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
	S0360	A. BUILDING: _____ B. WING _____	04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN ALP/D	1275 W FOREVERGREEN ROAD NORTH LIBERTY, IA 52317

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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 disorder: 3 Number of tenants with cognitive disorder: 16 TOTAL Census of Assisted Living Program for People with Dementia: 19 An onsite infection control survey was completed and no regulatory insufficiencies were identified. A comment was made to the Program regarding recommendations for personal protective equipment. A recertification visit was also conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program and the following regulatory insufficiencies were identified:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to follow policy and procedure related to medications. This pertained to 1 of 4 tenants observed on a medication pass (Tenant #2) and potentially affected all tenants with medications administered by the Program (18). Findings follow: 1. When observed on 3-30-21 at approximately 11:15 a.m. Staff G administered medications to four tenants, including Tenant #2. Staff G donned	A 150		

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A 150	Continued From page 1	A 150		

gloves and retrieved Tenant #2's bubblepack of acetaminophen 500 milligrams (mg) two tablets (1000 mg) and punched the medications into a medication cup. The sticker on the bubblepack reflected it was pro re nata (PRN). The dose was being given as a scheduled dose at noon according to the electronic medication administration record (MAR). Staff G took the medication to Tenant #2's apartment, assisted her to sit up and gave her the medication.

2. Review of Tenant #2's file on 3-30-21 revealed Tenant #2 had an order for acetaminophen 500 milligrams (mg), two tablets by mouth three times daily for pain and two tablets by mouth as needed for fever or pain. It was not to exceed 4 grams in a 24 hour period.

The March 2021 MARs reflected Staff G signed off the acetaminophen 500 mg two tablets (1000 mg), at noon on 3-30-21.

3. Medication error reports for the last three months were requested and included medication errors, for missing medication, medications not given and medications given to a wrong tenant.

An Incident Report dated 2-27-21 indicated it was a medication error for Tenant #1. Staff noted Tenant #1's Lorazepam bubblepack card reflected it was PRN and not scheduled. Staff could not find a scheduled card and Tenant #1 did not receive the medication PRN. Staff called the nurse and was told it was okay to administer the from the PRN card (the dosage and count matched the MAR). The report indicated a nurse replaced the sticker at the top of the card to reflect scheduled and not PRN. The report indicated steps to help prevent reoccurrence included to double check medication cards when

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A 150	Continued From page 2 they arrived from pharmacy to ensure it matched the MAR. 4. Further record review revealed the Program's policy and procedure for medications reflected when medications were administered by the Program medications would be labeled and maintained in compliance with the label and applicable laws. All current medications and dosage schedules would be recorded on the MAR. When the medications arrived from pharmacy the label was checked against the MAR to ensure correct information was available for administration. The staff would only administer medication ordered by the physician and scheduled by the pharmacy on the MAR. The six rights of medication administered were "always observed" when medications were administered including: right medication, dose, route, time, tenant and documentation. It indicated never to re-label or label any medication and if in doubt about the medication and label to return it to the pharmacy. 5. When interviewed on 4-6-21 the Director of Health and Wellness revealed Tenant #2's order was written as three times daily and as needed (combined order). The issue with the labels had been discussed with pharmacy.	A 150		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all	A 345		

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A 345	Continued From page 3 program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse delegated training within 30 days of hire. This pertained to 3 of 6 staff reviewed (Staff B, E and F). Findings follow: 1. Record review on 3-30-21 of Staff B's training documents revealed Staff B was hired on 1-7-21. Nurse delegations documents for Staff B were not found at the time of the recertification visit. 2. Record review on 3-30-21 of Staff E's training documents revealed Staff E was hired on 10-12-20. Nurse delegations were completed on 11-25-20 and 1-7-21; however, were not completed within 30 days of employment. 3. Record review on 3-30-21 of Staff F's training documents revealed Staff F was hired on 1-22-21. Nurse delegations were completed on 2-23-21. 4. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed all nurse delegation training documents for the staff listed above were provided.	A 345		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section	A 380		

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A 380	Continued From page 4 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review revealed the Program failed to ensure completion of dependent adult abuse training within six months of employment. This pertained to 2 of 2 staff reviewed employed six months or greater (Staff C and D). Findings follow: 1. Record review on 3-30-21 of Staff C's training documents revealed Staff C's hire date was 3-10-20. Staff C did not have a completed dependent adult abuse course. 2. Record review on 3-30-21 of Staff D's training documents revealed Staff D's hire date was 3-9-20. Staff D did not have a completed dependent adult abuse course. 3. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed no additional dependent adult abuse training for the staff listed above was found.	A 380		
A 400	481-67.19(3) Record Checks 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. This REQUIREMENT is not met as evidenced	A 400		

