

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/03/2022
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NAME OF PROVIDER OR SUPPLIER PRAIRIE HILLS AT CLINTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 13TH AVENUE NORTH CLINTON, IA 52732
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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>General Population Number of tenants without cognitive disorder: 28 Number of tenants with cognitive disorder: 6</p> <p>Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 14 Total Census: 48</p> <p>No regulatory insufficiencies were cited regarding Complaint #973390-C or the onsite infection control survey.</p> <p>The following regulatory insufficiencies were cited during the investigation of Incident #97708-I and Complaint #101239-C as well as the recertification visit completed to determine if the program is in substantial compliance with certification rules for an ALP/D program.</p>	A 000		
A 130	<p>481-67.2(1)e Program Policies and Procedures</p> <p>67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:</p> <p>e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents.</p> <p>This REQUIREMENT is not met as evidenced</p>	A 130	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 130	<p>Continued From page 1</p> <p>by: Based on interview and record review the program failed to complete incident reports for 2 of 6 tenants reviewed (Tenant #5 and Tenant #6). Findings follow:</p> <p>1) Interview on 12/16/21 at 1:25 PM with the Clinical Educator revealed she received a telephone call from an unknown staff person at the program on 11/14/21 letting her know Tenant #5 returned from the Emergency Department (ED). The staff person provided her with the discharge information from the hospital for Tenant #5.</p> <p>A review of Tenant #5's record revealed no incident report for him on 11/14/21. There were no progress notes or hospital records regarding the incident.</p> <p>On 12/15/21 at 10:00 AM, the Director of Clinical Care reported the program had not had a copy of Tenant #5's Emergency Room (ER) discharge notes but received a copy from the hospital on that date. According to the hospital notes, on 11/14/21 the tenant was transported from the program by ambulance. According to the ER record, blood in his urine was noted 4 days prior and had gotten worse, so the patient was transported for an evaluation. The patient was complaining of increasing pain in his lower back. He reported dark urine but no blood clots in his urine. Tenant #5 reported having a hard time urinating at the time of the ER visit. A urinalysis was completed and no infection was found.</p> <p>A CT of his kidneys and bladder found his bladder was markedly distended. It could be secondary to outlet obstruction, possibly related to an enlarged prostate. There was also thickening of the</p>	A 130		

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A 130	<p>Continued From page 2</p> <p>posterior/lateral bladder wall.</p> <p>The doctor's impression was the patient was febrile but not hypoxic. Tenant #5 was very uncomfortable and had a palpable bladder. Moderate blood was noted on urinalysis. A foley catheter was inserted and over 1500 cc of brownish colored urine was evacuated. The patient reported significant improvement in his discomfort.</p> <p>On 12/16/21 at 10:00 AM, the Director of Clinical Care confirmed there was no incident report documenting Tenant #5 went to the emergency room on 11/14/21.</p> <p>2) Staff A reported an incident in which Tenant #6 called for help due to feeling short of breath. He was found in his apartment and sent to the emergency room where she believed he was hospitalized with pneumonia. A review of incident reports revealed there was not one for Tenant #6 with this description.</p> <p>During an interview with Tenant #6 on 12/20/21 at 1:45 PM, he revealed he pushed his pendant and felt as if it took staff two hours to arrive at his apartment. A review of a Device Activity Report revealed it took 41 minutes for staff to provide him with assistance at 4:12 AM on 11/20/21. Tenant #6 stated he rarely used his call button and only pressed it that night due to his shortness of breath. Tenant #6 reported he was hospitalized for 2.5 days for pneumonia.</p> <p>A review of facility progress notes with a "late entry" notation and dated 11/20/21 indicated Tenant #6 notified staff he was not feeling well and requested to go to the hospital. Tenant #6 was sent to the hospital and admitted for</p>	A 130		

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A 130	<p>Continued From page 3</p> <p>pneumonia.</p> <p>On 12/22/21 at 11:30 AM, the Portfolio Leader confirmed an incident report was not completed for Tenant #6 on 11/20/21.</p> <p>3) The program had an incident report policy which identified staff would notify the Nurse/Manager if a resident had fallen, had unusual behaviors or for any unusual event occurs. An incident form would be completed by the Nurse or Manager for documentation purposes. The Nurse was responsible to follow up with a review within 24 hours of a reportable incident and enter into Point Click Care (PCC).</p>	A 130		
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 adequate care and treatment to 1 of 5 tenants reviewed (Tenant #5). Findings follow:</p> <p>1) Interview on 12/16/21 at 1:25 PM with the Clinical Educator revealed she received a telephone call from an unknown staff person at the program on 11/14/21 letting her know Tenant #5 returned from the Emergency Department. The staff person faxed her with discharge</p>	A 160		

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A 160	<p>Continued From page 4</p> <p>information from the hospital for Tenant #5.</p> <p>A review of Tenant #5's record revealed no information of an incident for him on 11/14/21 in the progress notes, medical records or incident reports.</p> <p>On 12/16/21 at 10:00 AM, the Director of Clinical Care reported the program had not had a copy of Tenant #5's Emergency Room (ER) notes but received a copy from the hospital that morning (12/16).</p> <p>According to the hospital notes, the tenant was transported from the program by ambulance on 11/14/21. According to the ER record, blood in his urine was noted 4 days prior and had gotten worse, so the patient was transported for an evaluation. The patient was complaining of increasing pain in his lower back. He reported dark urine but no blood clots in his urine. Tenant #5 reported having a hard time urinating at the time of the ER visit. A urinalysis was completed and no infection was found. A CT of his kidneys and bladder found his bladder was markedly distended. It could be secondary to outlet obstruction, possibly related to an enlarged prostate. There was also thickening of the posterior/lateral bladder wall. The ER doctor's impression was the patient was febrile but not hypoxic. Tenant #5 was very uncomfortable and had a palpable bladder. Moderate blood was noted on urinalysis. A foley catheter was inserted and over 1500 cc of brownish colored urine was evacuated. The patient reported significant improvement in his discomfort. The discharge plan directed staff to have Tenant #5 follow up with a urologist within ___ (there was no set number of days on the plan). The tenant was to stop taking Xarelto (a medication used to treat</p>	A 160		

