul style="list-style-type: none"> - the July 2024 Monthly Task Log reflected the task of bathing scheduled twice weekly was charted as the task was not completed twice. - the September 2024 Monthly Task Log reflected the task of bathing scheduled twice weekly was charted as the task was not completed one time. - the October 2024 Monthly Task Log (from 10/1/24 to 10/8/24) reflected the task of bathing scheduled twice weekly was charted as the task was not completed one time. <p>Review of Tenant #6's file on 10/9/24 revealed Tenant #6 received assistance with bathing.</p> <ul style="list-style-type: none"> - the June 2024 Monthly Task Log reflected the task of bathing scheduled twice weekly was charted as the task was not completed one time. - the August 2024 Monthly Task Log reflected the task of bathing scheduled twice weekly was charted as the task was not completed one time. - the September 2024 Monthly Task Log (from 9/1/24 to 9/20/24) reflected the task of bathing scheduled twice weekly was charted as the task was not completed one time. <p>Review of Tenant #7's file on 10/10/24 revealed Tenant #7 received assistance with bathing.</p> <ul style="list-style-type: none"> - the June Monthly Task Log reflected the task of bathing scheduled twice weekly was charted as the task was not completed one time. - the July 2024 Monthly Task Log reflected the 	A 160		

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A 160	<p>Continued From page 13</p> <p>task of bathing scheduled twice weekly was charted as the task was not completed one time. - the September 2024 Monthly Task Log reflected the tasks of bathing scheduled twice weekly was charted as the task was not completed one time.</p> <p>When interviewed on 10/24/24 at 11:10 a.m. the DON confirmed all task records were provided for the tenants reviewed. She said staff should document tasks as they did the tasks and if not, by the end of the shift. She said first shift staff had reported laundry was not getting completed if it was left in the dryer.</p>	A 160		
A 285	<p>481-67.5(2)f(4) Medications</p> <p>67.5(2) Each program shall follow its own written medication policy, which shall include the following:</p> <p>f. When medications are administered traditionally by the program:</p> <p>(4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications as ordered. This pertained to 7 of 7 current tenants reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7) and 4 of 4 discharged tenants reviewed (Tenants C1, C2, C3 and C4). Findings follow:</p> <p>1. Review of Tenant #1's on 10/8/24 file revealed</p>	A 285		

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A 285	<p>Continued From page 14</p> <p>a Medication/Treatment Error Report dated 8/14/24 indicating an error was identified on 8/13/24 regarding Tenant #1's Novolog sliding scale insulin scheduled for three times daily. The medication was not administered as ordered. The order was entered into the medication administration record (MAR) as a PRN (as needed) medication and staff were unaware to routinely administer additional units of insulin with meals since February of 2024. The type of error indicated the order was not in the MAR correctly. Tenant #1's legal representative, the Executive Director and primary care provider (PCP) were notified. The cause was listed as a pharmacy error and verification error.</p> <p>Continued review revealed a Discharge Planning/Recapitulation of Stay document indicating Tenant #1 was admitted to a nursing facility on 1/4/24 and discharged on 2/8/24. An Order Summary Report dated 2/5/24 reflected the following orders:</p> <ul style="list-style-type: none"> - Novolog Solution 100 unit/milliliters (ML), inject 7 units subcutaneously (SQ) three times per day - Novolog Solution 100 unit/ML inject per sliding scale SQ three times per day with meals. The sliding scale was 150-199 (2 units), 200-249 (4 units), 250-299 (6 units), 300-349 (8 units), 350-399 (10 units), if 400 and above (inject 10 units and call the PCP). - Blood glucose monitoring three times per day. Notify the PCP if below 70 or greater than 400. <p>Review of Tenant #1's 2024 MARs revealed the following:</p> <ul style="list-style-type: none"> - February MARs contained the orders for Novolog 100 unit/ML 7 units three times daily. An order for Novolog Injection Solution 100 unit/ML reflected the sliding scale at 8:00 a.m., 11:30 a.m. and 4:30 p.m. It had a start date of 2/8/24 and 	A 285		

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A 285	<p>Continued From page 15</p> <p>discontinuation date of 2/13/24. The Novolog sliding scale insulin three times per day with meals was reflected as a PRN (as needed) medication with a start date of 2/9/24. After 2/13/24 there were no units of Novolog documented as given in February. Additionally, blood glucose readings were not completed and documented three times per day as ordered. There were 13 blood glucose readings documented for the month of February despite being ordered three times per day. On 2/29/24 it was noted Tenant #1's blood glucose was 327 at 5:00 p.m. Sliding scale insulin was not administered as ordered.</p> <ul style="list-style-type: none"> - March MARs reflected the orders for Novolog 100 unit/ML 7 units three times daily with a start date of 2/9/24. This was completed for all meals for the month with the exception of one 5:00 pm time on 3/11/24. The PRN Novolog sliding scale of insulin three times per day with meals was also included on the MAR. It also had a start date of 2/9/24. There were no PRN units documented as given in March. There were over 50 entries of recorded blood glucose readings that were 150 or greater that would have required sliding scale insulin be administered. - April MARs reflected the scheduled orders of 7 units of Novolog before meals. It was documented as being administered at all times with the exception of two 5:00 pm times on 4/11/24 and 4/16/24 pm. The PRN Novolog sliding scale of insulin three times per day with meals was also included on the MAR. There were no PRN units documented as given in April. There were over 40 entries of recorded blood glucose readings that were 150 or greater that would have required sliding scale insulin be administered. On 4/2/24 at 5:00 p.m. Tenant #1's blood glucose was 484. - May MARs reflected the scheduled orders of 7 	A 285		