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A 400	Continued From page 5 by: Based on interview and record review the Program failed to complete background checks prior to employment. This pertained to 1 of 6 staff reviewed (Staff A and B). Findings follow: 1. Record review on 3-30-21 of Staff B's training documents revealed Staff B was hired on 1-3-21. A criminal history background check and abuse registries background check was completed on 1-7-21. The background check revealed further research was required for the criminal history background check. No results were found on the abuse registries background check. The abuse registries background check was not completed prior to Staff B's employment. 2. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed all background check information was provided for the staff listed above.	A 400		
A 415	481-67.19(3)c Record Checks 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 415		

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A 415	Continued From page 6	A 415		

Program failed to request the Department of Human Services (DHS) complete an evaluation to determine if employment was prohibited for a person considered for employment. This pertained to 1 of 1 staff reviewed that required a record check evaluation (Staff B). Findings follow:

1. Record review on 3-30-21 of Staff B's training documents revealed Staff B was hired on 1-3-21. A criminal history background check and abuse registries background check was completed on 1-7-21. The check revealed further research was required for the criminal history background check. No results were found on the abuse registries background check. The Iowa Record Check Request Form S dated 1-11-21, indicated a record was found. A Record Check Evaluation was not pending or completed until 4-6-21.

Continued record review revealed another criminal history background check and abuse registries background check was completed on 4-5-21. The check revealed further research was required for the criminal history background check. The Iowa Record Check Request Form S dated 4-6-21 indicated a record was found. The Record Check Evaluation was completed and returned with an approval notice dated 4-6-21.

Further record review revealed time records indicated Staff B first worked on 1-19-21, which was prior to the completion of the background check process, including the Record Check Evaluation with approval notice.

2. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed all background check information was provided for the staff listed

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A 415	Continued From page 7 above.	A 415		
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 observation, interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review on 3-30-21 of Tenant #1's file revealed Tenant #1 was staged at six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Observation Notes indicated the following: -On 1-26-21 it was noted that on 1-25-21 Tenant #1 was agitated and aggressive. Staff attempted to assist Tenant #1 with changing her protective undergarment and she hit, yelled, pinched and used foul language towards staff. Staff got Tenant #1 into the shower as there was bowel movement everywhere. When redressing Tenant #1, a staff was scratched on both arms, which left welts, had a twisted wrist and Tenant #1 grabbed staff's chest and hit staff. -On 1-28-21 it was noted Tenant #1 was very	A 140		

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physical during toileting rounds with staff. When staff tried to toilet Tenant #1 and get her ready for bed, she told staff she was going to kill them.

-On 2-1-21 it was noted staff reported an increase in aggressive behavior.

-On 2-2-21 it was noted staff reported Tenant #1 was aggressive during activities of daily living the prior night.

-On 2-5-21 it was noted some staff could assist Tenant #1 with toileting and other staff could not. Staff was instructed to have only one staff assist with her cares.

-On 2-12-21 it was noted an attempt was made for a COVID-19 retest; however, Tenant #1 was agitated and started to get aggressive.

-On 3-8-21 it was noted Tenant #1 was agitated and upset over the weekend. Tenant #1 ran down the halls and charged at staff.

-On 3-9-21 it was noted staff reported it was difficult to assist Tenant #1 with toileting. The night prior she was pounding on doors, chased staff and cried.

-On 3-9-21 it was noted orders were received to treat a urinary tract infection (UTI), with cephalexin, twice daily, for seven days.

-On 3-15-21 it was noted on 3-14-21 staff attempted to assist Tenant #1 with toileting twice and she yelled and used foul language. Staff were unable to assist Tenant #1 with toileting.

-On 3-17-21 it was noted Tenant #1 had refused some of her antibiotic. An order was received for

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cephalexin in capsule form to see if she would take it.

-On 3-24-21 it was noted staff reported Tenant #1 had been more resistive to cares.

-On 3-30-21 it was noted staff had difficulty getting Tenant #1 to shower. Tenant #1 yelled, cried and refused to get in. It was noted Tenant #1 also refused breakfast.

