DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 33 Number of tenants with cognitive impairment: 3 Total census: 36 The following regulatory insufficiencies were cited during the investigation of Complaints #119128-C, #119210-C, #119290-C and #119291-C:	A 000	See Attached POC 6/21/24	
A 105	481-67.2 Program Policies and Procedures 481-67.2 Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop incident reporting policies and procedures to meet the minimum standards and include all requirements. This	A 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 105	Continued From page 1 potentially affected all tenants (census of 36). Findings follow: 1. Record review on 2/29/24 of the Program's Incidents/Accidents policy and procedure indicated when there was an occurrence that resulted in an "unintentional Consequences and unfortunate happening" to a tenant, visitor or staff, an incident report would be be completed. The policy directed to notify the nurse as soon as possible if there was an injury, complete the form as soon after the incident with the Director of Resident Services, the Program would follow Iowa Code 235B and 235E and Iowa Administrative Code 481 Chatper 67.2 and 67.4 related to dependent adult abuse and the Program would follow procedures related to the Iowa Medicaid Critical Incident Report. 2. Continued record review revealed the policy and procedure provided related to incidents did not include the following required information: incident reports should be completed in detail on the form, the person in charge at the time of the incident should complete the form, any witnesses to the incident should complete a witness statement and a copy of the incident report would be maintained for a minimum of three years. 3. When interviewed on 3/6/24 at 12:20 p.m. the Executive Director confirmed all policies and procedures requested were provided.	A 105		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 2 which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide tenants with adequate and appropriate care, treatment services. This pertained to of 4 of 8 tenants reviewed (Tenants #2, #3, #6 and #7). Findings follow: 1. When interviewed on 3/5/24 at approximately 11:40 a.m. Tenant #2 reported she was supposed to receive a daily bath. She reported it occurred maybe two or three times per week. Record review on 2/27/24 of Tenant #2's file revealed the service plan reflected daily assistance with bathing. The January 2024 Activities of Daily Living (ADL) Log reflected shower assistance; however, it was listed at twice weekly. The ADL Log did not reflect completion of the bathing task daily as indicated on the service plan. The ADL Log also reflected dressing assistance twice daily. It reflected over 10 omissions when the dressing task was not documented as completed. The laundry was scheduled weekly and was documented twice for the month of January. The February 2024 ADL Log reflected shower assistance twice weekly; the service plan reflected it was scheduled daily. It was documented as completed four times in February. Dressing assistance was scheduled twice daily and there were over 10 omissions when it was not documented as completed. Laundry was scheduled weekly and was documented as	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 3	A 160		

completed twice in February.

The March ADL Log reflected bathing twice weekly and not daily as indicated on the service plan. There were no documented entries for bathing completed when provided on 3/5/24. The ADL Log reflected dressing assistance twice daily. There were two omissions when the task was not documented as completed from 3/1/24 to 3/5/24.

2. When interviewed on 3/5/24 at 11:55 a.m. Tenant #7 said it seemed like they were short staffed and staff did not help him put on his socks (hose) three to four times per week.

Record review on 3/5/24 of Tenant #7's file revealed the January medication administration record (MAR) reflected staff assisted with application of anti-embolism hose in the morning at 8:00 a.m. and removal at night at 8:00 p.m. It was charted as refused eight times. There were omissions on 1/21/24, 1/28/24 and 1/31/24. On 1/28/24 and 1/31/24 staff charted at 8:00 p.m. the hose were removed despite no documentation on 1/28/24 and 1/31/24 at 8:00 a.m. that the hose were applied by staff.

The February 2024 MAR reflected 10 omissions when Tenant #7's anti-embolism hose were not applied and all were at 8:00 a.m. There were also four charted refusals. When the 10 omissions occurred in the morning, staff charted they removed the hose on the dates they were not charted as being applied.

When interviewed on 3/5/24 at 2:32 p.m. Staff C said there had been times showers were not completed, maybe once per month. She said some staff would not go to Tenant #7's apartment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 4	A 160		

and would not put his anti-embolism hose on. The staff charted refused on the medication administration record when it occurred.

3. Record review on 2/27/24 of Tenant #3's file revealed the service plan reflected Tenant #3 received staff assistance including with bathing, dressing, laundry and medications. The January 2024 ADL Log reflected shower assistance was completed twice weekly starting on 1/18/24 and there were no documented entries of the task. Tenant #3 received assistance with her anti-embolism hose twice daily by either herself or the staff. There were no documented entries from 1/18/24 to 1/31/23. Tenant #3 was to have weekly housekeeping and there was one entry completed from 1/18/24 to 1/31/24. Tenant #3 was to receive laundry assistance weekly and there were no documented entries from 1/18/24 to 1/31/24. Medication administration was to be provided twice daily and was documented one time from 1/18/24 to 1/31/24.

4. Record review on 3/5/24 of Tenant #6's file revealed the service plan reflected staff assisted with bathing. The January 2024 ADL log reflected bathing assistance twice weekly and it was documented as completed once in January. Laundry was scheduled to be completed weekly and was documented as completed one time in January.

The February ADL Log bathing assistance twice weekly and it was was documented as completed once in February. Laundry was scheduled to be completed weekly and was not documented as completed.

The March ADL Log reflected bathing assistance twice weekly and it was not documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 5 completed (records collected on 3/5/24). Laundry was scheduled to be completed weekly and was not documented as completed (records collected on 3/5/24). 5. When interviewed on 3/4/24 at 1:56 p.m. Staff F said there was not enough staff and laundry and showers were not done at times. She said it happened maybe twice per week. When interviewed on 3/4/24 at 3:45 p.m. Staff I said sometimes laundry and showers were not getting done at the preferred time. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services reported on 3/5/24 a family member voiced a complaint regarding a tenant's linens not being washed. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services confirmed all ADL Logs for the tenants that had documentation of tasks were provided.	A 160		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 6	A 285		

by:
Based on observation, interview and record review the Program failed to administer medications and complete treatments as ordered. This pertained to 5 of 7 tenants reviewed that had medications administered (Tenants #1, #2, #3, #4 and #8). Findings follow:

1. When interviewed on 2/29/24 at 11:25 a.m. Staff A reported Tenant #1 had a hole in her toe and her bone could be seen. She said it had been that way since she started (December 2023). Her dressing change was scheduled every two days with Aquacel AG and gauze. She put Bacitracin on it because it stuck and pulled when removed. She said she asked the Former Health and Wellness Director about doing it. Staff A said Tenant #1 never refused the dressing change for her. She reported one time the Medication Administration Record (MAR) reflected refusals and the dressing was not changed for eight days. She explained Tenant #1 used to wear tight black shoes and now wore white shoes that were bigger. She complained to the Former Health and Wellness Director many times about it.

When interviewed on 2/28/24 at 7:49 a.m. Primary Care Provider (PCP) #1 revealed Tenant #1 was supposed to follow up in one week from 11/21/23 regarding her toe wound and was not seen again until 2/5/24. She said the dressing change was ordered three times per week and as needed. On 2/22/24 when PCP #1 pulled off the dressing there was an odor to it. The bone was exposed. It was noted Tenant #1 was not wearing open toed shoes. The dressing change for the wound was changed to daily.

When interviewed on 2/29/24 at 2:10 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 7	A 285		

Director of Clinical Services reported when she saw Tenant #1's toe wound before it was a tiny scab. When observed on 2/29/24 it was an open area on the second toe of the right foot. She said Tenant #1 started on an antibiotic yesterday. She said the nurse should look at it a couple times per week.

Record review on 2/27/24 of Tenant #1's file revealed orders and discharge summaries indicated the following:

-On 9/5/23 Tenant #1 was seen in the emergency department (ED) for an abrasion of the right third toe and orders were received to follow abrasion care instructions and follow up with her PCP.

-On 9/21/23 Tenant #1 as seen in the ED for cellulitis of the toe. It was noted she had redness and swelling in her toe. She was to avoid wearing hard shoes and was prescribed an antibiotic for the next seven days.

-On 9/28/23 it was noted a referral was made to the wound clinic, to apply Bactroban ointment to her toe wound twice daily and to change dressing to toe wound twice daily. It was also noted to not let her wear shoes that rubbed on her toe.

-An undated Physician Order Sheet indicated the ulcer was on the dorsal aspect of right second toe to the bone. The physician ordered Aquacel AG applied the ulcer three times per week and wrapped with gauze. Follow up in one week.

-A Physician Order Sheet dated 11/9/23 indicated the wound was debrided. To continue wound care as ordered.

-A Physician Order sheet dated 11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 8	A 285		

indicated to apply Aquacel AG as primary, rolled gauze as secondary and to change three times per week. It also indicated to follow up on 11/29/23.

Continued record review revealed medication administration records (MARs) for November 2023, December 2023, and January 2024 reflected the order for Aquacel AG 2 x 2, apply Aquacel AG to ulcer and wrap the toe with gauze three times per week (order date of 10/12/23), as well as an order for Kerlix, apply Aquacel AG to the ulcer and wrap with toe with gauze three times per week.
-The November 2023 MAR reflected 13 entries, including 8 charted as not completed and documented as tenant refused.
-The December 2023 MAR reflected 13 entries, including 5 charted as not completed and documented as tenant refused.
-The January 2024 MAR reflected 13 entries, including 6 charted as not completed and documented as tenant refused.

Continued record review revealed Wound Clinic documentation dated 2/5/24, indicated Tenant #1's accompanying family member indicated she had some digestive issues that prevented her from keeping her appointments. The toe ulcer dated back to at least September 2023. The wound was located on the right second toe and measured 0.5 x 0.7 x 0.2 centimeters (cm). Her right foot was warm to touch, as was her lower right extremity. The right second toe was large compared to other toe. The wound was 90% bone and 10% dried drainage. Debridement was completed to remove dried drainage. The assessment indicated it was pressure injury of the right foot toe and it was at a stage 4. The orders indicated to apply Aquacel AG, gauze and tape

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 9	A 285		

three times per week and as needed. She would be fitted for an open toed orthopedic shoe.