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A 160	<p>Continued From page 5</p> <p>blood clots) until seen by the urologist.</p> <p>On 12/16/21 at 11:00 AM, the Clinical Educator reported she left a message at the urologist's office stating the tenant was taken off his Xarelto and needed to be seen as soon as possible. She could not remember the date and could provide no documentation.</p> <p>On 12/16/21 at 1:50 PM, staff at the urologist's office reported they had no record of this message and did not have an appointment scheduled for Tenant #5.</p> <p>On 12/16/21 at 1:25 PM, Staff A reported she recalled Tenant #5 was urinating blood for a few days prior to his emergency room visit on 11/14/21 and reported pain. When she returned to work following his emergency room visit, Tenant #5 had a catheter. Staff A recalled other Resident Assistants at the program asking her how to provide catheter care for Tenant #5 as they were not familiar with this. Staff A assisted them with this as there was not a nurse in the building. Staff A did not report her concerns to the on-call nurses who were available by phone.</p> <p>On 12/21/21 at 8:45 AM, Staff C reported she was aware Tenant #5 returned from the emergency room with a catheter. She only provided catheter care to Tenant #5 once. One time she took another staff person to Tenant #5's apartment to empty his catheter because the staff person did not know how to do this.</p> <p>On 12/21/21 at 9:10 AM, Staff D reported Staff C taught her how to do catheter care for Tenant #5 as she was not familiar with how to do it.</p> <p>On 12/16/21 at 1:45 PM, the Director of Clinical</p>	A 160		

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A 160	<p>Continued From page 6</p> <p>Care confirmed she was not aware Tenant #5 returned from the emergency room with a catheter.</p> <p>On 12/15/21 at 8:50 AM and 12/16/21 at 11:25 AM, Tenant #5's hospice nurse reported she received a call from a staff person at the program notifying her Tenant #5 was in pain on 11/14/21. The staff person informed her Tenant #5's family wanted him sent to the emergency room. As Tenant #4 was receiving hospice, that service needed to be revoked in order for him to receive emergency treatment. The hospice nurse sent the appropriate paperwork to the program and the documents were signed that day. The hospice nurse did not recall being notified by anyone at the program of Tenant #5 experiencing pain or blood in his urine prior to 11/14/21. The nurse reported hospice was a service to keep a patient comfortable at home and prevent pain. It would have been appropriate for program staff to notify her if Tenant #5 was having symptoms.</p> <p>2) A review of ER records dated 11/21/21 revealed Tenant #5 was found in his room at the program at 6:16 PM drooling and staring off into space. He was sent to the ER where he presented with right arm numbness and facial droop. He had a history of strokes affecting his left side, dementia and A-fib (atrial fibrillation). Tenant #5 came in with a foley catheter. An EKG, CT scan and chest X-ray were completed. The neurology consult note documented the tenant had a history of A-fib but was not on anticoagulation medication (Xarelto had been discontinued on 11/14/21 at his last ER visit). The ED discharge summary note stated Tenant #5 had a stroke with mild left-sided weakness. Tenant #5 transferred to a different hospital where he remained until 12/8/21.</p>	A 160		

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A 160	Continued From page 7 Tenant #5's hospital course notes recorded he had a history of paroxysmal atrial fibrillation and presented without anticoagulation medication and a history of stroke. Tenant #5 was admitted for acute onset of altered mental status, aphasia and left facial droop. Tenant #5 was found to have an acute left middle cerebral artery stroke. This was felt to be cardioembolic due to the patient's atrial fibrillation, which he was not on an anticoagulation for. The patient did not require intervention and was treated with a heparin drip followed by the start of Eliquis (an anticoagulant). He continued to experience a left facial droop and dysphasia which speech therapy was evaluating. Tenant #5 did well on a pureed diet with frequent reminders regarding swallowing techniques. He was unable to follow commands and had incomprehensible speech. The patient was also treated for a symptomatic urinary tract infection during this hospitalization. He complained of suprapubic pain and burning when incontinent. A urinalysis was checked and initially grew gram negative rods (GNR) for which Tenant #5 was started on an antibiotic. The tenant's cultures were also positive for pan-sensitive E Coli as well as ESBL Proteus. He was treated with three days of Meropenem per infectious disease's recommendations. 3) The Director of Clinical Care and Portfolio Leader confirmed these findings on 1/3/22 at 1:50 PM.	A 160		
A 270	481-67.5(2)f(1) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following:	A 270		

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A 270	<p>Continued From page 8</p> <p>f. When medications are administered traditionally by the program:</p> <p>(1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure 4 of 9 staff reviewed completed a department approved medication manager course prior to administering medication to tenants (Staff D, Staff E, Staff F, Staff I). Findings follow:</p> <p>1) Record review on 12/14/21 revealed Staff D was hired on 8/11/21. Staff D had a certificate in her personnel record indicating she completed the Medication Management Course on 6/15/21, prior to her date of employment.</p> <p>On 12/21/21 at 11:15 AM, Staff D denied she had taken a medication management course as she was working at a restaurant on 6/15/21 and would not have been employed by an assisted living program which would have offered her medication management training. It could not be</p>	A 270		