Continued record review revealed evaluations were completed on 3-29-21. A 90 day evaluation was completed dated 1-5-21. Evaluations were not completed as need with a significant change of condition with increased behaviors and a UTI.

2. Record review on 3-30-21 of Tenant #2's file revealed Tenant #2 was staged at five on the Global Deterioration Scale (GDS), which indicated moderately severe decline. Observation Notes indicated the following:

-On 2-9-21 it was noted Tenant #2 had a 5 centimeter (cm) x 5 cm area to her coccyx that looked like a rug burn. The area was cleansed and Mepliex was applied.

-On 2-9-21 it was noted staff noted Tenant #2 had more episodes of confusions and hallucinations.

-On 2-23-21 it was noted Tenant #2 had a 3 cm x 3 cm superficial area to the coccyx.

-On 3-4-21 it was noted Tenant #2 qualified for hospice services. She previously received hospice services through a different hospice agency and was discharged on 1-22-21. Tenant #2 would be provided with a hospital bed, fall mat and air mattress. Hospice would provide wound

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care to the area on Tenant #2's buttocks. Toileting frequencies were changed to every two hours and staff was to reposition and ensure she was clean every two hours.

-On -3-25-21 it was noted staff noted Tenant #2 required increased assistance with transfers and transfer study was started.

When observed on 3-30-21 at approximately 11:55 a.m. two staff transferred Tenant #2 from the bed to the wheelchair.

Continued record review revealed evaluations were completed on 3-29-21. A 90 day evaluation was completed dated 1-7-21. Evaluations were not completed as needed with a significant change of condition with the discharge from hospice services and initiation of hospice services, increased transfer needs and the wound and treatment.

3. Record review on 3-30-21 of Tenant #3's file revealed Tenant #3 was staged at six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Observation Notes indicated the following:

-On 1-12-21 it was noted Tenant #3 was aggressive with staff during his shower and punched a staff in the mouth and grabbed her hand.

-On 1-21-21 it was noted Tenant #3 was aggressive with staff the last couple of nights when they assisted him to get ready for bed.

-On 1-28-21 it was noted staff attempted to toilet Tenant #3 and get him ready for bed and he refused twice and on the third attempt he kicked

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one of the staff in the face.

-On 2-2-21 it was noted Tenant #3 was aggressive with staff and some tenants, the night prior.

-On 2-18-21 it was noted an order was received to crush Tenant #3's medications.

-On 2-24-21 it was noted Tenant #3 used a wheelchair for mobility when unsteady.

-On 2-26-21 it was noted staff had taken Tenant #3 to the bathroom and he pushed a staff up against the wall and she had to call for assistance

-On 3-10-21 it was noted Tenant #3 was aggressive with cares the night prior.

-On 3-15-21 it was noted on 3-14-21 Tenant #3 refused assistance with toileting and cares and did not eat much supper. He spit out his medications in pudding on staff's hair and clothes, while he grabbed and twisted staff's arm. When staff removed his anti-embolism hose he kicked staff.

-On 3-18-21 it was noted Tenant #3 was sent to the hospital and returned with a new order for amoxicillin for a UTI.

-On 3-18-21 it was noted one to one daily care was set up with an outside home health agency to increase the safety for Tenant #3.

-On 3-19-21 it was noted Tenant #3 had two falls that morning and was sent to the hospital. Tenant #3 was admitted for pneumonia.

-On 3-22-21 it was noted Tenant #3 returned from

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A 140	Continued From page 12 the hospital and was placed on hourly safety checks during the day and 30 minute safety checks at bedtime. -On 3-25-21 it was noted Tenant #3 exposed himself to a female tenant. -On 3-25-21 it was noted Tenant #3 was offered his medications and he spit them in the staff's face. Continued record review revealed evaluations were completed on 3-23-21 and 3-29-21. A 90 day nurse review was completed on 1-12-21. Evaluations were not completed as needed until 3-23-21 and 3-29-21 despite significant changes occurring since the last evaluation including behaviors, refusals of care, increased frequency of checks and implementation of an outside agency for one to one services. 4. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed all of the evaluations available for the tenants listed above were provided.	A 140		
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. This REQUIREMENT is not met as evidenced	A 350		