Wound Clinic documentation dated 2/22/24, documented a concern the ulcer had a foul odor. The measurement of the wound included 0.6 x 0.7 x 0.4 cm. The assessment indicated it was a chronic right foot toe ulcer with necrosis of the bone. The document indicated conservative wound care failed and she was referred to a podiatrist regarding amputation of the toe. The dressing was betadine, Aquacel AG, rolled gauze and the dressing was to be completed daily.

Further record review revealed a podiatry clinic document dated 2/26/24 indicated Tenant #1 was seen for an initial evaluation of the right second toe wound. She reported she had the wound for about six months. She reported it worsened lately and she noticed redness and increased drainage. The wound dressing was Aquacel daily. The measurement of the wound included: 0.6 x 0.8 x 0.5 cm. It was indicated as a non-pressure chronic ulcer of part of the right foot with necrosis of the bone. An order was received for levofloxacin 750 milligram (mg) tablet daily.

A Physician Order Sheet dated 3/4/24 indicated to continue levofloxacin 750 mg daily and to continued Aquacel AG to the right second toe daily.

Continued record review revealed the February 2024 MARs reflected reflected the order for Aquacel AG 2 x 2, apply Aquacel AG to ulcer and wrap the toe with gauze three times per week (order date of 10/12/23). There was also an order for Kerlix, apply Aquacel AG to the ulcer and wrap with toe with gauze three times per week. The MAR was not updated after the 2/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 10	A 285		

visit and did not reflect the dressing change was three times per week and as needed. The as needed order was not reflected on the February MAR and was not documented as completed.

The February 2024 MAR was updated on 2/28/24 and reflected a new order to apply Aquacel AG and wrap the toe with gauze daily and reflected the discontinuation of the Aquacel AG three times per week order. The order was written dated 2/22/24; however, was not placed on the MAR until 2/28/24. Additionally, the 2/26/24 order for levofloxacin 750 milligram (mg) was placed on the MAR on 2/28/24. The first dose was documented as given on 2/28/24.

The Program failed to provide Tenant #1 wound care to her right toe wound as ordered and medication as ordered.

2. When interviewed on 3/4/24 at 4:20 p.m. PCP #2 revealed she first saw Tenant #2 on 12/11/23 when she took over her care as her PCP. Tenant #2 took her medications independently but she had concerns about her taking them appropriately. Tenant #2 was hospitalized on 1/7/24 and on 1/15/24 the Program started to manage her medications. She said communication fell through the cracks with nursing staff regarding the international normalized ratio (INR) and recommendations and Tenant #2 voiced concerns she was not receiving the correct medications.

When interviewed on 2/28/24 at approximately 11:15 a.m. Tenant #2 said she previously had issues with her medications. She said she did not feel all the way safe and her provider told her she was not safe related to her warfarin (blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 11	A 285		

thinner). Tenant #2 explained she received too much medication.

Record review on 2/27/24 revealed Quick Notes (electronic nurse's notes) documented 1/4/24 (noted 1/8/24) Tenant #2 was sent to the hospital due to chest pain and shortness of breath. On 1/9/24 it was noted Tenant #2 would be discharged back to the Program on 1/10/24 and the PCP wanted the staff to administer her medications.

Record review of orders included Patient Discharge Instructions, dated 1/10/24, reflected Tenant #2 admitted on 1/7/24 for chest pain and dyspnea and discharged on 1/10/24. The hospital records reflected new medications and changed medications including: Lovenox 120 milligram (mg)/0.8 milliliter (ml) 120 mg injected subcutaneously (SQ), once a day for 14 days; continue the medication along with warfarin; discontinue Lovenox injections when the INR reached 2 or above and then continue with warfarin alone (next dose was 1/11/24); Warfarin 4 mg daily (next dose was 1/11/24).

The facility failed to ensure discharge instructions were noted when received.

Continued record review revealed Tenant #2's January 2024 MARs reflected no medications administered from 1/11/24 to 1/17/24. The MARs reflected the following medications were not administered as ordered and were reflected charted as withheld per DR/RN orders from 1/21/24 to 1/26/24: Lovenox injection 120/0.8 ml, warfarin, allopurinol tablet 300 mg, metoprolol succinate tablet 25 mg ER, Clopidogrel 75 tablet, and isosorbide mononitrate mono tablet 60 mg ER, from 1/21/24 to 1/26/24; however, no orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 12 to hold the medications listed above were provided. Record review of orders revealed the former Health and Wellness Director sent a fax to the PCP dated 1/11/24 requesting an updated medication list before the Program began administering Tenant #2's medications. The PCP signed the fax sheet on 1/15/24 and attached the medication list. The medication list failed to indicate the orders were noted. One page of the fax report was unavailable. The Patient Communication document indicated current orders as of 1/16/24, included: Lovenox 120 mg/0.8 ml, SQ, 0.8 ml injected SQ every 12 hours until INR was greater than 2; Warfarin 5 mg tablet daily. A fax to the PCP dated 1/17/24 indicated the Program would begin to administer her medications now that they had a list of her medications and she was entered into the system. Continued record review of the January 2024 MARs revealed the following: -Lovenox 120 mg, inject 0.8 ml SQ every 12 hours until her INR was above 2 was documented as administered 13 times from 1/17/24 to 1/31/24. It was documented as not administered 16 times and charted as held per DR/RN order or medication not available. There was no order found to hold the Lovenox. Lovenox was not administered per order. -Warfarin 5 mg tablet, take one tablet daily was administered 4 times and not documented as administered once from 1/17/24 to 1/21/24. It was charted as held per DR/RN order; however, no order was found to hold the medication. Warfarin was not administered per order.	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 13 Record review of Tenant #2's orders indicated the following a PCP clinic note dated 1/22/24 (office visit) indicated Tenant #2 went to the ED on 1/21/24 due to her left hand bleeding and she was on anti-coagulation medications. She had other abrasions on her forearm, wrist, hand and left middle finger. It also indicated to follow up on her mood disorders, it indicated Tenant #2 picked her skin as a relieving factor related to her mood disorder. She picked when she was anxious. The document indicated her INR had been subtherapeutic for weeks after months of not checking her INR after her prior PCP left. It was complicated by Tenant #2's medication non-compliance. Her INR was 1.6 and would be rechecked on 1/26/24. The orders were not noted when received. New orders were received including Coumadin decreased to 3 mg daily and to recheck in 3 days and Lovenox was reflected as ordered on 1/16/24 with no changes. Continued record review revealed the January 2024 MARs reflected the following: -Warfarin 3 mg tablet, take one tablet by mouth daily with a start date of 1/22/24 and a stop date of 1/26/24 was documented as not administered 1/23/24 to 1/25/24 and it was charted as held per DR/RN orders; despite no order to hold the medication. The dose on 1/22/24 was not documented as administered and no explanation was provided. Warfarin was not administered as ordered. -Lovenox 120 mg, inject 0.8 ml SQ every 12 hours until her INR was above 2 was documented as administered 13 times from 1/17/24 to 1/31/24. It was documented as not administered 16 times and charted as held per DR/RN order or	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 14	A 285		

medication not available. There was no order found to hold the Lovenox and it was not administered per order.

Record review of orders revealed a PCP clinic document (Patient Plan) dated 1/26/24 indicated Tenant #2's INR was 1.3 and to recheck her INR on 1/30/24. The orders indicated to continue Lovenox and new orders were received for warfarin 3 mg once daily and 1 mg on Saturday, Tuesday and Thursday. The orders were not noted when received. A PCP clinic document (office visit) dated 1/26/24 indicated Tenant #2 was not sure if she was taking warfarin. She did not feel they were administering her Lovenox injections. The Program was contacted and verified twice they were dispensing and giving her the medication.

Continued record reviewed revealed the January 2024 MARs reflected the following:

-One order for warfarin 3 mg tablet, take one tablet by mouth daily at 8:00 p.m. on Sunday, Monday, Wednesday and Friday with a start date of 1/26/24 and a stop date of 1/31/24. It was documented as administered once on 1/31/24. It was documented as given by Staff D at 8:00 p.m.

-Another order for warfarin 3 mg tablet, take one tablet every Sunday, Monday, Wednesday and Friday at 8:00 a.m. with a start date of 1/27/24 and a stop date of 2/1/24. It reflected doses were given on 1/28/24, 1/29/24 and 1/31/24. On 1/31/24 was documented as given by Staff A at 8:00 a.m.

-A third order for warfarin 1 mg tablet take by mouth daily on Tuesdays, Thursdays and Saturdays at 8:00 a.m. with a start date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 15	A 285		

1/26/24 and stop date of 1/31/24 reflected one dose on 1/27/24 was charted as physically unable to take and one dose was documented as given on 1/30/24.

The MARs reflected warfarin twice daily at 8:00 a.m. and 8:00 p.m. despite only being ordered once daily. On 1/31/24 it was documented as administered twice once at 8:00 a.m. and once at 8:00 p.m. The MARs also failed to reflect warfarin 3 mg order as daily and it was reflected as Sunday, Monday, Wednesday and Friday, despite it ordered daily. The additional 1 mg of warfarin ordered on Saturday, Tuesday and Thursday, was not administered on 1/27/24 (Saturday). Warfarin was not administered per order.

-Lovenox 120 mg, inject 0.8 ml SQ every 12 hours until her INR was above 2 was documented as administered 13 times from 1/17/24 to 1/31/24. It was documented as not administered 16 times and charted as held per DR/RN order or medication not available. There was no order found to hold the Lovenox and it was not administered per order.

Record review revealed a PCP clinic document dated 1/31/24 indicated after reviewing INR instructions for 1/26/24 it should have been 3 mg daily and an additional 1 mg on Tuesday, Thursday and Saturday. Tenant #2's INR was 1.5. New orders were received to increase warfarin to 4 mg daily, to take 1 mg today (1/31/24) since 3 mg had been given (total of 4 mg) and to continue Lovenox. It was scheduled to recheck her INR on 2/2/24. The orders were not noted.