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A 270	<p>Continued From page 9</p> <p>determined where this certificate came from.</p> <p>Staff D administered medication to tenants at the program prior to passing a medication manager course.</p> <p>2) Staff E was hired on 7/15/21. She had not passed a medication manager course.</p> <p>On 12/14/21 at 10:10 AM, Staff E reported she occasionally passed medication to tenants when there were no other staff members available to do this task.</p> <p>3) Staff F was hired on 10/4/21. She had not passed a Medication Manager course. A review of the Medication Administration Record (MAR) for Tenant #5 for the months of October and November 2021 revealed Staff F administered medication to him during these months.</p> <p>4) Staff I was hired on 8/24/21. She did not have a medication manager certificate in her record.</p> <p>On 12/21/21 at 10:30 AM, Staff I reported she previously administered medication to tenants. Staff I was told at one time not to do this any longer, however if the program was short staffed and there was no one else to administer medication, she might still do it.</p> <p>The Portfolio Leader confirmed these findings on 12/21/21 at 12:55 PM.</p>	A 270		
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>	A 285		

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A 285	<p>Continued From page 10</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 medication as prescribed by primary care provider (PCP) for 4 of 9 current (Tenant #1, Tenant #2, Tenant #3, Tenant #4) and 1 of 6 former (Tenant C4) tenants reviewed. Findings follow:</p> <p>1) Record review on 12/14/21 revealed Tenant #1 had signed orders from her physician for 50mg. of nitrofurantoin Macrocrystal capsules dated 9/23/21. She was to receive one capsule by mouth at bedtime for preventative treatment of urinary tract infections. A review of the Medication Administration Record (MAR) revealed the nitrofurantoin Macrocrystal capsules were only administered on 9/25/21, 9/26/21, 9/30/21, 10/7/21, 10/9/21, 10/10/21, 10/14/21, 10/15/21, 10/16/21 and 10/17/21.</p> <p>A Health Status note revealed Tenant #1's urine was cultured and it was determined she had a urinary tract infection on 10/14/21. She was prescribed an antibiotic on 10/14/21.</p> <p>These findings were confirmed by the Director of Clinical Care on 12/20/21 at 1:40 PM.</p> <p>2) A review of progress notes for Tenant #2 revealed the Health Care Coordinator talked with</p>	A 285		

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A 285	<p>Continued From page 11</p> <p>the tenant's daughter on 10/12/21 informing her she would need to access hospice services for her father or find another assisted living program due to him requiring more assistance on a consistent level. A progress note on 10/15/21 marked "late entry" documented Tenant #2's family met with hospice for admission that day. The program would follow up once he was admitted into the service. On 10/18/21, Tenant #2 was increasingly agitated and combative during cares. Staff attempted redirection but it was ineffective. The tenant was hitting staff during continence cares. New orders were received and noted.</p> <p>A review of orders from the hospice provider dated 10/14/21 indicated three medications for Tenant #2 were to be discontinued on that date: donepezil (a medication used to treat Alzheimer's disease), Mybetriq (a medication used to treat overactive bladder) and Remeron (a medication used to treat depression). According to the tenant's MAR, he continued to receive these meds until 10/19/21.</p> <p>These findings were confirmed by the Director of Clinical Care on 12/20/21 at 3:35 PM.</p> <p>3) Tenant #3 was seen by her primary care provider (PCP) on 11/7/21. According to the PCP's notes, Tenant #3 was seen for an evaluation of management and treatment of vascular dementia, hypertension, hypothyroidism and related metabolic diseases. The tenant had aggressive behavior which was fairly predictable.</p> <p>The PCP developed a plan of care to increase Tenant #3's seroquel (a medication used to treat mood and mental disorders) to 100 mg. twice daily due to the behaviors and dangers to staff.</p>	A 285		

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A 285	<p>Continued From page 12</p> <p>The program was also to increase Tenant #3's lorazepam to 1 mg. three times a day. Staff were to make sure they were giving the tenant the lorazepam one hour prior to showers as this was when she became the most combative with staff.</p> <p>A Progress Note with a descriptor of "late entry" dated 11/7/21 indicated Tenant #3 was seen on 11/2/21 and 11/7/21 due to her advancing dementia, weakness, incontinence and hypothyroidism. Tenant #3 displayed severe behaviors with staff for showers, and incontinence care. Staff reported she pulled their hair, pinched, hit and scratched. Tenant #3's seroquel and lorazepam were increased on 11/7/21.</p> <p>A review of the November MAR revealed no change to Tenant #3's medication following her visit with the PCP on 11/7/21. Her seroquel was not increased in November or December through 12/20/21. Tenant #3 was not started on lorazepam 1mg. three times a day. She was not given any lorazepam prior to a shower in the month of November following her appointment with her PCP.</p> <p>The Portfolio Leader confirmed these findings on 12/22/21 at 2:06 PM.</p> <p>4) Tenant #4 had a comprehensive assessment completed on 11/23/21. According to the assessment, Tenant #4 had a history of falls over the past three months, occurring on 8/24/21 and 10/6/21. The assessment noted Tenant #4 had an order from her physician to be treated for physical and occupational therapy as needed.</p> <p>The program had an order from Tenant #4's provider for the tenant to receive an evaluation for</p>	A 285		