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A 285	<p>Continued From page 16</p> <p>units of Novolog before meals. It was documented as being administered at all times with the exception of two mealtimes. The PRN Novolog sliding scale of insulin three times per day with meals was also included on the MAR. There were no PRN units documented as given in May. There were over 40 entries of recorded blood glucose readings that were 150 or greater that would have required sliding scale insulin be administered.</p> <ul style="list-style-type: none"> - June MARs contained the orders for 7 units of Novolog before meals three times daily. The PRN Novolog sliding scale of insulin three times per day with meals was also included. There were no PRN units documented as given in June. There were over 40 entries of recorded blood glucose readings that were 150 or greater that would have required sliding scale insulin be administered. - July MARs contained the orders for 7 units of Novolog before meals three times daily as well as the PRN orders of sliding scale insulin. There were no PRN units documented as given in July. There were over 50 entries of recorded blood glucose readings that were 150 or greater that would have required sliding scale insulin be administered. - August MARs contained the orders for 7 units of Novolog before meals three times daily as well as the PRN orders of sliding scale insulin. There were no PRN units documented as given in August. There were over 50 entries of recorded blood glucose readings that were 150 or greater that would have required sliding scale insulin be administered. On 8/13/24 at 5:00 p.m. Tenant #1's blood glucose was 262. <p>A review of Tenant #1's Progress Notes indicated the following:</p> <ul style="list-style-type: none"> - On 8/13/24 Tenant #1's blood glucose log was 	A 285		

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A 285	<p>Continued From page 17</p> <p>reviewed and it was noted that sliding scale insulin was documented as a PRN medication and not scheduled. Clarification was sought from the PCP regarding the order.</p> <ul style="list-style-type: none"> - On 8/14/24 a message was left to make the PCP aware of the error. No response received. - On 8/14/24 the PCP office called stating the message was received and were awaiting response back from the PCP. - On 8/16/24 it was noted the Program was still waiting for a response and sliding scale insulin was not administered pending clarification. - On 8/20/24 a follow up call was made to the PCP regarding clarification of the order. Tenant #1 was without a sliding scale insulin order. - On 8/23/24 it was noted messages were left multiple times to request clarification on sliding scale insulin. No phone calls were received. - On 8/26/24 it was noted calls were placed to the PCP regarding sliding scale insulin. No return calls received. - On 8/30/24 the PCP office was called again. - On 9/16/24 a call was placed and the PCP was faxed regarding sliding scale insulin. - On 10/1/24 Tenant #1 went to an appointment to the PCP and returned with new orders for sliding scale that was scheduled. <p>In summary, Tenant #1 did not receive her sliding scale insulin as ordered from February 2024 to August 2024. Clarification was not sought from the PCP until August regarding the sliding scale insulin which was ordered in February. A new order was finally obtained on 10/1/24 from the PCP making the sliding scale insulin a scheduled order instead of PRN.</p> <p>2. Review of Tenant #2's file on 10/9/24 file revealed staff administered his medications.</p>	A 285		

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A 285	<p>Continued From page 18</p> <p>The August 2024 Time Variance Report reflected medications were not given at prescribed times, including Levothyroxine 75 micrograms (mcg) which was ordered at 7:00 a.m. and Quetiapine 100 milligram (mg) which was ordered at 8:00 p.m. The Levothyroxine was documented as given more than one hour after the prescribed time 15 times, and the Quetiapine was documented as given more than one hour after the prescribed time 10 times.</p> <p>The September 2024 Time Variance Report reflected the Quetiapine (ordered at 8:00 p.m.) was documented as given more than one hour after the prescribed time 5 times.</p> <p>The October 2024 Time Variance Report reflected the Quetiapine (ordered at 8:00 p.m.) was documented as given more than one hour after the prescribed time 2 times.</p> <p>3. Review of Tenant #3's file on 10/9/24 revealed a Medication/Treatment Error Report dated 4/20/24 indicated Tenant #3 ran out of escitalopram oxalate 10 mg (selective serotonin reuptake inhibitors). Tenant #3 did not receive the medication from 3/8/24 to 4/23/24. Tenant #3 ran out of medication and it was not re-ordered by staff from the appropriate pharmacy. The effect noted was behaviors.</p> <p>Review of the tenant's MARs revealed the following:</p> <ul style="list-style-type: none"> - March 2024 MARs reflected Escitalopram Oxalate 10 mg tablet at 8:00 a.m. was documented as drug not available from 3/8/24 to 3/31/24, with the exception of 3/25/24 and 3/30/24, when staff charted they administered the medication (despite not being available). - April 2024 MARs reflected Escitalopram 	A 285		