Continued record review revealed the January

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 16	A 285		

2024 MARs reflected the following:

-Warfarin 4 mg daily was not reflected as a current order on the MAR. The added 1 mg dose ordered on 1/31/24 to add to the existing 3 mg dose on 1/31/24 (for a total of 4 mg) was not documented as administered. Warfarin was not administered per order.

-Lovenox 120 mg, inject 0.8 ml SQ every 12 hours until her INR was above 2 was documented as administered 13 times from 1/17/24 to 1/31/24. It was documented as not administered 16 times and charted as held per DR/RN order or medication not available. There was no order found to hold the Lovenox and it was not administered per order.

Record review revealed a PCP clinic document dated 2/2/24 indicated Tenant #2 was seen for long term anticoagulants. Her INR was 3.9 An order was received dated 2/2/24 to stop Lovenox and change warfarin to 3 mg on 2/2/24, 2/4/24, and 2/5/24 and 4 mg on 2/3/24. It indicated to recheck the INR on 2/6/24. It also indicated Tenant #2 reported staff did not give her the Lovenox for three days. The dates she did not get Lovenox were 1/25/24, 1/26/24 and 1/27/24 per the Former Health and Wellness Director. Tenant #2 had an appointment on 1/31/24 and the provider that saw her was not informed she did not get Lovenox on those days. The orders were not noted.

Continued record review revealed the February 2024 MARs reflected the following:

-Warfarin 3 mg tablet, take one tablet by mouth on 2/2/24, 2/4/24 and 2/5/24 was documented as administered on 2/4/24 and 2/5/24; however, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 17	A 285		

not documented as administered on 2/2/24. Warfarin 4 mg, take one tablet, by mouth on 2/3/24 was not documented as administered. Warfarin was not administered as ordered.

-Lovenox 120 mg, inject 0.8 ml SQ every 12 hours until her INR was above 2 was documented as not administered on 2/1/24 both doses and was charted as medication not available and physically unable to take. On 2/2/24 at 8:00 p.m. it was not given and the reason indicated Tenant #2 told staff her PCP told her to stop taking it. Lovenox was not administered as ordered.

Record review of orders revealed a PCP document (patient communication), dated 2/6/24, reflected Tenant #2's INR was critical lab value and was 6.9. New orders were received to hold warfarin for the next two days and recheck her INR on 2/8/24. The orders were not noted. A PCP clinic document dated 2/8/24 indicated Tenant #2 was seen for anti-coagulation and a urinary tract infection. Tenant #2's INR was 6.1. Orders were received to continue to hold warfarin until 2/12/24 and to recheck the INR. If the INR was below 2 would start Eliquis.

Continued record review revealed the February 2024 MARs reflected Warfarin 1 mg tablet on Tuesdays, Thursdays and Saturdays (discontinued on 1/31/24) was documented as administered on 2/3/24 and 2/6/24. It was charted as tenant refused on 2/8/24 and 2/10/24 and it was noted Tenant #2 said her PCP did not want her to take the medication. On 2/13/24 it was charted as physically unable to take and on 2/15/24 was charted as withheld per DR./RN orders. Warfarin was not administered per order.

A PCP Patient Communication document dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 18	A 285		

2/13/24 indicated orders were received to discontinue all warfarin and start Eliquis 5 mg twice daily. The orders were not noted.

Continued record review revealed the February 2024 MARs reflected Eliquis 5 mg tablet twice daily. It was documented as administered from 2/13/24 to 2/16/14 (a.m. dose). It was documented as not administered 2/16/24 to 2/18/24 due to being out of the facility. It was then documented as administered 2/18/24 at 8:00 p.m., 2/19/24 both doses, and once on 2/20/24.

Review of Tenant #2's orders revealed a PCP note dated 2/15/24 indicated Tenant #2 voiced concerns they were not giving her the correct medications. Orders were received including to decrease Lasix 40 mg 1.5 tablets to 1 tablet daily. Continued record review revealed February 2024 MARs failed to reflected the order change from Lasix 1.5 mg tablets to 1 tablet daily. The MARs reflected 1.5 tablets (60 mg) was documented as administered on 2/16/24 after the order had been changed. Lasix was not administered as ordered.

Record review revealed Hospital Discharge Instructions indicated Tenant #2 was hospitalized on 2/16/24 to 2/18/24. Updated medications included: start acetaminophen 325 mg tablet, two tablets by mouth every six hours; start Eliquis 2.5 mg tablet, twice per day; Gabapentin 300 mg capsule at bedtime; Trazadone 50 mg tablet at bedtime. The orders further indicated the following medications were discontinued: acetaminophen-oxycodone 325 mg/5 mg tablet, 1 tablet every six hours as needed for pain; Clopidogrel 75 mg tablet once daily; Lasix 40 mg, take 1.5 mg tablet once daily; Lisinopril 5 mg tablet once per day; nitroglycerin 0.4 mg sublingual tablet every 5 minutes as needed;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 19	A 285		

Spironolactone 25 mg tablet once per day.

A PCP note dated 2/27/24 indicated Tenant #2 was seen post hospital visit. She was admitted on 2/16/24 and discharged on 2/18/24 due to bleeding from lacerations on the bilateral upper extremities and one laceration on the right calf. Tenant #2 indicated she would like to start administering her own medications. It indicated to continue off of Lasix and Lisinopril that were stopped in the hospitalization. It was ordered to continue Spironolactone 25 mg daily and continue metoprolol ER 25 mg take 1/2 tablet daily. It also indicated to continue on Eliquis 5 mg twice daily.

Continued record review of the February 2024 MARs indicated Tenant #2 was discharged and returned to the program on 2/18/24 with new medication orders dated 2/18/24. The acetaminophen 325 mg, take two tablets, was not started until 2/20/24 at the 12:00 p.m. dose. Eliquis 5 mg take, take twice daily, was administered on 2/18/24 8:00 p.m. dose, 2/19/24 both a.m. and p.m. doses and the morning dose on 2/20/24. The order for Eliquis 2.5 mg, take one tablet, by mouth, twice daily was not started until 2/20/24 at the 8:00 p.m. dose despite being ordered on 2/18/24. The order from the 2/27/24 office visit indicated to continue on Eliquis 5 mg twice daily, was not reflected on the MAR.

Tenant #2's medications including: Lovenox, warfarin, Eliquis and Lasix were not administered per order. Tenant #2 was seen in the ED on 1/21/24 for bleeding and being on anti-coagulant medications, she had a critical high lab of 6.9 INR on 2/6/24 and was hospitalized on 2/16/24 to 2/18/24 including for bleeding and lacerations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 20 3. Record review on 2/27/24 of Tenant #3's file revealed staff administered her medications. The January 2024 MAR reflected an order for Cyanocobalamin injection 1000 microgram (mcg), inject 0.1 milliters (ml) every month. There was no indicated it had been give previously in the month and was not documented as given in January. The MAR also reflected an order for Prolia injection 60 mg/ml, inject 1 ml, SQ, every six months. It was suspended from 1/29/24 to 7/24/24 and was noted as given on 1/26/24. The order was still reflected as a daily medication on the MAR, despite being ordered every six months. The February 2024 MARs reflected the order for Cyanocobalamin injection 1000 mcg, inject 0.1 ml every month. It was not administered in February and on 2/22/24 was not given due to being held per RN/DR order; however, no order was found to hold the medication. It was charted by Staff B, who was not a licensed nurse and was not able to administer an IM inject via nurse delegation. 4. Record review on 3/4/24 of Tenant #4's file revealed staff administered her medications. The February 2024 MAR reflected an order for acetaminophen ER 650 mg one tablet, by mouth every 8 hours. It was started on 2/12/24. The medication was not documented as given for any doses on 2/12/24, the 8:00 a.m. and 10:00 p.m. dose were not documented as given on 2/13/24. Doses were also not administered on 2/20/24 (10:00 p.m.), 2/21/24 (2:00 p.m.) and 2/24/24 (2:00 p.m.) When observed on the medication pass on 3/6/24 at 11:00 a.m. Staff B administered medications six tenants including Tenant #4. Her acetaminophen ER 650 mg tablet was ordered at	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 21	A 285		

2:00 p.m. Staff B went to administer the medication at 11:10 a.m. (which was prior to the prescribed time at 2:00 p.m.) and the medication was not available to administer. It was charted as not given at 2:00 p.m. due to Tenant #4 being physically unable to take.

5. Record review on 3/5/24 of Tenant #8's file revealed the January 2024 MAR reflected an order for duloxetine 30 mg capsule was ordered twice daily at 8:00 a.m. and 8:00 p.m. The medication was not given from 8:00 p.m. on 1/25/24 through 1/31/24. It was charted as medication not available.

Discharge instructions from a hospital stay dated 1/23/24 indicated to stop taking cefdinir 300 mg capsule by mouth every 12 hours. The January MAR did not reflect the discontinuation of the medication and it was charted as not available to administer. The orders also indicated to start Eliquis 5 mg tablet , take 0.5 tablet, every 12 hours and to start Namenda 5 mg tablet, take one tablet by mouth at bedtime, and to start Seroquel 25 mg tablet, take 1/2 tablet by mouth at bedtime. The orders were dated 1/23/24. The MAR did not reflect the orders until 1/26/24, which was three days after they were ordered. Medications were not administered as ordered.