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A 285	<p>Continued From page 13</p> <p>physical therapy on 10/12/21.</p> <p>On 12/20/21 at 1:40 PM the Director of Clinical Care reported she could not find evidence Tenant #4 was referred for physical therapy .</p> <p>5) A review of progress notes for discharged Tenant C4 revealed on 3/9/21 the Health Care Coordinator left a message for the PCP because the tenant was refusing to eat, throwing up her pills and refusing to take her medication. Tenant C4's daughter reported the behaviors were intermittent. Tenant C4 went to the doctor on 3/11/21 and was diagnosed with a urinary tract infection (UTI) and a yeast infection. The doctor reportedly stated the UTI was contributing to the nausea, vomiting and decline in cognition/paranoia. Staff were to administer medication if Tenant C4 would take them and notify the doctor if Tenant C4 refused them. On 3/12/21, the RN, Health Care Coordinator documented Tenant C4 started her antibiotic therapy the previous evening for treatment of the UTI. Fluids were being encouraged as well. Tenant C4 was to be monitored closely. New orders came in on 3/15/21 to discontinue the Amoxicillin due to culture results and start a new antibiotic.</p> <p>A review of medication orders revealed Tenant C4 was prescribed Amoxicillin, an antibiotic, on 3/11/21. She was to take 1 tablet three times every day for 10 days. Tenant C4 received two doses on 3/12/21 and one dose on 3/15/21 according to her MAR (Medication Administration Record). She was put on a new antibiotic on 3/15/21, which was started on 3/16/21. The new antibiotic was to be given twice a day for 10 days. The tenant received 13 of 20 doses of the antibiotic medication according to the MAR.</p>	A 285		

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A 285	<p>Continued From page 14</p> <p>On 12/21/21 at 8:45 AM, Staff C reported it was not unusual for tenants' new medications to take several days to one week to be placed on the MAR. She could not think of a specific situation. The Health Care Coordinator would say she was working on getting a medication put on the MAR. The Heath Care Coordinator was often out of the building.</p> <p>Staff D reported in the past there were situations in which it could take 3-4 days for medications to be put on the MAR for tenants. Staff D could not remember any specific tenant or medication when questioned on 12/21/21 at 9:10 AM.</p> <p>6) The Director of Clinical Care confirmed these findings on 12/20/21 at 1:40 PM.</p>	A 285		
A 325	<p>481-67.9(1) Staffing</p> <p>67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to provide sufficient staff to meet the needs of tenants potentially affecting all tenants (census of 48). Findings follow:</p> <p>A group interview with 17 tenants on 12/15/21 revealed concerns with the time it took staff to respond to emergency pendants, especially on the second and third shifts and weekends. Tenants reported it could take up to one hour for staff to respond to their apartments when they</p>	A 325		

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A 325	<p>Continued From page 15</p> <p>pressed their emergency pendants.</p> <p>A Device Activity Report dated 11/15/21 to 12/16/21 was produced by the program with information on response times from staff following a tenant pushing the emergency pendant. The report was 51 pages long, with approximately 15 entries to a page. The longest response time was 174 minutes and the shortest response time was 1 second (a time of 326 minutes was disregarded as the tenant's pendant was malfunctioning).</p> <p>Of the 51 pages of the Device Activity Report 23 pages were calls from tenants who did not have their pendants answered within 7 minutes (approximately 345 emergency pendant notifications).</p> <p>Approximately 165 calls from tenants (11 of 51 pages), were not responded to by staff within 14 minutes.</p> <p>Approximately 60 calls from tenants (4 of 11 pages), were not responded to within 27 minutes by staff.</p> <p>Tenants pushed their emergency pendants 14 times and the calls were not responded to within 63 minutes.</p> <p>The program's Staffing policy noted they would employ sufficient trained staff to be available to meet identified tenant needs. Staff would be available 24-hours a day to respond to emergencies. Tenants were to access staff in an emergency by activating the provided emergency pendant system.</p> <p>On 1/3/22 at 12:58 PM, the Portfolio Leader</p>	A 325		
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A 325	Continued From page 16 reported the expectation within the building was staff would respond to a call from a tenant within 7 minutes. The Manager received a notification on their phone whenever a pendant was not answered within 5 minutes.	A 325		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to document initial training for 5 of 8 newly hired staff reviewed (Staff E, Staff F, Staff I, Staff J and Staff K). Findings follow: Record review on 12/14/21 revealed Staff E was hired on 7/15/21. The Health Care Coordinator did not document any training of Staff E to ensure she was sufficiently trained to complete the tasks she was assigned. Staff F had a hire date of 10/4/21. The Health Care Coordinator did not document any training of Staff F to ensure she was sufficiently trained to complete the tasks she was assigned. Staff I was hired on 8/24/21. There was documentation in her personnel record of delegation training by the Health Care	A 345		

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A 345	<p>Continued From page 17</p> <p>Coordinator 10/5/21. However, the training did not occur within Staff I's first 30 days of employment.</p> <p>Staff J had a hire date of 11/11/21. The Health Care Coordinator did not document any training of Staff J to ensure she was sufficiently trained to complete the tasks she was assigned.</p> <p>Staff K was hired on 4/9/21. There was documentation in her personnel record of delegation training by the Health Care Coordinator 6/2/21. However, the training did not occur within Staff K's first 30 days of employment.</p> <p>The Manager confirmed these findings on 12/14/21 at 3:40 PM.</p>	A 345		
A 380	<p>481-67.9(6) Staffing</p> <p>67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to provide Dependent Adult Abuse Training as required by Iowa Code section 235B.16 to 2 of 8 employees reviewed (Staff G and Staff K). Findings follow:</p> <p>Record review on 12/14/21 revealed Staff G was hired on 5/26/21. There was no evidence of dependent adult abuse training in her personnel file.</p> <p>Staff K was hired on 4/9/21 and did not have a</p>	A 380		

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A 380	<p>Continued From page 18</p> <p>dependent adult abuse training certificate in her file.</p> <p>Staff D was hired on 8/11/21. Her dependent adult abuse training certificate was dated 4/1/21. Staff D reported on 12/21/21 at 11:15 AM she did not complete dependent adult abuse training on that date.</p> <p>Staff I was hired on 8/24/21 and had a dependent adult abuse training certificate dated 4/1/21. Staff I reported on 12/21/21 at 11:00 AM she did not complete dependent adult abuse training on that date.</p> <p>Staff H was hired on 8/19/21 and also had dependent adult abuse training certificate dated 4/1/21.</p> <p>The Manager reported on 12/27/21 at 5:25 PM, she reviewed the dependent adult abuse training certificates for all employee files on 12/14/21. She found 12 employees with the same certificate. The Manager contacted the Department of Human Services, the agency who issued the certificates, to determine if they were authentic.</p> <p>The Manager confirmed the findings for Staff G and Staff K on 12/14/21 at 3:40 PM.</p>	A 380		
A 400	<p>481-67.19(3) Record Checks</p> <p>67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this</p>	A 400		