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A 285	<p>Continued From page 19</p> <p>Oxalate 10 mg tablet at 8:00 a.m. was documented as drug not available from 4/1/24 to 4/23/24 with the exception of 4/1/24, 4/2/24 and 4/23/24 which were charted as administered (despite not being available). On 4/8/24, 4/9/24, 4/12/24, 4/15/24, 4/17/24 and 4/22/24 there was no documentation provided.</p> <p>Further review revealed the May 2024 Time Variance Report reflected Propranolol 20 mg tablet which was ordered at 8:00 a.m. was documented as given more than one hour after the prescribed time over 5 times. The August 2024 Time Variance Report reflected escitalopram 10 mg tablet which was ordered at 8:00 a.m. was documented as given more than one hour after the prescribed time over 10 times.</p> <p>4. Review of Tenant #4's file on 10/9/24 revealed staff administered his medications.</p> <p>Review of the tenant's 2024 MARs revealed the following:</p> <ul style="list-style-type: none"> - April MARs reflected an order for Ammonium Lactate 12% external lotion to be applied externally to affected areas three times daily. The MAR reflected 20 entries of the treatment not documented as completed. It also reflected Trazodone 50 mg tablet, take 1.5 tablets (75 mg) by mouth three times daily. It was not documented as administered 8 times at 8:00 p.m. - May MARs reflected an order for Ammonium Lactate 12% external lotion to be applied externally to affected areas three times daily. The MAR reflected 20 entries of the treatment not documented as completed. It also reflected Trazodone 50 mg tablet, take 1.5 tablets (75 mg) by mouth three times daily. It was not documented as administered 4 times (twice at 8:00 a.m. and twice at 12:00 p.m.) 	A 285		

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A 285	<p>Continued From page 20</p> <ul style="list-style-type: none"> - August MARs reflected an order for Ammonium Lactate 12% external lotion to be applied externally to affected areas three times daily. The MAR reflected 5 entries of the treatment not documented as completed. <p>5. Review of Tenant #5's file on 10/9/24 revealed staff administered her medications.</p> <p>Review of the tenant's 2024 MARs revealed the following:</p> <ul style="list-style-type: none"> - August MARs reflected an order for acetaminophen 500 two tablets, three times daily, was charted as drug not given/not available or not charted at all over 25 times. The MAR also reflected an order for miconazole cream 2% external to be applied topically to affected areas twice daily. It was charted as not administered/not available or not charted at all over 15 times. Mometasone nasal spray 50 mcg, 2 sprays in each nostril daily was either charted as not given/not available or not charted at all over 15 times. - September MARs reflected an order for acetaminophen 500 tablet, two tablets three times daily, was charted as not given/not available or not charted at all over 5 times. The order for miconazole cream to be applied to affected areas twice daily was charted as not administered/not available or not charted at all over 20 times. The Mometasone nasal spray (2 sprays in each nostril daily) was either charted as not given/not available or not charted at all over 5 times. - October MARs reflected an order miconazole cream to be applied to affected areas twice daily was charted as not administered/not available or not charted at all over 5 times. The Mometasone nasal spray (2 sprays in each nostril daily) was either charted as not given/not available or not charted at all 2 times. 	A 285		

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A 285	<p>Continued From page 21</p> <p>6. Review of Tenant #6's file on 10/9/24 revealed staff administered her medications.</p> <p>The August 2024 MARs reflected an order for Timolol Maleate solution 0.25% one drop into both eyes twice daily. It was charted as drug not given/not available or not charted at all over 5 times.</p> <p>The May Time Variance Report reflected Levothyroxin 75 mcg tablet ordered at 8:00 a.m. was documented as given more than one hour after the prescribed time over 10 times.</p> <p>7. Review of Tenant #7's file on 10/10/24 revealed staff administered her medications.</p> <p>Review of the tenant's 2024 MARs revealed the following:</p> <ul style="list-style-type: none"> - August MARs reflected Nitrofurantoin capsule 100 mg, twice daily was charted as not given/not available or not charted at all over 20 times. - September MARs reflected an order to monitor oxygen levels twice daily was charted as not completed 5 times. <p>The August Time Variance Report reflected Levothyroxin 75 mcg tablet which was ordered at 8:00 a.m. was documented as given more than one hour after the prescribed time over 10 times.</p> <p>8. Review of Tenant C1's file on 10/9/24 revealed staff administered her medications.</p> <p>The March 2024 MARs reflected an ordered carbidopa/levodopa 25-250 mg tablet three times daily was not documented as given 10 times. Eliquis 2.5 mg tablet twice daily was not documented as given 4 times.</p>	A 285		

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A 285	<p>Continued From page 22</p> <p>9. Review of Tenant C2's file on 10/9/24 revealed staff administered his medications.</p> <p>Review of MARs for 2024 revealed the following :</p> <ul style="list-style-type: none"> - April MARs reflected an order for fish pill 1000 mg one capsule daily. It was charted as not given/not available or not charted at all over 15 times from 4/1/24 to 4/24/24. It was noted as on hold from 4/25/25 to 4/30/24. - July MARs reflected an order for compression stockings twice per day at 8:00 a.m. and 8:00 p.m. It was charted as not completed or not charted at all over 15 times. - August MARs (from 8/1/24 to 8/14/24) reflected an order for compression stockings twice per day at 8:00 a.m. and 8:00 p.m. It was charted as not completed or not charted at all over 15 times <p>The May Time Variance Reports reflected venlafaxine capsules 150 mg ER which was ordered at 8:00 a.m. was documented as given more than one hour after the prescribed time over 5 times.</p> <p>10. Review of Tenant C3's on 10/10/24 file revealed a Medication/Treatment Error Report dated 5/6/24 indicating nitrofurantoin 100 mg tablet twice daily was not administered to Tenant C3 at 8:00 p.m. on 5/3/24, 5/4/24 and 5/5/24. The 8:00 a.m. doses had been administered. There was no apparent reaction noted. Staff responsible for administering reported she did not find the medication cards and thought it had not arrived. It was noted as a category one error, an error that occurred but did not cause harm. The report indicated the medication cards were examined and the medication at 8:00 p.m. had not been administered on 5/3/24, 5/4/24 and 5/5/24.</p>	A 285		