The February 2024 MARs order for duloxetine 30 mg capsule was ordered twice daily at 8:00 a.m. and 8:00 p.m. The medication was charted as not given and not available from 2/1/24 to 2/15/24, with the exception of one dose on 2/10/24 at 8:00 p.m. It was noted as discontinued (no order provided) and then ordered again on 2/22/24 at the same dosing and frequency. It was documented as given starting on 2/24/24 at 8:00 p.m. and then documented as given until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 285	Continued From page 22 2/29/24. No other doses were documented as given in February. The March MARs reflected vitamin B-12 tablet, 500 mcg, take one tablet by mouth daily. The medication was not administered from 3/1/4 to 3/5/24 and it was charted as not physically able to take or held per DR/RN orders. No order was found to hold the medication. The MAR also reflected Cephalexin 500 mg capsule, take one capsule, by mouth, every 12 hours for 7 days. It was ordered on 3/1/24 and was not administered on 3/1/23 at 8:00 p.m., both doses on 3/2/24, 3/3/24 and 3/4/24. It was charted as physically unable to take. 6. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services confirmed all orders and MARs were provided for the tenants reviewed.	A 285		
A 335	481-67.9(3) Staffing 67.9(3) Training documentation. The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to maintain accurate documentation of staff training for program staff. This pertained to 2 of 7 staff reviewed for training transcripts (Staff A and Staff J). Findings follow: 1. Record review revealed Staff A's training	A 335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 335	Continued From page 23 transcript documented 19/20 of training courses dated 12/1/23 for a total of 12.75 hours, including tenant rights, infection control, falls, safe food handling, bloodborne pathogens and preventing, recognizing and reporting abuse. Continued record review revealed Staff A's hire date was 12/6/23, which was after the date of the training provided on 12/1/23. Timecard records reflected Staff A did not work on 12/1/23. 2. Record review revealed Staff J's training transcript revealed 20 courses completed on 12/1/23 for total 12.75 hours, including tenant rights, infection control, falls, safe food handling, bloodborne pathogens and preventing, recognizing and reporting abuse. Continued record review revealed Staff J worked 11.75 hours on 12/1/23; however, did not work the 12.75 hours the training on 12/1/23 reflected. When interviewed on 3/5/24 at 10:50 a.m. Staff J confirmed he did not complete the training reflected as completed on 12/1/23. When interviewed on 3/6/24 at 12:20 p.m. the Executive Director confirmed staff were paid for training and he did not know why the training would be reflected when Staff A did not work or why Staff J's training hours exceeded the hours worked.	A 335		
A 355	481-67.9(4)d Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 355	Continued From page 24 individual needs of tenants. Nurse delegation shall, at a minimum, include the following: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on observation and record review the Program failed to ensure staff received training on service plan including medication management and wound care. This pertained to 7 of 7 staff reviewed related to delegations (Staff A, B, C, D, F, G and L). Findings follow: 1. Observation on 3/6/24 at the lunch medication pass revealed Staff B administered or attempted to administer medications to six tenants. During the medication pass the medication cart was left outside of the apartments in the hallway unlocked and unattended in the assisted living. In memory care the medication cart was left in the common area unlocked and unattended by Staff B, when he was in a tenant apartment. Staff B completed hand hygiene once at the conclusion of the medication pass, no other hand hygiene was observed. Staff B administered eye drops, without donning gloves and hand hygiene before or after administration. One medication dropped on the counter and he used a bubble pack container and moved the pill into the cup. The tenant consumed the medication after touching a contaminated surface. Staff B signed off one of the mediations administered prior to the tenant consuming the medication. Staff B discarded an empty bubble pack in a garbage with the tenant's	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 355	Continued From page 25	A 355		

identifying information still on the bubble pack. One medication was not available to administer and he charted it as not able to physically take the medication. The medication was ordered at 2:00 p.m. and was not within the timeframe of the medication; however, was not administered as it was not available.

When interviewed on 2/29/24 at 11:25 a.m. Staff A said she was asked to train new people.

When interviewed on 3/6/24 at 10:20 a.m. Staff B said he was given no training and had 15 minutes with another care staff who was no longer there. He did not have any nurse delegated training.

When interviewed on 3/4/23 at 1:56 p.m. Staff F said they were provided videos regarding training and no training on catheter care and ostomy care. Staff F said she was trained (medications) by Staff B and had training from her prior employment.

Record review of an entry dated 2/15/24 in the Communication Log indicated Staff A would be following medication managers and delegating next week. There were a lot of errors and retraining could be helpful.

An entry in the Communication Log dated 2/17/24 indicated the mediation bubble packs were being punched out backwards. The bubble packs were numbered and should be punched out in order.

An entry in the Communication Log dated 2/7/24 indicated videos will be sent to staff to watch and review cares and the way to complete them.

2. Record review of Tenant #1's file revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 355	Continued From page 26	A 355		

November 2023, December 2023, January 2024 and February 2024 medication administration records (MARs) reflected an order for Aquacel AG 2 x 2, apply Aquacel AG to the ulcer and wrap the toe with gauze three times per week (order date of 10/12/23). There was also an order for Kerlix, apply Aquacel AG to the ulcer and wrap with toe with gauze three times per week. The February 2024 MAR was updated on 2/28/24 to reflect a new order to apply Aquacel AG and wrap the toe with gauze daily and reflected the discontinuation of the Aquacel AG three times per week order. The MARs reflected staff documented assistance with the wound including Staff A, B, F,G and L.

Continued record review revealed Wound Clinic documentation dated 2/5/24, indicated the wound location was the right second toe, the measurements were 0.5 x 0.7 x 0.2 centimeters (cm). Her right foot was warm to touch as was her lower right extremity. The right second toe was large compared to the other toe. The wound was 90% bone and 10% dried drainage. Debridement was completed to remove dried drainage. The assessment indicated it was pressure injury of the right foot toe and it was at a stage 4.

Record review on 2/29/24 revealed Staff A's training documents documented a hire date of 12/6/23. A Nurse Delegation Flowsheet indicated on 1/10/24 tasks were initialed by Staff A; however, lacked the signature or initials of a nurse. The delegation included training on medication management. There was no wound care training documented, including for Tenant #1's wound.

Record review on 2/29/24 revealed Staff B's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 355	Continued From page 27	A 355		

training documents documented a hire date of 8/17/23. A Nurse Delegation Flowsheet indicated on 2/19/24 staff had training on tasks including mediation management. The training provided was documented as provided by Staff A (not a licensed nurse). There was no wound care training documented, including for Tenant #1's wound.

Record review on 3/5/24 revealed Staff C's training documents documented a hire date of 8/17/23. A Nurse Delegation Flowsheet indicated there had been no training on tasks including medication management completed. There was also no wound care training documented, including for Tenant #1's wound care.

Record review on 3/5/24 revealed Staff D's training documents documented a hire date of 5/19/23. A Nurse Delegation Flowsheet indicated training on tasks including medication management was documented on 1/10/24. The training lacked initials or signature of a nurse. The document only reflected Staff D's initials. There was also no wound care training documented, including for Tenant #1's wound.

Record review on 3/4/24 revealed Staff F's training documents documented a hire date of 12/11/23. A Nurse Delegation Flowsheet indicated on 1/10/23 and 2/19/24 Staff F had training on tasks including medication management. The names listed were the Former Health and Wellness Director and Staff A. Staff A (not a licensed nurse) signed off on the February skills training for Staff F. There was no wound care training documented, including for Tenant #1's wound.

Record review on 3/4/24 revealed Staff G's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 355	Continued From page 28 training documents documented a hire date of 9/8/23. A Nurse Delegation Flowsheet failed to reveal wound care training documented, including for Tenant #1's wound. Record review on 2/29/24 revealed Staff L's training documents documented a hire date of 2/1/24. A Nurse Delegation Flowsheet indicated Staff L had training on tasks including medication management completed by Staff A (not a licensed nurse). Staff L did not have training on wound care, including for Tenant #1's wound.	A 355		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days of tenants taking occupancy. This pertained to 1 of 1 tenant reviewed admitted in the last three months (Tenant #3). Finding follows: 1. Record review on 2/27/24 revealed Tenant #3 was admitted on 1/18/24. Tenant #3's initial evaluations were dated 1/18/24. Continued record review failed to reveal Tenant #3's 30 day cognitive, health and functional evaluations.	A 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 140	Continued From page 29 2. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services confirmed all evaluations were provided for the tenants reviewed.	A 140		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 6 of 8 tenants reviewed (Tenants #1, #2, #4, #6, #7 and #8). Findings follow: 1. Record review on 2/27/24 of Tenant #1's file revealed orders and discharge summaries indicated the following: -On 9/5/23 Tenant #1 was seen in the emergency department (ED) for an abrasion of the right third	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 30	A 145		

toe and orders were received to follow abrasion care instructions and follow up with her PCP.

-On 9/21/23 Tenant #1 as seen in the ED for cellulitis of the toe. It was noted she had redness and swelling in her toe. She was to avoid wearing hard shoes and was prescribed an antibiotic for the next seven days.

-On 9/28/23 it was noted a referral was made to the wound clinic, to apply Bactroban ointment to her toe wound twice daily and to change dressing to toe wound twice daily. It was also noted to not let her wear shoes that rubbed on her toe.

-An undated Physician Order Sheet indicated the ulcer was on the dorsal aspect of right second toe to the bone. The physician ordered Aquacel AG applied the ulcer three times per week and wrapped with gauze. Follow up in one week.

-A Physician Order Sheet dated 11/9/23 indicated the wound was debrided. To continue wound care as ordered.

-A Physician Order sheet dated 11/17/23 indicated to apply Aquacel AG as primary, rolled gauze as secondary and to change three times per week. It also indicated to follow up on 11/29/23.

Continued record review revealed Wound Clinic documentation dated 2/5/24, indicated Tenant #1's family member who accompanied her indicated she had some digestive issues that prevented her from keeping her appointments. The toe ulcer was the same ulcer which dated back to at least September 2023. The wound location was the right second toe, the measurements were 0.5 x 0.7 x 0.2 centimeters

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 31	A 145		

(cm). Her right foot was warm to touch as was her lower right extremity. The right second toe was large compared to other toe. The wound is 90% bone and 10% dried drainage. Debridement was completed to remove dried drainage. The assessment indicated it was pressure injury of the right foot toe and it was at a stage 4. The orders indicated to apply Aquacel AG, gauze and tape three times per week and as needed. She would be fitted for an open toed orthopedic shoe.

Wound Clinic documentation dated 2/22/24, documented a concern the ulcer had a foul odor. The measurement of the wound included 0.6 x 0.7 x 0.4 cm. The assessment indicated it was a chronic right foot toe ulcer with necrosis of the bone. The document indicated conservative wound care failed and she was referred to a podiatrist regarding amputation of the toe. The dressing was betadine, Aquacel AG, rolled gauze and the dressing was to be completed daily.