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A 400	<p>Continued From page 19 state.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to conduct a background check prior to hiring 2 of 8 employees (Staff G and Staff K). Findings follow:</p> <p>Record review on 12/14/21 revealed Staff G was hired on 5/26/21. The program did not complete a background check prior to starting her employment.</p> <p>Staff K was hired on 4/9/21. The program completed a background check on 12/4/21, not prior to her first day of employment. Staff K did not have a criminal history or a history of abuse.</p> <p>The Manager confirmed these findings on 12/14/21 at 3:40 PM.</p>	A 400		
A 155	<p>481-69.23(1)b Criteria for Admission / Retention of Tenants</p> <p>69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who:</p> <p>b. Requires routine, two-person assistance with standing, transfer or evacuation</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 2 of 5 tenants reviewed who routinely required two-person assistance with transfers (Tenant #2 and Tenant #3). Findings</p>	A 155		

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A 155	<p>Continued From page 20</p> <p>follow:</p> <p>1) Record review on 12/21/21 revealed Tenant #2 was diagnosed with Alzheimer's disease, aphasia following cerebral infarction, benign prostatic hyperplasia, major depressive disorder and a history of falling. A Comprehensive Assessment was completed for Tenant #2 on 10/13/21. Tenant #2 was a one person assist with transfers while using a wheelchair at the time the assessment was completed. Tenant #2 had a history of multiple falls. He had a fall mat alarm on the floor provided by his family. There were also side rails on his bed. A note on 10/15/21 (late entry) indicated Tenant #2's family met with hospice. The Health Care Coordinator documented Tenant #2 was increasingly agitated and combative during cares. Attempted redirection from staff was ineffective. Tenant #2 was hitting staff when they provided continence cares. His physician sent over orders for new medication.</p> <p>2) Tenant #3 was diagnosed with vascular dementia with hypertension, hypothyroidism and related metabolic diseases. Tenant #3 had an appointment with her Primary Care Provider (PCP) on 11/7/21. He documented Tenant #3's conditions had advanced to the point of requiring long-term care. The PCP noted Tenant #3 had aggressive behavior which was fairly predictable, but dangerous to staff.</p> <p>On 12/14/21 at 11:00 AM, Staff B stated Tenant #2 hit, kicked and scratched when staff attempted to transfer him. It took two staff members to safely transfer him. He would also try to stand up and sit down while using the toilet so two staff members needed to be there to help him with this. Staff B reported if Tenant #3 became physically aggressive, she was not safe to</p>	A 155		

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A 155	<p>Continued From page 21</p> <p>transfer with only one person.</p> <p>On 12/14/21 at 8:50 AM, Staff C reported Tenant #2 and Tenant #3 were unsafe to transfer alone.</p> <p>On 12/14/21 at 9:30 AM, Staff D reported Tenant #2 often stood up and down when attempting to transfer him or help him with toileting. She stated Tenant #3 became physically aggressive during transfers which was why two staff members needed to be present to keep him safe.</p> <p>On 12/14/21 at 10:10 AM, Staff E reported she believed both Tenant #2 and Tenant #3 required two staff members to assist them when transferring.</p> <p>On 12/20/21 at 3:35 PM, the Director of Clinical Care reported staff attempted to transfer Tenant #2 alone three times that day and were unable to do it.</p> <p>On 12/20/21 at 12:45 PM, the Portfolio Leader reported the program had a waiver for Tenant #3, submitted in March 2021, as they knew she exceeded level of care, but this expired on 9/30/21. The program did not apply for a new waiver.</p>	A 155		
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 needed.</p>	A 350		