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A 285	<p>Continued From page 23</p> <p>11. Review of Tenant C4's file on 10/10/24 revealed staff administered his medications.</p> <p>Review of MARs for 2024 revealed the following :</p> <ul style="list-style-type: none"> - May 2024 MARs reflected an order for Viteyes AREDS formula/lutein oral capsule twice daily was charted as not given/not available 9 times. Lubricating eye ointment once per day was charted as not given/not available over 10 times. Blood pressure check once per day was charted as not completed or not charted at all over 10 times. - June MARs reflected an order for lubricating eye ointment once per day was charted as not given or not charted at all over 15 times. The blood pressure check once per day was not documented as completed over 10 times. - July MARs blood pressure check once per day was not documented as being completed over 5 times. - August MARs reflected an order for Sertraline 100 mg 1/2 tablet daily was charted as drug not available 8 times. Lubricating eye ointment once per day was not documented as administered 8 times. Blood pressure check once per day was not documented as completed over 5 times. <p>12. When interviewed on 10/24/24 at 11:10 a.m. the Director of Nursing confirmed all MARs and orders were provided for the tenants reviewed. She also confirmed the timeframe for administration of medications was one hour before and one hour after the prescribed time.</p>	A 285		
A 145	<p>481-69.22(3) Evaluation of Tenant</p> <p>69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's</p>	A 145		

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A 145	<p>Continued From page 24</p> <p>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.</p> <p>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 4 of 7 current tenants reviewed (Tenant #1, #2, #3 and #5) and 1 of 4 discharged tenants reviewed (Tenant C2). Findings follow:</p> <p>1. Review of Tenant #1's file on 10/8/24 revealed Progress Notes indicating the following: <ul style="list-style-type: none"> - On 2/16/24 it was noted Tenant #1 fell on 2/15/24. - On 2/27/24 it was documented Tenant #1 fell on 2/25/24. She had a skin tear. - On 3/5/24 staff reported Tenant #1 was on the floor on 2/29/24 and 3/3/24. On 3/3/24 Tenant #1 was holding her head and she was sent out to the emergency department (ED) to be evaluated. - On 3/7/24 at 7:44 a.m. Tenant #1 lost her balance and fell. She hit her head on the air conditioner. - On 3/7/24 Tenant #1 was found on the floor next to her bed at 7:30 p.m. </p>	A 145		

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A 145	<p>Continued From page 25</p> <ul style="list-style-type: none"> - On 4/4/24 Tenant #1 was discharged from physical therapy (PT) on 4/3/24 and occupational therapy (OT) on 4/1/24. - On 4/29/24 it was documented Tenant #1 was found on the floor on 4/27/24. On 4/28/24 Tenant #1 was observed on the floor. - On 5/6/24 Tenant #1 was observed on the floor of her apartment. - On 5/22/24 Tenant #1 got out of her wheelchair independently and fell. - On 7/2/24 staff assisted Tenant #1 to transfer on 6/29/24 and her feet got tangled up. She was lowered to the floor. - On 7/8/24 staff reported Tenant #1 was found on the floor leaning against her bed on 7/5/24 at 7:15 a.m. - On 7/8/24 staff reported Tenant #1 was on the floor beside her bed on 7/5/24 at 4:45 p.m. - On 7/23/24 Tenant #1 had an unwitnessed fall in her apartment. - On 8/20/24 Tenant #1 was observed laying on the floor in front of her chair. - On 8/21/24 Tenant #1 fell while in the shower and hit her head. She was sent to the ED for evaluation. She returned with no new orders. - On 8/24/24 Tenant #1 fell and struck her head and complained of neck pain. She was sent to the ED for evaluation. She returned with a band-aid on her toe. - On 8/25/24 staff found Tenant #1 laying on the floor on the right side of her bed. <p>Continued record review revealed Tenant #1's most recent evaluations were dated 5/9/24. Since these last change of condition evaluations, Tenant #1 had an additional 10 falls. Evaluations were not completed as needed related to Tenant #1's continued falls.</p> <p>2. Review of Tenant #2's file on 10/9/24 revealed</p>	A 145		

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A 145	<p>Continued From page 26</p> <p>a Progress Note dated 8/8/24 indicating staff reported Tenant #2 was very agitated and confused and went into a female tenant's apartment and started touching her "private parts" while she laid in bed. Staff attempted to get him out of her apartment as he was agitated and violent. He grabbed staff's phone and punched staff.</p> <p>An Incident Report dated 8/6/24 at 7:45 p.m. indicated Tenant #2 was very agitated and confused and went to a female tenant's apartment and touched her "private parts" while she laid in bed. Staff attempted to have him leave the apartment but he became more agitated and violent. He punched staff and grabbed staff's phone.</p> <p>When interviewed on 10/8/24 at approximately 10:35 a.m. Staff A said staff tried to stop Tenant #2 when he went into Tenant #1's apartment and touched her. She said he had inappropriately touched other tenants. He had demonstrated physical behaviors towards staff when redirection occurred. He punched Staff A. He had also gone into Tenant #7's apartment. He thought she was his spouse.</p> <p>Tenant #2's most recent evaluations were dated 6/12/24 and were not completed as needed with Tenant #2's behavior noted above.</p> <p>3. Review of Tenant #3's file on 10/9/24 revealed Progress Notes indicating the following: - On 4/4/24 staff observed Tenant #3 walk out of the memory care with someone. Staff followed and returned him to the unit. Tenant #3 also made sexual comments towards staff and said he wanted to kiss them. - On 4/4/24 (late entry) a review of staff</p>	A 145		