Further record review revealed a podiatry clinic document dated 2/26/24 indicated Tenant #1 was seen for an initial evaluation of the right second toe wound. She reported she had the wound for about six months. She reported it worsened lately and she noticed redness and increased drainage. The wound dressing was Aquacel daily. The measurement of the wound included: 0.6 x 0.8 x 0.5 cm. It was indicated as a non-pressure chronic ulcer of part of the right foot with necrosis of the bone. An order was received for levofloxacin 750 milligram (mg) tablet daily.

A Physician Order Sheet dated 3/4/24 indicated to continue levofloxacin 750 mg daily and to continued Aquacel AG to the right second toe daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 32 A Physical Therapy Clarification Order reflected Tenant #1 started physical therapy (PT) services on 11/8/23 three times per week for 10 weeks. The recertification date was 1/31/24 and the plan was to extend to 4/9/24. The PCP did not agree and indicated she had an open wound on her toe that needed to be treated before therapy and her toe might need amputation. Continued record review revealed evaluations were completed on 5/24/23 and on 1/15/24. Evaluations were not completed as needed with the development of the wound, wound clinic visits, orders for an open toed shoe, treatment of the wound and worsening of the wound, including a change to daily dressings, orders for antibiotics and a referral regarding possible amputation of the toe. 2. Record review on 2/27/24 of Tenant #2's file revealed Quick Notes (electronic nurse's notes) reflected the following: -On 1/8/24 it was noted on 1/4/24 Tenant #2 was sent to the hospital for chest pain and shortness of breath. -On 1/9/24 it was noted Tenant #2 would be discharged back to the Program on 1/10/24 and the PCP wanted staff to administer her medications. -On 2/16/24 it was noted Tenant #2's orders changed and was currently no longer taking Lovenox or warfarin and was on Eliquis. On 2/16/24 Tenant #2's arm started bleeding and bled through several gauze dressings. Tenant #2's family was taking her to the hospital to control the bleeding.	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 33 -On 2/23/24 it was noted Tenant #2 wanted staff to dry off her back after showers and put on lotion. She also requested they stay in the bathroom when she showered. Continued record review revealed an incident report dated 1/21/24 reflected Tenant #2 bled from open wounds at different sites since her hospital visit on Thursday. Staff went to her apartment and found Tenant #2 removed the dressing from the hospital visit and Tenant #2 bled through the gauze. The nurse was notified and told staff to apply pressure and call an ambulance to transport her to the hospital. Emergency Medical Services (EMS) arrived and contacted the ED to get their opinion. The ED advised them to apply more pressure and if it did not stop or Tenant #2 wanted to be evaluated to go to the ED. Further record review revealed discharge summaries, clinic visit notes and orders reflected the following: -An office visit was completed on 1/22/24 to follow up from an ED visit on 1/21/24 due to left hand bleeding. There were noted abrasions on the forearm, wrist, hand and left middle finger. It was noted Tenant #2 picked at her skin when she was anxious. -A Clinical Summary (hospital record) indicated Tenant #2 was admitted on 2/16/24 and discharged on 2/18/24. Diagnoses included: anticoagulated, laceration of the arm and shortness of breath. Continued record review revealed a health evaluation was last completed dated 12/27/23.	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 34	A 145		

Functional and cognitive evaluations were last completed on 5/10/23. Evaluations were not completed as needed with significant change including when the Program started to administer her medications in January 2024, with hospital visits and ED visits related to bleeding and picking at her skin and the changes with her anti-coagulant medication.

3. Record review on 3/4/24 of Tenant #4's file revealed Emergency Department records dated 1/17/24, indicated Tenant #4's diagnosis was decreased oral intake, dementia and a fall.

Continued record review revealed a Quick Note entry dated 1/24/24 reflected Tenant #4 was admitted to hospice services, she would have nurse visits twice per week, and a hospice aide twice per week. They would provide bathing cares.

Further record review revealed the most recent evaluations were dated 4/14/23. Evaluations were not completed with Tenant #4's admission to hospice services and change in services including bathing.

4. Record review on 3/5/24 of Tenant #6's file revealed Quick Notes reflected the following:

-On 2/1/24 (late entry for 1/2/24) noted the former Health and Wellness Director reminded Tenant #6 to discuss her refusal of sertraline and to request a capsule form at her appointment. Tenant #6 returned with a capsule form of sertraline.

-On 2/16/24 it was noted on 2/15/24 the nurse assisted Tenant #6 to a behavioral/mental health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 35	A 145		

evaluation due to behaviors and refusals of medications. Some behaviors witnessed by staff included gathering knives from the kitchen to take to her apartment and sitting on them indicating she needed to protect herself against "them." She was sitting in the dark with no clothes on and yelled at staff to leave her apartment. She reported visual hallucinations, had paranoia, secluding herself at times in her apartment, refused medications daily.

Continued record review revealed January medication administration record (MARs) reflected consistent refusals of medications from 1/24/24 to 1/31/24. February and March MARs reflected daily refusals of all of her medications.

When observed on the medication pass on 3/6/24 at 11:00 a.m. Staff B asked Tenant #6 if she wanted to take her medications and she declined.

Further record review revealed evaluations were completed on 11/29/23 and on 2/26/24. Evaluations were not completed as needed with significant change including changes in behaviors noted above and routine refusals of all of her medications.

5. Record review on 3/5/24 of Tenant #7's file revealed Quick Notes dated 2/8/24 indicated Tenant #7 declinedPT and occupational therapy (OT). He also refused to use his walker and had a decrease in his mobility. He relied more on a scooter. Tenant #7 refused to use the toilet or urinal for most of his toileting needs and was incontinent. He refused to allow staff to clean up and his carpet and belongings were soiled with urine, which created an odor including into the hallway. Tenant #7's legs gave out frequently and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 36	A 145		

he required several staff to stand by and assist when he transfered. He had some falls and staff was not able to assist him up and a lift assist was called.

Evaluations were completed on 10/16/23 and were not updated as needed with a change in condition related to increased incontinence, decreased mobility, PT/OT and refusals of therapy.

6. Record review on 3/5/24 of Tenant #8's file reflected Quick Notes (electronic nurse's notes) dated 2/3/24, indicated on 1/13/24 Tenant #8 went to the ED and was diagnosed with a urinary tract infection (UTI), COVID and cognitive decline. On 1/19/24 Tenant #8 was sent to the hospital due to increased confusion and aggressive behavior and was admitted. On 1/23/24 he returned to the Program and was admitted to the memory care unit. On 1/24/24 it was noted he had controlling behavior related to his spouse.

On 2/29/24 it was noted Tenant #8 had increased confusion and staff thought he might have a UTI.

On 3/1/24 it was noted a new order was received for cephalexin 500 mg, by mouth every 12 hours for 7 days.

Continued record review revealed a cognitive evaluation was dated 1/19/24; however, functional and health evaluations were not completed. Evaluations were not completed as needed with increased confusion, behavioral changes, a move to memory care and UTIs.

When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services indicated all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 145	Continued From page 37 evaluations for the tenants reviewed were provided.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 6 of 8 tenants reviewed (Tenants #1, #2, #3, #4, #7 and #8). Findings follow: 1. Record review on 2/27/24 of Tenant #1's file revealed orders and discharge summaries indicated the following: -On 9/5/23 Tenant #1 was seen in the emergency department (ED) for an abrasion of the right third toe and orders were received to follow abrasion care instructions and follow up with her PCP. -On 9/21/23 Tenant #1 as seen in the ED for cellulitis of the toe. It was noted she had redness and swelling in her toe. She was to avoid wearing hard shoes and was prescribed an antibiotic for the next seven days.	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 38	A 290		

-On 9/28/23 it was noted a referral was made to the wound clinic, to apply Bactroban ointment to her toe wound twice daily and to change dressing to toe wound twice daily. It was also noted to not let her wear shoes that rubbed on her toe.

-An undated Physician Order Sheet indicated the ulcer was on the dorsal aspect of right second toe to the bone. The physician ordered Aquacel AG applied the ulcer three times per week and wrapped with gauze. Follow up in one week.

-A Physician Order Sheet dated 11/9/23 indicated the wound was debrided. To continue wound care as ordered.

-A Physician Order sheet dated 11/17/23 indicated to apply Aquacel AG as primary, rolled gauze as secondary and to change three times per week. It also indicated to follow up on 11/29/23.

Continued record review revealed Wound Clinic documentation dated 2/5/24, indicated Tenant #1's family member who accompanied her indicated she had some digestive issues that prevented her from keeping her appointments. The toe ulcer was the same ulcer which dated back to at least September 2023. The wound location was the right second toe, the measurements were 0.5 x 0.7 x 0.2 centimeters (cm). Her right foot was warm to touch as was her lower right extremity. The right second toe was large compared to other toe. The wound is 90% bone and 10% dried drainage. Debridement was completed to remove dried drainage. The assessment indicated it was pressure injury of the right foot toe and it was at a stage 4. The orders indicated to apply Aquacel AG, gauze and tape three times per week and as needed. She would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 39	A 290		

be fitted for an open toed orthopedic shoe.

Wound Clinic documentation dated 2/22/24, documented a concern the ulcer had a foul odor. The measurement of the wound included 0.6 x 0.7 x 0.4 cm. The assessment indicated it was a chronic right foot toe ulcer with necrosis of the bone. The document indicated conservative wound care failed and she was referred to a podiatrist regarding amputation of the toe. The dressing was betadine, Aquacel AG, rolled gauze and the dressing was to be completed daily.

Further record review revealed a podiatry clinic document dated 2/26/24 indicated Tenant #1 was seen for an initial evaluation of the right second toe wound. She reported she had the wound for about six months. She reported it worsened lately and she noticed redness and increased drainage. The wound dressing was Aquacel daily. The measurement of the wound included: 0.6 x 0.8 x 0.5 cm. It was indicated as a non-pressure chronic ulcer of part of the right foot with necrosis of the bone. An order was received for levofloxacin 750 milligram (mg) tablet daily.

