

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/16/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF WAUKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SE LAUREL STREET WAUKEE, IA 50263
---	--

(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	<p>Initial Comments</p> <p>Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site.</p> <p>Number of tenants without cognitive disorder: 0</p> <p>Number of tenants with cognitive disorder: 12</p> <p>TOTAL Census of Assisted Living Program for People with Dementia: 12</p> <p>A recertification visit was conducted to determine compliance with certification for an Assisted Living Program for People with Dementia. During the recertification visit, investigations 104577-C & 97810-C were also completed. The following regulatory insufficiencies were cited as a result:</p>	A 000		
A 160	<p>481-67.3(2) Tenant Rights</p> <p>481-67.3 Tenant rights. All tenants have the following rights:</p> <p>67.3(2) To receive care, treatment and services which are adequate and appropriate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure tenants received care, treatment and services which were adequate and appropriate. This affected 1 of 2 tenants reviewed (Tenant #1). Finding follows:</p>	A 160		

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/16/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF WAUKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SE LAUREL STREET WAUKEE, IA 50263
---	--

(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	<p>Continued From page 1</p> <p>Observations on 6/6/22 revealed Staff A could not administer Tenant #1's pain medication because it was not available. When interviewed the staff said she could not administer the medication because she did not have any.</p> <p>Record review on 6/8/22 revealed Tenant #1's Medication Administration Record (MAR) for June 2022 according to the MAR Tenant #1 received Tramadol HCL tab 50 mg at 8:00 a.m. on 6/1/22. Further review revealed Tenant #1 should have received the Tramadol three times a day. According to the MAR Tenant #1 had not received Tramadol prescribed for pain in unspecified knee 16 times and the notes reflected the medication unavailable.</p> <p>When interviewed on 6/7/22 the Registered Nurse (RN) said the supplier of medication failed to send the medication and she would follow up with them. The RN provided email communication with the supplier of the medication as she attempted to determine the issue with Tenant #1's Tramadol. According the the nurse and record review Tenant #1 received her Tramadol at 5:00 p.m. as the Program had received the medication.</p>	A 160		
A 400	<p>481-67.19(3) Record Checks</p> <p>67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.</p>	A 400		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/16/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF WAUKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SE LAUREL STREET WAUKEE, IA 50263
---	--

(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 400	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently perform criminal history and child/dependent adult abuse record checks prior to employment. This affected 1 of 4 staff reviewed (Staff A). Finding follows:</p> <p>Record review on 6/7/22 revealed the Program hired Staff A on 2/1/21. Further review revealed the SING (Single Contact License and Background Check) dated 2/3/21.</p> <p>When interviewed on 6/7/22 the Registered Nurse (RN) said the Program used an on boarding company to do the record checks and they had not ensured the check was completed before Staff A began employment.</p>	A 400		
A 145	<p>481-69.22(3) Evaluation of Tenant</p> <p>69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	A 145		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/16/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF WAUKEE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SE LAUREL STREET WAUKEE, IA 50263
---	--

(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	<p>Continued From page 3</p> <p>Based on interview and record review the Program failed to consistently evaluate tenants' functional status annually or with a significant change. This affected 1 of 4 tenants reviewed (Tenant #1). Finding follows:</p> <p>Record review on 6/7/22 revealed no current cognitive evaluation for Tenant #1.</p> <p>When interviewed on 6/7/22 the Registered Nurse (RN) confirmed the evaluation had not been completed for Tenant #1. She said she knew it needed to be done but didn't have enough nurses to keep up.</p>	A 145		