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A 145	<p>Continued From page 27</p> <p>communication reports revealed on 3/23/24 Tenant #3 attempted to open the doors; on 3/25/24 he wanted staff to climb into bed with him; on 3/26/24 he displayed aggression and agitation towards staff and attempted to open the doors to leave; and on 3/28/24 he wanted to touch and kiss staff's hands, put his hands on staff and said sexual comments.</p> <ul style="list-style-type: none"> - On 4/15/24 staff reported Tenant #3 touched his genital area when they went into the apartment and did not stop touching himself while they were there. - On 4/23/24 Tenant #3 was seeing someone in his bathroom mirror, became violent and wanted to beat the person up. Staff covered the mirror with garbage bags. - On 4/28/24 staff reported he had behaviors related to nudity and inappropriate touching of his genitals when staff were present. <p>The tenant's most recent evaluations were dated 3/14/24 and 6/17/24. Evaluations were completed on 6/17/24; however, evaluations were not completed when the behaviors were observed in later March and April.</p> <p>4. Review of Tenant #5's file on 10/9/24 revealed Progress Notes indicating the following:</p> <ul style="list-style-type: none"> - On 4/15/25 staff reported incidents of Tenant #5 hitting staff twice during the day on 4/8/24. She had refused her morning medications, was agitated and exit seeking. - On 7/21/24 staff reported at 2:38 p.m. the tenant was being aggressive, agitated and more disoriented. She was being rude and struck staff four times with her hand and once with a soda can. - On 7/21/24 staff reported at 8:33 p.m. Tenant #5 became aggressive towards staff because they would not let her go into other tenants' 	A 145		

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A 145	<p>Continued From page 28</p> <p>apartments. She struck staff multiple times. Staff moved away from her but she continued to be aggressive.</p> <ul style="list-style-type: none"> - On 9/6/24 a staff communication sheet for 8/26/24 was received related to Tenant #5's behaviors. She had PRN orders in place for increased agitation. Staff were encouraged to use de-escalation tools. <p>When interviewed on 10/8/24 at approximately 10:35 a.m. Staff A said Tenant #5 fought everyone, she was very confused and wanted to get out. She displayed verbal and physical behaviors almost daily. Trazodone PRN was not always effective for her. There were days staff had to call the Director of Nursing (DON).</p> <p>When interviewed on 10/9/24 at 4:01 p.m. Staff F said Tenant #5 was physically and verbally aggressive, mainly towards staff. It was care related and occurred almost daily. No injuries ad occurred as a result of these behaviors.</p> <p>Tenant #5's most recent evaluations were dated 4/25/24. Evaluations were not completed with increased behaviors as noted above.</p> <p>5. Review of Tenant C2's file on 10/9/24 revealed Progress Notes indicated the following:</p> <ul style="list-style-type: none"> - On 8/12/24 at 8:15 a.m. Tenant C2 was in a physical altercation with staff. When staff attempted to de-escalate the situation, the tenant fell. He complained of back and hip pain. He was sent out to the hospital for evaluation and returned on 8/12/24. - On 8/15/24 Tenant C2 fell and complained of back pain and was sent out for evaluation. He was admitted with a compression fracture. - On 8/19/24 Tenant C2 was found on the floor, was sent out to the hospital and admitted. 	A 145		

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A 145	<p>Continued From page 29</p> <p>- On 8/30/24 Tenant C2's legal representative called and said the tenant would be admitted to hospice and only had a week or two to live. The legal representative was told that they could do hospice at the Program. The legal representative said she believed the tenant needed a higher level of care than the Program could provide.</p> <p>When interviewed on 10/23/24 at 10:21 a.m. Staff B said Tenant C2 displayed behaviors towards staff at least three to four times per week, both verbal and physical. He threw a frozen water bottle at her head once.</p> <p>When interviewed on 10/10/24 at approximately 9:50 a.m. Staff C said Tenant C2 was quite aggressive. She said the behaviors were mostly physical behaviors and usually on second shift. His behaviors had gotten progressively worse. She said the last few months, his dementia worsened which was pretty rough on him.</p> <p>Tenant C2's most recent evaluations were dated 7/12/24. Evaluations were not completed as needed related to the behaviors as noted above.</p> <p>6. When interviewed on 10/24/24 at 11:10 a.m. the DON confirmed all evaluations were provided for the tenants reviewed.</p>	A 145		
A 350	<p>481-69.26(1) Service Plans</p> <p>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</p>	A 350		

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A 350	<p>Continued From page 30</p> <p>needed.</p> <p>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 5 of 7 tenants reviewed (Tenants #1, #2, #3, #4, and #5) and 2 of 4 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow:</p> <p>1. Review of Tenant #1's file on 10/8/24 revealed Progress Notes indicating the following:</p> <ul style="list-style-type: none"> - On 2/16/24 it was noted Tenant #1 fell on 2/15/24. - On 2/27/24 it was documented Tenant #1 fell on 2/25/24. She had a skin tear. - On 3/5/24 staff reported Tenant #1 was on the floor on 2/29/24 and 3/3/24. On 3/3/24 Tenant #1 was holding her head and she was sent out to the emergency department (ED) to be evaluated. - On 3/7/24 at 7:44 a.m. Tenant #1 lost her balance and fell. She hit her head on the air conditioner. - On 3/7/24 Tenant #1 was found on the floor next to her bed at 7:30 p.m. - On 4/4/24 Tenant #1 was discharged from physical therapy (PT) on 4/3/24 and occupational therapy (OT) on 4/1/24. - On 4/29/24 it was documented Tenant #1 was found on the floor on 4/27/24. On 4/28/24 Tenant #1 was observed on the floor. - On 5/6/24 Tenant #1 was observed on the floor of her apartment. - On 5/22/24 Tenant #1 got out of her wheelchair independently and fell. 	A 350		