A Physician Order Sheet dated 3/4/24 indicated to continue levofloxacin 750 mg daily and to continued Aquacel AG to the right second toe daily.

A Physical Therapy Clarification Order reflected Tenant #1 started physical therapy (PT) services on 11/8/23 three times per week for 10 weeks. The recertification date was 1/31/24 and the plan was to extend to 4/9/24. The PCP did not agree and indicated she had an open wound on her toe that needed to be treated before therapy and her toe might need amputation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 40 Continued record review revealed the last entry in Resident Notes was dated 7/3/23. Quick Notes (electronic nurse's notes) reflected three entries from 11/1/23 to 2/27/24. Two entries were regarding cardiology appointments and one entry for a 90 day nurse review. Nurse's notes were not documented by exception related to Tenant #1's ED visits and return to the Program, new orders for dressing changes for the wound and orders for PT. 2. Record review on 2/27/24 of Tenant #2's file revealed incident reports indicated the following: -On 1/21/24 it was noted Tenant #2 bled from open wounds at different sites since her hospital visit on Thursday. Staff went to her apartment and found Tenant #2 removed the dressing from the hospital visit and Tenant #2 bled through the gauze. The nurse was notified and told staff to apply pressure and call an ambulance to transport her to the hospital. Emergency Medical Services (EMS) arrived and contacted the ED to get their opinion. The ED advised them to apply more pressure and if it did not stop or Tenant #2 wanted to be evaluated, to go to the ED. -On 1/25/24 it was noted Tenant #2 asked for her pain medications. She complained of a bruise on her side that made her uncomfortable. It was noted Tenant #2 bruised easily due to her medications. She declined to go to the hospital and would follow up with PCP that day. -On 2/18/24 it was noted Tenant #2 was found on the floor by staff and reported she slipped out of her chair. Continued record review revealed an office visit	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 41	A 290		

was completed on 1/22/24 to follow up from an ED visit on 1/21/24 due to left hand bleeding. There were noted abrasions on the forearm, wrist, hand and left middle finger. It was noted Tenant #2 picked at her skin when she was anxious.

Further record review revealed on 2/16/24 it was noted in Quick Notes (electronic nurse's notes) Tenant #2's orders had changed and was currently no longer taking Lovenox or warfarin and was on Eliquis. On 2/16/24 Tenant #2's arm started bleeding and bled through several gauze dressings. Tenant #2's family was taking her to the hospital to control the bleeding.

-A Clinical Summary (hospital record) indicated Tenant #2 was admitted on 2/16/24 and discharged on 2/18/24. Diagnoses included: anticoagulated, laceration of the arm and shortness of breath.

Further record review revealed a nurse's note was not completed related to the incident on 1/21/24 and subsequent ED visit or when Tenant #2 returned to the Program. A nurse's note was completed when Tenant #2 went out to the hospital on 2/16/24; however, a note was not completed when she returned from the hospital. Additionally, nurse's notes were not documented by exception related to the incident reports noted above.

3. Record review on 2/27/24 of Tenant #3's file revealed Tenant #3 was admitted on 1/18/24. Quick Notes reflected one entry in nurse's notes since her admission. The entry was dated 2/9/24 and was related to a 30 day update. Nurse's notes were not documented by exception

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 42 including when Tenant #3 was admitted on 1/18/24. 4. Record review on 3/4/24 of Tenant #4's file revealed an Emergency Department record indicated Tenant #4's diagnosis was decreased oral intake, dementia and a fall. Resident Notes (handwritten nurse's notes) were provided and the last entry was 4/14/23. Quick Notes were provided from 1/1/24 to current and only one entry was provided dated 1/24/24, that indicated Tenant #4 was admitted to hospice services. Nurse's notes were not completed by exception, including when Tenant #4 went out to the ED and returned. 5. Record review on 3/5/24 of Tenant #7's file revealed Resident Notes had an entry last dated 10/16/23 regarding a 30 day update. Quick Notes were provided from 1/1/24 to the current time and reflected one entry on 2/8/24. The entry in Quick Notes on 2/8/24 indicated Tenant #7 had been declining PT and occupational therapy (OT). He also refused to use his walker and had a decrease in his mobility. He relied more on scooter. Tenant #7 refused to use the toilet or urinal for most of his toileting needs and was incontinent. He refused to allow staff to clean up and his carpet and belongings were soiled with urine, which created an odor including into the hallway. Tenant #7's legs gave out frequently and he required several staff to stand by and assist when he transfered. He had some falls and staff was not able to assist him up and a lift assist was called. Continued record review revealed there entries after the 2/8/24 to follow up on issues identified in	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 43 the note 2/8/24. Nurse's notes were not documented by exception. 6. Record review on 3/5/24 of Tenant #8's file revealed Quick Notes dated 2/3/24 indicated on 1/13/24 Tenant #8 went to the ED and was diagnosed with a urinary tract infection (UTI), COVID and cognitive decline. On 1/19/24 Tenant #8 was sent to the hospital due to increased confusion and aggressive behavior and was admitted. On 1/23/24 he returned to the Program and was admitted to the memory care unit. On 1/24/24 it was noted he had controlling behavior related to his spouse. Continued record review revealed the nurse's notes were not documented by exception when the noted above incidents occurred. An entry on 2/3/24 reflected issues that were documented from 1/13/24 to 1/24/24. Nurse's notes were not documented by exception. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services confirmed all nurse's notes for the tenants reviewed were provided.	A 290		
A 320	481-69.25(1)o Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record)	A 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 320	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete medication error reports as required. This pertained to 6 of 7 tenants reviewed who had medications administered by the Program and potentially affected all tenants that had medication administered by the Program (34). The Program also failed to completed incident reports as needed. This pertained to 1 of 8 tenants reviewed (Tenant #2). Findings follow: 1. Record review revealed the Program provided one medication error report for the last three months. It was dated 1/26/24 and was for Tenant #8 related to medications that were not started promptly post discharge from the hospital. Continued review of Tenant #1, #2, #3, #4, and #8's medication administration records (MARs) and orders revealed there were medication errors noted in the review of the files. See section 67.5(2) for more information related to the specific medication errors. 2. Record review of Med Variance reports indicated the following: -For January 2024 there were 53 missed medications/treatments and there were 541 early or late medications/treatments. -For February 2024 there 74 missed medications/treatments and there were 371 early or late medications/treatments. -For March 2024, from 3/1/24 to 3/5/24, there were 19 total missed medications/treatments, there were 72 early or late	A 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 320	Continued From page 45 medications/treatments and there were six as needed medications documented without an effectiveness charted. Continued record review revealed with the exception of the one medication error report (noted above) for Tenant #8 on 1/26/24, no other medication error reports were completed when the medication errors occurred. Medication error reports were not completed as required. 3. Record review on 2/27/24 of Tenant #2's Quick Notes (electronic nurse's notes) dated 2/16/24, indicated Tenant #2's orders changed and she no longer took Lovenox or warfarin and was on Eliquis. On 2/16/24 Tenant #2's arm bled through several gauze dressings. Tenant #2's family took her to the hospital to control the bleeding. Continued record review revealed an incident report was not completed related to incident with Tenant #2 on 2/16/24. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services confirmed all incident and medication error reports were provided.	A 320		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed ensure service plans reflected the service needs of tenants. This pertained to 7 of 8 tenants reviewed (Tenants #1, #2, #3, #4, #6, #7 and #8). Findings follow: 1. When observed on 2/28/24 at 12:40 p.m. Tenant #1 was observed wearing closed toed tennis shoes. Record review on 2/27/24 of Tenant #1's file revealed orders and discharge summaries indicated the following: -On 9/5/23 Tenant #1 was seen in the emergency department (ED) for an abrasion of the right third toe and orders were received to follow abrasion care instructions and follow up with her PCP. -On 9/21/23 Tenant #1 as seen in the ED for cellulitis of the toe. It was noted she had redness and swelling in her toe. She was to avoid wearing hard shoes and was prescribed an antibiotic for the next seven days. -On 9/28/23 it was noted a referral was made to the wound clinic, to apply Bactroban ointment to her toe wound twice daily and to change dressing to toe wound twice daily. It was also noted to not let her wear shoes that rubbed on her toe. -An undated Physician Order Sheet indicated the ulcer was on the dorsal aspect of right second toe to the bone. The physician ordered Aquacel AG	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 47	A 350		

applied the ulcer three times per week and wrapped with gauze. Follow up in one week.

-A Physician Order Sheet dated 11/9/23 indicated the wound was debrided. To continue wound care as ordered.

-A Physician Order sheet dated 11/17/23 indicated to apply Aquacel AG as primary, rolled gauze as secondary and to change three times per week. It also indicated to follow up on 11/29/23.

Continued record review revealed Wound Clinic documentation dated 2/5/24, indicated Tenant #1's family member who accompanied her indicated she had some digestive issues that prevented her from keeping her appointments. The toe ulcer was the same ulcer which dated back to at least September 2023. The wound location was the right second toe, the measurements were 0.5 x 0.7 x 0.2 centimeters (cm). Her right foot was warm to touch as was her lower right extremity. The right second toe was large compared to other toe. The wound is 90% bone and 10% dried drainage. Debridement was completed to remove dried drainage. The assessment indicated it was pressure injury of the right foot toe and it was at a stage 4. The orders indicated to apply Aquacel AG, gauze and tape three times per week and as needed. She would be fitted for an open toed orthopedic shoe.

Wound Clinic documentation dated 2/22/24, documented a concern the ulcer had a foul odor. The measurement of the wound included 0.6 x 0.7 x 0.4 cm. The assessment indicated it was a chronic right foot toe ulcer with necrosis of the bone. The document indicated conservative wound care failed and she was referred to a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 48	A 350		

podiatrist regarding amputation of the toe. The dressing was betadine, Aquacel AG, rolled gauze and the dressing was to be completed daily.