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A 350	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure service plans were updated as needs changed for 2 of 5 tenants reviewed (Tenant #4 and Tenant #5). Findings follow:</p> <p>1) Record review on 12/20/21 revealed a Progress Note dated 11/23/21. According to the Progress Note, Tenant #4 was in the memory care courtyard and trying to leave the program. Tenant #4 was fighting and hitting staff. The Emergency Medical Services (EMS) and police were called but they refused to take Tenant #4 to the hospital as she did not want to go. After the police left the building, Tenant #4 broke a piece of the gutter off the down spout, entered the building and attempted to hit staff with the gutter. EMS was contacted again and took Tenant #4 to the emergency room where she was treated and released back to the program.</p> <p>A Nurse Review dated 11/26/21 indicated Tenant #4 was upset and wanted to call her brother. Staff attempted to redirect Tenant #4 at which point she became angry with them. Tenant #4 was again upset with staff on 11/28/21 and went to the memory care courtyard area. She refused to take her medication. Tenant #4 went to the emergency room for treatment of her distress. Tenant #4 received new medication orders at the emergency room. On 11/29/21, she became agitated and attempted to hit staff and leave the building. Tenant #4 saw the nurse practitioner on 12/7/21 and received a new order for medication to assist with severe agitation and refusal to take medication, if she continued to refuse her daily pills. A Nurse Review dated 12/11/21</p>	A 350		
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A 350	<p>Continued From page 23</p> <p>documented staff reported to the on-call nurse Tenant #4 was using her cane to strike out at staff. The on-call nurse informed staff to take the tenant's cane and give Tenant #4 her walker to use. Staff also were directed to wait and ask another staff member to give pills to Tenant #4 if she refused.</p> <p>Tenant #4 had a Service Plan dated 11/23/21. According to her Service Plan, Tenant #4 had mild to moderate disorientation. She demonstrated deficits in judgement and related safety with a history of paranoia. Tenant #4 had a diagnosis of anxiety and major depressive disorder, recurrent. Staff were to encourage Tenant #4 to express her feelings as needed. They were to notify the nurse of changes in her mood/behavior or worsening anxiety. Tenant #4's service plan identified she needed assistance with ordering medication. Staff were to administer her medications. Tenant #4's Service Plan indicated she was independent with ambulation. It did not note the use of a cane or walker. Tenant #4's Service Plan did not address her physically aggressive behaviors toward staff or her medication refusals.</p> <p>On 12/14/21 at 11:00 AM Staff B reported being harmed by Tenant #4. Staff B recalled Tenant #4 got her on the floor and had her knee on Staff B's neck. On another occasion, Tenant #4 grabbed two staff member's by the ponytails and banged their heads together. Tenant #4 was responding better to a new medication she was prescribed, according to Staff B.</p> <p>On 12/14/21 at 8:50 AM, Staff C said Tenant #4 tried to hurt staff who worked at the program.</p> <p>Staff D stated Tenant #4 slammed two staff</p>	A 350		
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A 350	<p>Continued From page 24</p> <p>member's heads together during an interview on 12/14/21 at 9:30 AM. She stated Tenant #4's aggression had improved with a medication change.</p> <p>On 12/14/21 at 10:10 AM, Staff E reported Tenant #4 hit staff, especially those who worked on the second shift.</p> <p>The Director of Clinical Care confirmed Tenant #4's service plan did not address all of her identified needs on 12/20/21 at 1:40 PM.</p> <p>2) A review of progress notes revealed an entry on 9/23/21 by Health Care Coordinator indicating Tenant #5 was yelling at staff for the past week. Tenant #5 insisted he had a pill due at midnight and staff were waking him up for it. The Health Care Coordinator told him staff were not doing this and tried to speak with Tenant #5 about it but he would not redirect. Staff reported Tenant #5 pushed his pendant to scream at them. On 9/24/21, the Health Care Coordinator noted Tenant #5 was in the office yelling about missing his oxycodone. They discussed the timing of his medication. On 9/29/21, Tenant #5 was in the office yelling at the nurse and other staff, calling them vulgar names and worthless people who would not help him call his doctor. They gave the tenant his doctor's phone number. The Health Care Coordinator noted Tenant #5 was having a psychotic episode associated with his schizophrenia diagnosis. His physician was notified as well as hospice. The physician started Tenant #5 on a new medication.</p> <p>Interview on 12/16/21 at 1:25 PM with the Clinical Educator revealed she received a telephone call from an unknown staff person at the program on 11/14/21 letting her know Tenant #5 returned from</p>	A 350		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/03/2022
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NAME OF PROVIDER OR SUPPLIER PRAIRIE HILLS AT CLINTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 13TH AVENUE NORTH CLINTON, IA 52732
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A 350	<p>Continued From page 25</p> <p>the Emergency Department. The staff person provided her with the discharge information from the hospital for Tenant #5.</p> <p>On 12/15/21 at 10:00 AM, the Director of Clinical Care reported the program did not have a copy of Tenant #5's Emergency Room (ER) discharge notes at that time but received a copy from the hospital. According to the hospital notes, on 11/14/21, the tenant was transported from the program by ambulance. According to the ER record, blood in his urine was noted 4 days prior and had gotten worse, so the patient was transported for an evaluation. The patient was complaining of increasing pain in his lower back. He reported dark urine but no blood clots in his urine. Tenant #5 reported having a hard time urinating at the time of the ER visit. A urinalysis was completed and no infection was found.</p> <p>A CT of his kidneys and bladder found his bladder was markedly distended. It could be secondary to outlet obstruction, possibly related to an enlarged prostate. There was also thickening of the posterior/lateral bladder wall.</p> <p>The ER doctor's impression was the patient was febrile but not hypoxic. Tenant #5 was very uncomfortable and had a palpable bladder. Moderate blood was noted on urinalysis. A foley catheter was inserted and over 1500 cc of brownish colored urine was evacuated. The patient reported significant improvement in his discomfort.</p> <p>On 12/16/21 at 1:25 PM, Staff A reported she recalled Tenant #5 was urinating blood for a few days and reported pain. Staff A did not notify the on-call nurse Tenant #5 was urinating blood. When she returned to work a few days later,</p>	A 350		

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A 350	<p>Continued From page 26</p> <p>Tenant #5 had a catheter.</p> <p>On 12/15/21 at 8:50 AM and 12/16/21 at 11:25 AM, Tenant #5's hospice nurse reported she received a call from a staff person at the program notifying her Tenant #4 was in pain on 11/14/21. The staff person informed her Tenant #5's family wanted him sent to the emergency room. As Tenant #5 was receiving hospice, that service needed to be revoked in order for him to receive emergency treatment. The hospice nurse sent the appropriate paperwork to the program and the documents were signed that day.</p> <p>The hospice nurse reported Tenant #5 could be extremely verbally inappropriate. He made comments about wanting to have female staff members assist him with showering and became angry when the hospice nurse arranged to have a male aide assist with his showers.</p> <p>On 12/14/21 at 8:50 AM, Staff C reported Tenant #5 was often sexually and verbally inappropriate to staff. He would masturbate in front of staff. Staff C would not enter his apartment unless she was administering his medication.</p> <p>Tenant #5 had a service plan dated 2/19/21. Tenant #5 was to shower/bathe on Wednesday and Friday on the day shift, provided by the Hospice Aide. Tenant #5 needed assistance with transfers in and out of the showers and cues to wash and dry himself. There was no mention of Tenant #5 masturbating in the shower or how staff should address this. Tenant #5 had mild to moderate disorientation or difficulty recalling/retaining information. Staff were to administer his medication. There were no interventions for staff on how to assist Tenant #5 if he became upset during the administration</p>	A 350		