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A 350	<p>Continued From page 31</p> <ul style="list-style-type: none"> - On 7/2/24 staff assisted Tenant #1 to transfer on 6/29/24 and her feet got tangled up. She was lowered to the floor. - On 7/8/24 staff reported Tenant #1 was found on the floor leaning against her bed on 7/5/24 at 7:15 a.m. - On 7/8/24 staff reported Tenant #1 was on the floor beside her bed on 7/5/24 at 4:45 p.m. - On 7/23/24 Tenant #1 had an unwitnessed fall in her apartment. - On 8/20/24 Tenant #1 was observed laying on the floor in front of her chair. - On 8/21/24 Tenant #1 fell while in the shower and hit her head. She was sent to the ED for evaluation. She returned with no new orders. - On 8/24/24 Tenant #1 fell and struck her head and complained of neck pain. She was sent to the ED for evaluation. She returned with a band-aid on her toe. - On 8/25/24 staff found Tenant #1 laying on the floor on the right side of her bed. <p>Tenant #1's service plan dated 5/9/24 reflected Tenant #1 had a history of falls and drug her left foot when ambulating. The service plan reflected to ensure she had proper footwear, that her walker was accessible and the area was free of clutter. Staff were to remind her to ask for assistance with all transfers. Since the service plan update on 5/9/24 Tenant #1 had an additional 10 falls. The service plan was not updated to reflect additional interventions related to her safety.</p> <p>2. Review of Tenant #2's file on 10/9/24 revealed a Progress Note dated 8/8/24 indicating staff reported Tenant #2 was very agitated and confused and went into a female tenant's apartment and started touching her "private parts" while she laid in bed. Staff attempted to get him</p>	A 350		

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A 350	<p>Continued From page 32</p> <p>out of her apartment as he was agitated and violent. He grabbed staff's phone and punched staff.</p> <p>An Incident Report dated 8/6/24 at 7:45 p.m. indicated Tenant #2 was very agitated and confused and went to a female tenant's apartment and touched her "private parts" while she laid in bed. Staff attempted to have him leave the apartment but he became more agitated and violent. He punched staff and grabbed staff's phone.</p> <p>When interviewed on 10/8/24 at approximately 10:35 a.m. Staff A said staff tried to stop Tenant #2 when he went into Tenant #1's apartment and touched her. She said he had inappropriately touched other tenants. He had demonstrated physical behaviors towards staff when redirection occurred. He punched Staff A. He had also gone into Tenant #7's apartment. He thought she was his spouse.</p> <p>Tenant #2's service plan was dated 6/12/24 and reflected he had no behavior issues. The service plan was not updated as needed related to the behaviors noted above.</p> <p>3. Review of Tenant #3's file on 10/9/24 revealed Progress Notes indicating the following:</p> <ul style="list-style-type: none"> - On 4/4/24 staff observed Tenant #3 walk out of the memory care with someone. Staff followed and returned him to the unit. Tenant #3 also made sexual comments towards staff and said he wanted to kiss them. - On 4/4/24 (late entry) a review of staff communication reports revealed on 3/23/24 Tenant #3 attempted to open the doors; on 3/25/24 he wanted staff to climb into bed with him; on 3/26/24 he displayed aggression and 	A 350		

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A 350	<p>Continued From page 33</p> <p>agitation towards staff and attempted to open the doors to leave; and on 3/28/24 he wanted to touch and kiss staff's hands, put his hands on staff and said sexual comments.</p> <ul style="list-style-type: none"> - On 4/15/24 staff reported Tenant #3 touched his genital area when they went into the apartment and did not stop touching himself while they were there. - On 4/23/24 Tenant #3 was seeing someone in his bathroom mirror, became violent and wanted to beat the person up. Staff covered the mirror with garbage bags. - On 4/28/24 staff reported he had behaviors related to nudity and inappropriate touching of his genitals when staff were present. - On 5/23/24 staff reported Tenant #3 had torn his apartment apart and there was broken glass in his room. He uncovered his mirror and had broken picture frames. His cable box was pulled from the television and was thrown in the garbage. His sexual comments and touching had apparently stopped. Family was notified. <p>Review of the Monthly Task Logs reflected 7 refusals for bathing in April with no documented bathing completed, 4 bathing refusals and one documented bathing completed in May, 4 refusals for bathing in June, 7 refusals for bathing in July, 2 refusals in August and 3 bathing refusals in September.</p> <p>Tenant #3's service plans were dated 3/14/24 and 6/17/24. The service plan dated 6/17/24 reflected the history of sexual comments and behavior and the anxiety related to the mirror and his reflection. The service plan was updated; however, it was not updated when the behaviors were observed in late March and April. The service plan reflected Tenant #3 preferred whirlpools and did not like showers and would refuse if offered a shower.</p>	A 350		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2024
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NAME OF PROVIDER OR SUPPLIER STIRLINGSHIRE OF CORALVILLE MC	STREET ADDRESS, CITY, STATE, ZIP CODE 1140 KENNEDY PARKWAY CORALVILLE, IA 52241
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A 350	<p>Continued From page 34</p> <p>The service plan did not provide other interventions related to his routine refusals of bathing.</p> <p>4. Review of Tenant #4's file on 10/9/24 revealed Progress Notes indicating the following:</p> <ul style="list-style-type: none"> - On 4/11/24 Tenant #4 had bowel movement (BM) in the toilet and took it out with his hands and smeared it all over his bathroom, his furniture in the living room and himself. He smeared it in his eyes and mouth. Tenant #4 was cleaned up as well as his apartment. His physician's office was notified and it was determined he needed to go to the ED to have his eyes and possibly his nose flushed out. - On 4/19/24 it was noted staff reported on 4/17/24 that Tenant #4 was spitting on the floor wherever he wanted. - On 4/30/24 it was noted staff completed staff communication sheets on 4/28/24 and 4/29/24. On 4/28/24 Tenant #4 was spitting on the floor at meal times. On 4/29/24 Tenant #4 attempted to open exit doors. <p>Tenant #4's service plans were dated 4/8/24 and 7/3/24. The service plan dated 7/3/24 reflected spitting in inappropriate areas; however, the service plan was not updated to reflect the behavior when the behavior was observed in April. Additionally, the service plan did not reflect Tenant #4 had a history of smearing BM in his apartment and on his person.</p> <p>5. Review of Tenant #5's file on 10/9/24 revealed Progress Notes indicating the following:</p> <ul style="list-style-type: none"> - On 4/15/25 staff reported incidents of Tenant #5 hitting staff twice during the day on 4/8/24. She had refused her morning medications, was agitated and exit seeking. - On 7/21/24 staff reported at 2:38 p.m. the 	A 350		