Further record review revealed a podiatry clinic document dated 2/26/24 indicated Tenant #1 was seen for an initial evaluation of the right second toe wound. She reported she had the wound for about six months. She reported it worsened lately and she noticed redness and increased drainage. The wound dressing was Aquacel daily. The measurement of the wound included: 0.6 x 0.8 x 0.5 cm. It was indicated as a non-pressure chronic ulcer of part of the right foot with necrosis of the bone. An order was received for levofloxacin 750 milligram (mg) tablet daily.

A Physician Order Sheet dated 3/4/24 indicated to continue levofloxacin 750 mg daily and to continued Aquacel AG to the right second toe daily.

A Physical Therapy Clarification Order reflected Tenant #1 started physical therapy (PT) services on 11/8/23 three times per week for 10 weeks. The recertification date was 1/31/24 and the plan was to extend to 4/9/24. The PCP did not agree and indicated she had an open wound on her toe that needed to be treated before therapy and her toe might need amputation.

Continued record review revealed the service plans were dated 2/24/23 and 1/15/24. The service plan was not updated as needed and did not reflect the development of the wound, wound clinic visits, orders for an open toed shoe, PT services, treatment of the wound and worsening of the wound, including a change to daily dressings, orders for antibiotics and referral regarding possible amputation of the toe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 49	A 350		

2. Record review on 2/27/24 of Tenant #2's file revealed Quick Notes (electronic nurse's notes) reflected the following:

-On 1/8/24 it was noted on 1/4/24 Tenant #2 was sent to the hospital for chest pain and shortness of breath.

-On 1/9/24 it was noted Tenant #2 would be discharged back to the Program on 1/10/24 and the PCP wanted staff to administer her medications.

-On 2/16/24 it was noted Tenant #2's orders changed and no longer took Lovenox or warfarin and was on Eliquis. On 2/16/24 Tenant #2's arm bled through several gauze dressings. Tenant #2's family took her to the hospital to control the bleeding.

-On 2/23/24 it was noted Tenant #2 wanted staff to dry off her back after showers and put on lotion. She also requested they stay in the bathroom when she showered.

Continued record review revealed an incident report dated 1/21/24 reflected Tenant #2 had been bleeding from open wounds at different sites since her hospital visit on Thursday. Staff went to her apartment and found Tenant #2 had removed the dressing from the hospital visit and Tenant #2 had bled through the gauze. The nurse was notified and told staff to apply pressure and call an ambulance to transport her to the hospital. Emergency Medical Services (EMS) arrived and contacted the ED to get their opinion. The ED advised them to apply more pressure and if it did not stop or Tenant #2 wanted to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 50 evaluated to go to the ED. Further record reviewed discharge summaries, clinic visit notes and orders reflected the following: -An office visit was completed on 1/22/24 to follow up from an ED visit on 1/21/24 due to left hand bleeding. There were noted abrasions on the forearm, wrist, hand and left middle finger. It was noted Tenant #2 picked at her skin when she was anxious. -A Clinical Summary (hospital record) indicated Tenant #2 was admitted on 2/16/24 and discharged on 2/18/24. Diagnoses included: anticoagulated, laceration of the arm and shortness of breath. Continued record review revealed a signed service plan was dated 12/27/23. An unsigned service plan was dated 1/15/24; however, it was not based on evaluations as evaluations were not completed. The service plan did not reflect the administration of anticoagulant medications, Tenant #2's picking at her skin and incidents of bleeding that were not controlled. The service plan also reflected staff assisted daily with bathing and that she needed moderate assistance. It did not reflect the assistance as indicated in notes and as requested by Tenant #2. 3. Record review on 2/27/24 of Tenant #3's file revealed a service plan was provided dated 2/9/24. The service plan was not based on evaluations, as evaluations were not completed when the service plan was developed. The January and February medication administration records (MARs) reflected two injectable	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 51	A 350		

medications, Prolia ordered once every six months and Cyanocobalamin ordered once per month. Both were intramuscular injections (IM). The MARs also reflected staff administered Plavix and Eliquis (anti-coagulant mediations).

Continued record review revealed the service plan reflected staff administered her medications; however, did not reflect the injectable medications or the anti-coagulant mediations.

4. Record review on 3/4/24 of Tenant #4's file revealed a service plan was dated 1/22/24 and reflected hospice assisted with bathing. The service plan was not signed and was not based on evaluations, as evaluations were not completed at the time of the update. The service plan did not reflect any additional services provided by hospice including nursing visits.

5. Record review on 3/5/24 of Tenant #6's file revealed Quick Notes reflected the following:

-On 2/1/24 (late entry for 1/2/24) noted the former Health and Wellness Director reminded Tenant #6 to discuss her refusal of sertraline and to request a capsule form at her appointment. Tenant #6 returned with a capsule form of sertraline.

-On 2/16/24 it was noted on 2/15/24 the nurse assisted Tenant #6 to a behavioral/mental health evaluation due to behaviors and refusals of medications. Some behaviors witnessed by staff included gathering knives from the kitchen to take to her apartment and sitting on them indicating she needed to protect herself against "them". She sat in the dark with no clothes on and yelled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 52	A 350		

at staff to leave her apartment. She reported visual hallucinations, had paranoia, secluding herself at times in her apartment and refused medications daily.

Continued record review revealed January MARs reflected consistent refusals of medications from 1/24/24 to 1/31/24. February and March MARs reflected daily refusals of all of her medications.

When observed on the medication pass on 3/6/24 at 11:00 a.m. Staff B asked Tenant #6 if she wanted to take her medications and she declined.

Further record review revealed the service plan was dated 2/26/24 and reflected staff administered her medications. The service plan indicated she was alert and oriented under behavioral/mental status. The service plan was not updated with significant change and did not reflect changes in behaviors noted above and routine refusals of all of her medications.

6. Record review on 3/5/24 of Tenant #7's file revealed Quick Notes dated 2/8/24 indicated Tenant #7 declined PT and occupational therapy (OT). He also refused to use his walker and had a decrease in his mobility. He relied more on a scooter. Tenant #7 refused to use the toilet or urinal for most of his toileting needs and was incontinent. He refused to allow staff to clean up and his carpet and belongings were soiled with urine, which created an odor including into the hallway. Tenant #7's legs gave out frequently and he required several staff to stand by and assist when he transfered. He had some falls and staff was not able to assist him up and a lift assist was called.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 53 The service plan was dated 1/29/24 and was not based on evaluations, as evaluations were not completed. The service plan was not updated as needed with a change in condition related to increased incontinence, decreased mobility. PT/OT and refusals of therapy. It also did not reflect an odor in his apartment and any interventions to mitigate the odor. 7. Record review on 3/5/24 of Tenant #8's file revealed Quick Notes dated 2/3/24, reflected on 1/13/24 Tenant #8 went to the ED and was diagnosed with a urinary tract infection (UTI), COVID and cognitive decline. On 1/19/24 Tenant #8 was sent to the hospital due to increased confusion and aggressive behavior and was admitted. On 1/23/24 he returned to the Program and was admitted to the memory care unit. On 1/24/24 it was noted he had controlling behavior related to his spouse. On 2/29/24 it was noted Tenant #8 had increased confusion and staff thought he might have a UTI. On 3/1/24 it was noted a new order was received for cephalexin 500 mg, by mouth every 12 hours for 7 days. Continued record review revealed a service plan was updated on 1/19/24, it was not signed and was not based on health and functional evaluations, as evaluations were not completed. The service plan did not reflect Tenant #8's history of UTIs. The service plan also did not reflect increased confusion and behaviors as noted above. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services confirmed all service	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 54 plans were provided for the tenants reviewed.	A 350		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans prior to taking occupancy. This pertained to 1 of 1 tenant reviewed admitted in the last three months (Tenant #3). Finding follows: Record review on 2/27/24 of Tenant #3's file revealed an admission date of 1/18/24. The only service plan provided was dated 2/9/24. Continued record review revealed the signed Resident Service Agreement (occupancy agreement) was dated 1/18/24. A service plan was not developed prior to taking occupancy and was not developed prior to signing the occupancy agreement. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services confirmed all service plans were provided for the tenants reviewed.	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews every 90 days and as needed. This pertained to tenants reviewed 2 of 8 tenants reviewed (Tenant #1 and Tenant #6). Findings follow: 1. Record review on 2/27/24 of Tenant #1's file revealed orders and discharge summaries indicated the following: -On 9/5/23 Tenant #1 was seen in the emergency department (ED) for an abrasion of the right third toe and orders were received to follow abrasion care instructions and follow up with her PCP. -On 9/21/23 Tenant #1 as seen in the ED for cellulitis of the toe. It was noted she had redness and swelling in her toe. She was to avoid wearing hard shoes and was prescribed an antibiotic for the next seven days. -On 9/28/23 it was noted a referral was made to the wound clinic, to apply Bactroban ointment to	A 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 430	Continued From page 56	A 430		

her toe wound twice daily and to change dressing to toe wound twice daily. It was also noted to not let her wear shoes that rubbed on her toe.

-An undated Physician Order Sheet indicated the ulcer was on the dorsal aspect of right second toe to the bone. The physician ordered Aquacel AG applied the ulcer three times per week and wrapped with gauze. Follow up in one week.

-A Physician Order Sheet dated 11/9/23 indicated the wound was debrided. To continue wound care as ordered.

-A Physician Order sheet dated 11/17/23 indicated to apply Aquacel AG as primary, rolled gauze as secondary and to change three times per week. It also indicated to follow up on 11/29/23.