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A 350	Continued From page 27 process. Tenant #5 was noted to be independent with continence cares. There was no mention of Tenant #5 using a catheter. Tenant #5's service plan did not address sexual or verbally aggressive behaviors. 3) The Portfolio Leader confirmed these findings on 1/3/22 at 12:50 PM.	A 350		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide 8 of 8 employees reviewed (Staff D, E, F, G, H, I, J and K) with eight hours of dementia specific education within 30 days of beginning employment. Findings follow: Record review on 12/14/21 revealed Staff D was hired on 8/11/21. She did not receive eight hours of dementia specific education within 30 days of her hire date. Staff E was hired on 7/15/21. She did not receive eight hours of dementia specific education within 30 days of her hire date. Staff F was hired on 10/4/21. She did not receive	A 545		

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A 545	<p>Continued From page 28</p> <p>eight hours of dementia specific education within 30 days of her hire date.</p> <p>Staff G was hired on 5/26/21. She did not receive eight hours of dementia specific education within 30 days of her hire date.</p> <p>Staff H was hired on 8/19/21. She did not receive eight hours of dementia specific education within 30 days of her hire date.</p> <p>Staff I was hired on 8/24/21. She did not receive eight hours of dementia specific education within 30 days of her hire date.</p> <p>Staff J was hired on 11/11/21. She did not receive eight hours of dementia specific education within 30 days of her hire date.</p> <p>Staff K was hired on 4/9/21. She did not receive eight hours of dementia specific education within 30 days of her hire date.</p> <p>The Manager confirmed these findings on 12/14/21 at 3:40 PM.</p>	A 545		
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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the program failed to ensure the alarm system was utilized on all exit doors affecting 1 of 1 former tenants reviewed specific to Incident</p>	A 635		

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A 635	<p>Continued From page 29</p> <p>#97708 (Tenant C1), and potentially affecting all current tenants (census 48). Findings follow:</p> <p>1) An incident report dated 5/19/21 revealed the Life Enrichment Coordinator (LEC) was returning from transporting another tenant that day when she observed Tenant C1 in the parking lot. She was wearing a t-shirt, sweatshirt, jeans and tennis shoes. The temperature outside was 74 degrees. The LEC brought Tenant C1 into the building. The Healthcare Coordinator assessed Tenant C1 and determined she had no injuries. Tenant C1 stated she was looking for her mother outside the building but could not report how she got out doors due to her confusion.</p> <p>On 12/16/21 at 2:35 PM, the LEC confirmed the information in the incident report. She pulled into the program's parking lot and found Tenant C1 standing by a lamp post appearing confused. The LEC was unsure how long Tenant C1 was outside the building. The LEC returned Tenant C1 to the program and determined no one was aware she was out of the building.</p> <p>Review of Tenant C1's file revealed a diagnosis of unspecified dementia without behavioral disturbance. Her Global Deterioration Scale score was a 6 indicating severe cognitive decline. She had a history of wandering in the building but was not known to open doors in an attempt to go outside. The tenant lived in the general population of the program. Following the elopement, she was moved to the locked unit.</p> <p>On 12/21/21 at 9:50 AM, Staff N stated she believed Tenant C1 left the building on 5/19/21 via the 200 hallway exit door (a hallway in the general population unit). Staff N recalled seeing the door wide open that day. Staff N recalled when the</p>	A 635		

DEPARTMENT OF INSPECTIONS AND APPEALS

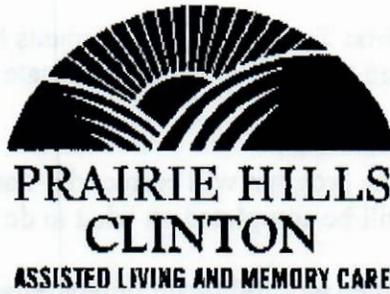
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A 635	<p>Continued From page 30</p> <p>former maintenance person worked at the program, he would leave the building doors open with the alarm off when tenants were moving in or out.</p> <p>2) Observation of the front entrance door throughout the day on 12/13/21, 12/14/21 and 12/15/21 revealed individuals were able to enter and exit the program. There was no evidence the locking or alarm system on the main entrance door was in use.</p> <p>On 12/16/21 at 1:45 PM, the Assistant Manager reported the main entrance door was not locked or alarmed until the last management person left at the end of the day. Until about three weeks ago, the door was kept locked and she scanned people in and out of the building. However, currently it was not locked or alarmed. The monitoring systems did alert staff when individuals entered or exited through the door on their iPads, but staff did not respond to the front door. The Assistant Manager, who sat at the front desk, confirmed there were times she was not at her seat and would not be able to monitor if there were cognitively impaired individuals who wandered in and out of the building. The Assistant Manager did not think there were any individuals with cognitive impairment living outside of the memory care unit. According to the Entrance Form, there were six tenants with a Global Deterioration Score of 4 or above living in the unsecured (general population) part of the building as of 12/13/21.</p> <p>On 12/21/21 at 8:45 AM, Staff C reported the main entrance doors were locked and alarmed up until three weeks ago. They were open since that time.</p>	A 635		