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A 350	<p>Continued From page 35</p> <p>tenant was being aggressive, agitated and more disoriented. She was being rude and struck staff four times with her hand and once with a soda can.</p> <ul style="list-style-type: none"> - On 7/21/24 staff reported at 8:33 p.m. Tenant #5 became aggressive towards staff because they would not let her go into other tenants' apartments. She struck staff multiple times. Staff moved away from her but she continued to be aggressive. - On 9/6/24 a staff communication sheet for 8/26/24 was received related to Tenant #5's behaviors. She had PRN orders in place for increased agitation. Staff were encouraged to use de-escalation tools. <p>When interviewed on 10/8/24 at approximately 10:35 a.m. Staff A said Tenant #5 fought everyone, she was very confused and wanted to get out. She displayed verbal and physical behaviors almost daily. Trazodone PRN was not always effective for her. There were days staff had to call the Director of Nursing (DON).</p> <p>When interviewed on 10/9/24 at 4:01 p.m. Staff F said Tenant #5 was physically and verbally aggressive, mainly towards staff. It was care related and occurred almost daily. No injuries ad occurred as a result of these behaviors.</p> <p>Tenant #5's service plan dated 4/25/24 reflected she had occasional behavior issues and had a current or history of disruptive, aggressive, verbally or socially inappropriate behavior. It also reflected Tenant #5 had a history of care refusals. The service plan was not updated to reflect the extent of the tenant's increasing behaviors as noted above.</p> <p>6. Review of Tenant C2's file on 10/9/24 revealed</p>	A 350		

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A 350	<p>Continued From page 36</p> <p>a Progress Notes indicated on 8/12/24 at 8:15 a.m. Tenant C2 was in a physical altercation with staff. When staff attempted to de-escalate the situation, the tenant fell. He complained of back and hip pain. He was sent out to the hospital for evaluation and returned on 8/12/24.</p> <p>When interviewed on 10/23/24 at 10:21 a.m. Staff B said Tenant C2 displayed behaviors towards staff at least three to four times per week, both verbal and physical. He threw a frozen water bottle at her head once.</p> <p>When interviewed on 10/10/24 at approximately 9:50 a.m. Staff C said Tenant C2 was quite aggressive. She said the behaviors were mostly physical behaviors and usually on second shift. His behaviors had gotten progressively worse. She said the last few months, his dementia worsened and it was pretty rough on him.</p> <p>Tenant C2's service plan dated 7/12/24 reflected he had current or history of occasional behavior that was disruptive, aggressive or socially inappropriate. It indicated he might require special tolerance or staff training. The service plan was not updated as needed and did not reflect the extent of Tenant C2's behavior.</p> <p>7. When interviewed on 10/24/24 at 11:10 a.m. the DON confirmed all service plans were provided for tenants requested.</p>	A 350		
A 635	<p>481-69.32(2) Life Safety - Emergency Policies / Structure</p> <p>69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.</p>	A 635		

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A 635	<p>Continued From page 37</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to have an operating door alarm on each exit door in the memory care unit. This potentially affected all tenants (census of 19). Findings follow:</p> <ol style="list-style-type: none"> When observed on 10/10/24 at approximately 12:05 p.m. the door to the patio was not alarmed. The patio was elevated (not at ground level) and was fenced in. The rest of the exit doors were also observed. The lower level stairwell door had hardware on the door. The door was opened; however, the alarm was not audible. The Executive Director and Maintenance Director who were present reported the alarm went to phones carried by staff. Upon returning upstairs it was requested to see the phone to observe if a notification was received when the door was opened. There were three direct care staff in the unit and none of the staff had a phone with them. The Assistant Director of Nursing (ADON) left the memory care unit and went to the general population side of the building to get the phone. The ADON said one of the other staff had it. Once the phone was available for review it indicated a message had been sent regarding the exit door being opened. At the time the door was opened and no audible alarm was heard, a message was sent to phone to alert staff; however, none of the direct care staff in the memory care had a phone to be able to acknowledge and respond to the door alarm. When interviewed at the time of the observation on 10/10/24 at approximately 12:05 p.m. the Executive Director (ED) said at times the 	A 635		