Continued record review revealed Wound Clinic documentation dated 2/5/24, indicated Tenant #1's family member who accompanied her indicated she had some digestive issues that prevented her from keeping her appointments. The toe ulcer was the same ulcer which dated back to at least September 2023. The wound location was the right second toe, the measurements were 0.5 x 0.7 x 0.2 centimeters (cm). Her right foot was warm to touch as was her lower right extremity. The right second toe was large compared to other toe. The wound is 90% bone and 10% dried drainage. Debridement was completed to remove dried drainage. The assessment indicated it was pressure injury of the right foot toe and it was at a stage 4. The orders indicated to apply Aquacel AG, gauze and tape three times per week and as needed. She would be fitted for an open toed orthopedic shoe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 430	Continued From page 57 Wound Clinic documentation dated 2/22/24, documented a concern the ulcer had a foul odor. The measurement of the wound included 0.6 x 0.7 x 0.4 cm. The assessment indicated it was a chronic right foot toe ulcer with necrosis of the bone. The document indicated conservative wound care failed and she was referred to a podiatrist regarding amputation of the toe. The dressing was betadine, Aquacel AG, rolled gauze and the dressing was to be completed daily. Further record review revealed a podiatry clinic document dated 2/26/24 indicated Tenant #1 was seen for an initial evaluation of the right second toe wound. She reported she had the wound for about six months. She reported it worsened lately and she noticed redness and increased drainage. The wound dressing was Aquacel daily. The measurement of the wound included: 0.6 x 0.8 x 0.5 cm. It was indicated as a non-pressure chronic ulcer of part of the right foot with necrosis of the bone. An order was received for levofloxacin 750 milligram (mg) tablet daily. A Physician Order Sheet dated 3/4/24 indicated to continue levofloxacin 750 mg daily and to continued Aquacel AG to the right second toe daily. Continued record review revealed a Resident Assessment Parameters document (health evaluation) was completed on 5/24/23 and the next entry was on 1/15/24. The assessment on 1/15/24 only reflected there was an open area on the right second toe. Nurse reviews were not completed every 90 days and as needed related to routine assessments of Tenant #1's toe wound and to make recommendations and referrals.	A 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 430	Continued From page 58 2. Record review on 3/5/24 of Tenant #6's file revealed Quick Notes (electronic nurse's notes) indicated the following: -On 2/1/24 (late entry for 1/2/24) noted the former Health and Wellness Director reminded Tenant #6 to discuss her refusal of sertraline and to request a capsule form at her appointment. Tenant #6 returned with a capsule form of sertraline. -On 2/16/24 it was noted on 2/15/24 the nurse assisted Tenant #6 to a behavioral/mental health evaluation due to behaviors and refusals of medications. Some behaviors witnessed by staff included gathering knives from the kitchen to take to her apartment and sitting on them indicating she needed to protect herself against "them" She sat in the dark with no clothes on and yelled at staff to leave her apartment. She reported visual hallucinations, had paranoia, secluding herself at times in her apartment and refused medications daily. Continued record review revealed January 2024 medication administration records (MARs) reflected consistent refusals from 1/24/24 to 1/31/24. February and March 2024 MARs reflected daily refusals of all of her medications. Further record review revealed a fax was sent to the PCP dated 12/22/23, indicated Tenant #6 refused her sertraline as it did not have a coating. It was requested to have a prescribed coated medication. It was indicated Tenant #6's behavior had been slightly aggressive and negative with many people and staff. The PCP ordered to transition to a capsule after her appointment that day (1/2/24).	A 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 430	Continued From page 59 When observed on the medication pass on 3/6/24 at 11:00 a.m. Staff B asked Tenant #6 if she wanted to take her medications and she declined. There was one notification sent to the PCP dated 12/22/23 related to her refusals of sertraline. There were no nurse reviews completed related to daily refusals of all medications, there were no additional referrals or recommendations or documented communication to the PCP regarding the refusals or behaviors. Nurse reviews were not completed as needed. When interviewed on 3/5/24 at 4:12 p.m. the Director of Clinical Services confirmed all nurse reviews for the tenants reviewed were provided.	A 430		
A 510	481-69.28(8) Food Service 69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure food was cooked and held at safe temperatures. This potentially affected all tenants (census of 36). Findings follow: 1. When observed on 3/4/24 during lunch staff served plated meals to the tenants at the table. Staff B took the temperature of the food and the Salisbury steak was 160 degrees, the sweet potatoes were 159.8 degrees, the vegetable blend was 123 degrees and the apple crisp was 77 degrees. The breakfast food temperatures	A 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 510	Continued From page 60 were not recorded for the meal prior on 3/4/24. Record review on 3/4/24revealed the temperature logs from the memory care indicated the following: -On 3/4/24 at breakfast there were no temperatures documented for breakfast -On 3/4/24 at lunch the Salisbury steak was 160 degrees, sweet potatoes were 159.8 degrees, vegetable blend was 123 degrees, and apple crisp was 77 degrees -On 3/5/24 at lunch the chicken was 109.9 degrees, mashed potatoes were 124.3 degrees, carrots were 90.3 degrees and the fruit salad was 55 degrees. Record review on the temperature logs from the main dining room (assisted living) were reviewed and indicated the following: -On 2/2/24 at lunch there were no temperatures recorded -On 2/22/24 at lunch there were no temperatures recorded -On 2/26/24 at lunch there were were no temperatures recorded -On 2/27/24 at supper there were no temperatures recorded When interviewed on 3/5/24 at 11:55 a.m. Tenant #7 said the food was not always cooked at the evening meal. Tenant #7 said the food was not cooked right.	A 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0166	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	405 27TH AVENUE SOUTH CLEAR LAKE, IA 50428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 510	Continued From page 61 When interviewed on 2/29/24 Staff K, the Dietary Supervisor, said the temperature of the food was expected to be 165 and over and there had been no issues with temperatures. She said the food for memory care was put on plates and covered with plastic and transported to memory care. She said the temperature of the food was taken in the kitchen. An additional temperature was not taken prior to being served in memory care. She said she heard from the tenants the french fries were under cooked the night prior by the cook and she reported it to the Executive Director. There were no temperatures recorded for that meal. When interviewed on 3/5/24 at 3:14 p.m. the Executive Director confirmed all temperatures logs requested were provided.	A 510		

A105 Program Policies and Procedures

- Omega updated Incident Report Policy 6/3/24
- We will have an Inservice regarding the new incident report policy to educate all staff on 6/21/24.
- We will review the previous month's incident reports at our monthly staff meeting.

A160 Tenant Rights

- Program RN has reviewed and/or updated all current residents service plans to ensure that these match the needs of the resident and current abilities completed by 4/15/24.
- Reviewed and updated laundry and shower list according to service plan by 4/15/24.
- RN created a refusal form that staff are required to fill out if a refusal occurs. RN will triage this form and follow up if we need to create a new service plan tailored to residents' preferences.

A285

- Effective 5/29/24 RN will review anticipated order invoice and received invoice from Consonus weekly to ensure accurate deliveries. For Thrifty White RN will compare staff order sheets with invoices received at delivery from Thrifty White to ensure accurate delivery.
- Leadership staff will reach out to residents/families to educate them on the importance of using our preferred pharmacy. We would like to encourage resident's med managed to utilize the integrated pharmacy by 7/1/24.
- On 5/29/24 a monthly staff meeting was held, educating, and reviewing Medication policy and procedures. This will be standard to educate and review at every Monthly staff meeting along with incident report policy and procedures.

A335 Staffing

- All current staff have 8 hours of Dementia training completed as of 4/24/2024. Going forward dementia training will be completed within 30 days of hire and is a part of the new hire packet.
- Effective on 04/08/24 all current staff completed Safe Food Handling and Sanitation. All staff will be educated prior to being scheduled to work. This will be completed annually going forward.
- On 5/30/24 the new hire checklist was updated to have all required training completed and checked off before they are scheduled on the floor.
- Going forward all staff training must be completed prior to being scheduled on the floor to work.

- It is standard practice going forward that all associates that are completing Relias training that they are in building, and clocked in.

A355

- Delegation packet updated to include required delegations according to resident care plans. On 4/12/2024 all staff delegations updated to include updated paperwork.
- Going forward, training and signed off delegations with the RN will be completed before being scheduled on the floor.

A140 Evaluation of Tenant

- RN was trained on 3/25/24 regarding regulations and how to conduct evaluating residents during a new admit, 30-days, 90-days, every 90-days after (per communities' policy) and change of condition.
- All residents are current on assessments. RN will run reports in Vitals each month to show what assessments are scheduled due for that month.

A145 Evaluation of Tenant

- RN was trained on 3/25/24 regarding regulations and how to conduct evaluating residents during a new admit, 30-days, 90-days, every 90-days after (per communities policy), and change of condition.
- All residents are current on assessments. RN will run reports in Vitals each month to show what assessments are scheduled due for that month to ensure timely completion.

A290 Tenant Documents

- RN was trained on charting by exception on 3/25/24
- Delegation packet updated to include required delegations according to resident care plans. On 4/12/2024 all staff delegations updated to include updated paperwork.
- Med managers, medication aides, and care partners will have training and signed off delegations with the RN completed before being scheduled on the floor.

A320 Tenant Documents

- RN was trained on Incident Report completion on 3/25/24
- 3/4/24 mandatory staff training was completed regarding incident report policy and procedures.

- Incident report policy and procedures staff training will be completed at time of hire and at monthly trainings.

A350 Service Plans

- RN was trained on 3/25/24 regarding regulations and how to conduct evaluating residents during a new admit, 30-days, 90-days, every 90-days after (per communities' policy) and change of condition.
- Going forward, RN will update ISP at time of evaluation/assessment.
- Going forward, quarterly audits reviewing 3 resident charts will be conducted by ED and RN.

A355 Service Plans

- ED, RN, Sales Director were trained on 4/9/24 regarding regulations that the service plan must be signed, dated, and timed prior to reviewing the occupancy agreement-signing, dating and timed.
- Going forward, quarterly audits reviewing 3 resident charts will be conducted by ED and RN

A430 Nurse Review

- On 3/25/24 the new RN was trained in proper procedures related to personal and health related care of residents and including assessment at least every 90-days, and at all changes of conditions.
- RN will run a report in Vitals every month to show what assessments are scheduled to be completed that month.

A510 Food Service

- The Assistant Director will review frequently to ensure temps are being completed on all food being served to residents.
- Effective 3/06/24 a Hot cart is now being utilized in memory care to ensure food is being held to required temperatures.
- Cook training was provided on 5/29/24 regarding safe food temperatures.
- Temperature checks will be completed by staff at each meal in AL and MC prior to serving.