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A 635	<p>Continued From page 31</p> <p>On 12/21/21 at 9:10 AM, Staff D reported the main entrance doors were unlocked about 3-4 weeks ago so individuals could go in and out. Prior to that, people needed a code to enter and exit the building.</p> <p>Staff M reported the main entrance doors were locked at night but unlocked during the day on 12/21/21 at 9:30 AM.</p> <p>On 12/27/21 at 5:25 PM, the Manager reported the main entrance doors were locked until 11/29/21. At that point her boss asked why the main entrance doors were locked and she was told they needed to remain unlocked. The Manager locked and alarmed the main entrance doors when she left at the end of the day.</p> <p>On 12/16/21 at 2:50 PM the Portfolio Leader confirmed the program doors should be locked and alarmed.</p>	A 635		



March 14th, 2022

Prairie Hills at Clinton: Recertification, Investigation #97330-C, #97708-I, #101239-C, Onsite
Infection Control Survey

Iowa Department of Inspections and Appeals
Health Facilities Division
Lucas State Office Building
321 East 12th St.
Des Moines, IA 50319-0083

To Whom It May Concern:

Please consider this as our plan of correction for the Statement of findings/violations cited during 11/3/2021 incident survey completed by the Iowa Department of Inspections and Appeals in accordance with the Code 295.1090.

- A. 481-67.2(1)e Program Policies and Procedures:** The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents.
1. Elements detailing how the program will correct the statement of findings/violations.
 - a. All staff will be reeducated on incident reports; timepoints of completion and how to accurately complete
 - b. The new Healthcare Coordinator will be trained on incident reports timepoints and completion along with Point Click Care (PCC) process and the appropriate follow-up documentation.
 2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance

5/6/22

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

1. Elements detailing how the program will correct the statement of findings/violations.
 - a. Staff education will be completed on what to do when a resident returns from the ER
 - b. HCC and/or designee will follow up timely regarding medication changes, ensure that appropriate follow up is completed and will ensure ISP is updated as appropriate.
2. What measures will be taken to ensure the problem does not recur?
 - ~~a. New Healthcare Coordinator will be educated/trained on sending residents to the emergency department and following up upon return to community.~~
 - b. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

C. 481-67.5(2)f(1) Medications: Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (1) The administration of medications shall be provided by a registered nurse, licenses practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manger course and passed the respective department-approved medication aide or medication examination, or by a PA in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by law by a RN, LPN, ARNP, physician, pharmacist, or PA.

1. Elements detailing how the program will correct the statement of findings/violations.
 - a) All current RA's will have the required Medication Management Course completed before passing medications.
 - b) All new hires will complete the required Medication Management Course within 30 days of hire.
2. What measures will be taken to ensure the problem does not recur?
 - a) All current RA's will have the required Medication Management Course completed before passing medications.
 - b) All new hires will complete the required Medication Management Course within 30 days of hire.
 - c) Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

D. 481-67.5(2)f(1) Medications: Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.

1. Elements detailing how the program will correct the statement of findings/violations.
 - a) All current clinical staff will be reeducated on the 6 Rights of Medication Administration.
 - b) All new clinical staff will be reeducated on the 6 Rights of Medication Administration.

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2. What measures will be taken to ensure the problem does not recur?
 - a) Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

E. 481-67.9(1) Staffing: Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

1. Elements detailing how the program will correct the statement of findings/violations.
 - a. All current staff will be reeducated on pendant use and response time expectations
 - b. All new hires will be educated on pendant use and response time expectations.
2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

F. 481-67.9(4) Staffing: Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

1. Elements detailing how the program will correct the statement of findings/violations.
 - a. All current staff will have delegations completed before providing cares.
 - b. New HCC will complete staff delegations within 60 days of hire.
 - c. All new clinical staff will be delegated within 30 days of hire.

2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

G. 481-67.9(6) Staffing: Dependent adult abuse training. Program staff shall receive training related to the identification and reporting of dependent adult abuse as required by Iowa code section 235B.16.

1. Elements detailing how the program will correct the statement of findings/violations.
 - a. All current staff will have the required D.A.A. training completed
 - ~~b. All new hires will have the required D.A.A. training completed within 30 days of hire~~
2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

H. 481-67.19(3) Record Checks: Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.

1. Elements detailing how the program will correct the statement of findings/violations.
 - a. All current employees have background check on file.
 - b. All new hires will have background check completed prior to hire.
2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

I. 481-69.23(1)b Criteria for Admission/Retention of Tenants: Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b/
Requires routine, two-person assistance with standing, transfer or evacuation.

1. Elements detailing how the program will correct the statement of findings/violations.
 - a. Tenant # 2 DIA granted a health care waiver on 03/10/2022.
 - b. Tenant # 3 was issued a 30-day discharge notice on 02/28/2022 due to resident being outside AL criteria.

- c. New HCC will be trained/educated on Iowa Regulations related to admission/retention of tenants into Assisted Living.
- 2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance.

J. 481-69.26(1) Service Plans: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(a) 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.

- 1. Elements detailing how the program will correct the statement of findings/violations.
 - a. New HCC will be trained/educated on Service Plan requirements, timepoints of completion Annually or with any change of condition.
- 2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance

K. 481-69.30(1) Dementia Specific Education for Personnel: All personnel employed by or contracted with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.

- 1. Elements detailing how the program will correct the statement of findings/violations.
 - a. All current staff will have the required Dementia Specific education training completed.
 - b. All new hires will have the required Dementia Specific education training completed within 30 days of employment.
- 2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance

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

1. Elements detailing how the program will correct the statement of findings/violations.
 - a. All current staff will be reeducated on use of door alarms, notification and appropriate response
 - b. All new hires will be reeducated on use of door alarms, notification and appropriate response

2. What measures will be taken to ensure the problem does not recur?
 - a. Director and/or designee will monitor that the solutions implemented are in place: weekly, monthly, as needed as determined by the Director/RN or designee to ensure compliance

All corrections will be in place by 04/08/2022

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 regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Regards,



Amy McAtee

Portfolio Leader, Jaybird Senior Living
Interim Director, Prairie Hills at Clinton