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A 635	<p>Continued From page 38</p> <p>patio door was propped open and she confirmed the door was not alarmed, but said staff could lock it. She said staff were either outside with tenants on the patio or observing them from the windows. In addition, there were usually two phones in the memory care unit.</p> <p>When interviewed on 10/10/24 at 4:52 p.m. the ED confirmed an alarm had been put on the patio door.</p> <p>When interviewed on 10/10/24 at approximately 9:50 a.m. Staff C said tenants were sometimes on the patio without staff, however they could be seen through the windows.</p> <p>On 10/24/24 at 11:10 a.m. the Director of Nursing said the medication aides on each side (memory care and general pop) had a golden phone for communication between administration and staff. Pendants and door alarms also came to the phones. She said staff had tenants in eyeshot through the windows to the patio. They were not left unattended.</p> <p>3. On 10/10/24 review of the Program's policy regarding door alarms indicated all doors leading to the outside were alarmed.</p> <p>In summary, when observed initially the patio door was not alarmed. Additionally, when other exit doors were tested, one door did not have an audible alarm. Administrative staff explained the alarm did not sound at the door but instead went to staff phones. No staff responded to the alarm. None of the three staff in the memory care unit was carrying a phone which provided the alert that an exit door had opened.</p>	A 635		

Plan of Correction for Stirlingshire of Coralville In response to

Investigation #121001-C, Complaint #121004-C, and Stirlingshire of Coralville MC Revisit FC #10312

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Regulatory Insufficiency: Tenant Rights 481-67.3(2)

481-67.3(2) Tenant Rights. All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate.

- **Elements detailing how the program will correct the insufficiency.**
 - The DON and/or designee will ensure all leadership and or direct care staff will be notified of residents with special diet orders.
 - Resident code status documentation will be reviewed on all residents for completion and documentation stored in a common location.
 - All nursing team members will be re-educated regarding resident shower schedules and documentation of completion or resident refusal.
- **What measures will be taken to ensure the problem does not recur.**
 - Re-education will be completed with all nursing staff to include documentation of ADL's, where to locate any special diet orders, and where to locate residents code status documentation.
- **How the program plans to monitor performance to ensure compliance.**
 - Director of Nursing and or designee will periodically review where to find these supporting documents with floor staff and periodically check on staff documentation.
 - Regional Nurse and or designee will periodically audit supporting documentation for completion during visits to community.
- **The date by which the regulatory insufficiency will be corrected.**
 - This regulatory insufficiency will be corrected by 2/14/2025.

Regulatory Insufficiency: Medications 481-67.5(2) f(4)

67.5(2)f(4) Each program shall follow its own written medication policy, which shall include the following: When medications are administered traditionally by the program: Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.

- **Elements detailing how the program will correct the insufficiency.**
 - Certified Medication Aides will be re-education on Medication Administration Policy, Medication Administration Record Policy, and Medication Error Policy.
- **What measures will be taken to ensure the problem does not recur.**
 - The DON, ADON, and/or designee will routinely review resident medication administration records to ensure compliance.

- **How the program plans to monitor performance to ensure compliance.**
 - The Regional Nurse and/or designee will periodically audit supporting documentation for completion during visits to community.
- **The date by which the regulatory insufficiency will be corrected.**
 - This regulatory insufficiency will be corrected by 2/14/2025.

Regulatory Insufficiency: 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.

- **Elements detailing how the program will correct the insufficiency.**
 - DON or designee will update tenant's service plans and assessments at minimum annually and or with significant changes to accurately reflect tenant status and needs.
- **What measures will be taken to ensure the problem does not recur.**
 - DON and ADON will be educated on Resident Assessments Policy and triggers for a change in condition assessment.
- **How the program plans to monitor performance to ensure compliance.**
 - The DON, Regional Nurse, and/or designee will complete random audits of resident chart notes, assessments, and service plans to ensure accuracy and compliance.
- **The date by which the regulatory insufficiency will be corrected.**
 - This regulatory insufficiency will be corrected by 2/14/2025.

Regulatory Insufficiency: 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.

- **Elements detailing how the program will correct the insufficiency.**
 - Tenant's #1, #2, #3, and #5 service plans to be updated adequately to reflect specific care needs.
 - Tenant #4 moved out of community on 11/11/2024.
- **What measures will be taken to ensure the problem does not recur.**
 - Assessments and Service Plans will be created and kept updated to adequately reflect each tenants individualized care needs.
- **How the program plans to monitor performance to ensure compliance.**
 - The DON, Regional Nurse, and/or designee will complete random audits of resident chart notes, assessments, and service plans to ensure accuracy and compliance.
- **The date by which the regulatory insufficiency will be corrected.**
 - This regulatory insufficiency will be corrected by 2/14/2025

Regulatory Insufficiency: 481-69.32(2) Life Safety - Emergency Policies / Structure
69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program

- **Elements detailing how the program will correct the insufficiency.**
 - The patio door alarm was fixed on 10/10/24 and now alarms appropriately.
- **What measures will be taken to ensure the problem does not recur.**
 - The ED, DON, ADON, and/or designee will randomly check alarmed doors for proper functioning to ensure compliance.
- **How the program plans to monitor performance to ensure compliance.**
 - The Regional Nurse and/or designee will periodically audit supporting documentation for completion during visits to community.
- **The date by which the regulatory insufficiency will be corrected.**
 - This regulatory insufficiency was completed on 10/10/24.

Sincerely,

Amy Kubik- Hasley,
Executive Director