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A 350	Continued From page 13 by: Based on interview and record review the Program failed to complete service plans as needed and failed to develop service plans to reflect the identified needs of tenants. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review on 3-30-21 of Tenant #1's file revealed Tenant #1 staged at six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Observation Notes indicated the following: -On 1-26-21 it was noted that on 1-25-21 Tenant #1 was agitated and aggressive. Staff attempted to assist Tenant #1 with changing her protective undergarment and she hit, yelled, pinched and used foul language towards staff. Staff got Tenant #1 into the shower as there was bowel movement everywhere. When redressing Tenant #1, a staff was scratched on both arms, which left welts, had a twisted wrist and Tenant #1 grabbed staff's chest and hit staff. -On 1-28-21 it was noted Tenant #1 was very physical during toileting rounds with staff. When staff tried to toilet Tenant #1 and get her ready for bed, she told staff she was going to kill them. -On 2-1-21 it was noted staff reported an increase in aggressive behavior. -On 2-2-21 it was noted staff reported Tenant #1 was aggressive during activities of daily living the prior night. -On 2-5-21 it was noted some staff could assist Tenant #1 with toileting and other staff could not. Staff was instructed to have only one staff assist	A 350		

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	S0360	A. BUILDING: _____ B. WING _____	04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN ALP/D	1275 W FOREVERGREEN ROAD NORTH LIBERTY, IA 52317

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A 350	Continued From page 14 with her cares. -On 2-12-21 it was noted an attempt was made for a COVID-19 retest; however, Tenant #1 was agitated and started to get aggressive. -On 3-8-21 it was noted Tenant #1 was agitated and upset over the weekend. Tenant #1 ran down the halls and charged at staff. -On 3-9-21 it was noted staff reported it was difficult to assist Tenant #1 with toileting. The night prior she was pounding on doors, chased staff and cried. -On 3-9-21 it was noted orders were received to treat a urinary tract infection (UTI), with cephalexin 10 ml, twice daily for seven days. -On 3-15-21 it was noted on 3-14-21 staff attempted to assist Tenant #1 with toileting twice and she yelled and used foul language. Staff were unable to assist Tenant #1 with toileting. -On 3-17-21 it was noted Tenant #1 had refused some of her antibiotic. An order was received for cephalexin in capsule form to see if she would take it. -On 3-24-21 it was noted staff reported Tenant #1 had been more resistive to cares. -On 3-30-21 it was noted staff had difficulty getting Tenant #1 to shower. Tenant #1 yelled, cried and refused to get in. It was noted Tenant #1 also refused breakfast. Continued record review revealed the service plan was updated and reflected Tenant #1's behaviors on 3-29-21. The service plan provided	A 350		

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A 350	Continued From page 15 by the Program prior to the 3-29-21 service plan was dated 10-7-21. The service plan was not updated as needed with significant change and did not reflect the service needs of Tenant #1. 2. Record review on 3-30-21 of Tenant #2's file revealed Observation Notes indicated the following: -On 2-9-21 it was noted Tenant #2 had a 5 centimeter (cm) x 5 cm area to her coccyx that looked like a rug burn. The area was cleansed and Mepliex was applied. -On 2-9-21 it was noted staff noted Tenant #2 had more episodes of confusions and hallucinations. -On 2-23-21 it was noted Tenant #2 had a 3 cm x 3 cm superficial area to the coccyx. -On 3-4-21 it was noted Tenant #2 qualified for hospice services. She previously received hospice services through a different hospice agency and was discharged on 1-22-21. Tenant #2 would be provided with a hospital bed, fall mat and air mattress. Hospice would provide wound care to the area on Tenant #2's buttocks. Toileting frequencies were changed to every two hours and staff was to reposition and ensure she was clean every two hours. -On -3-25-21 it was noted staff noted Tenant #2 required increased assistance with transfers and transfer study was started. When observed on 3-30-21 at approximately 11:55 a.m. two staff transferred Tenant #2 from the bed to the wheelchair.	A 350		

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A 350	Continued From page 16 Continued record review revealed the service plan was updated on 3-29-21. The service plan provided by the Program prior to the 3-29-21 service plan was dated 10-15-20. The service plan was not updated with the discharge from hospice services and initiation of hospice services, increased transfer needs and the wound and treatment. 3. Record review on 3-30-21 of Tenant #3's file revealed Observation Notes indicated the following: -On 1-12-21 it was noted Tenant #3 was aggressive with staff during his shower and punched a staff in the mouth and grabbed her hand. -On 1-21-21 it was noted Tenant #3 was aggressive with staff the last couple of nights when they assisted him to get ready for bed. -On 1-28-21 it was noted staff attempted to toilet Tenant #3 and get him ready for bed and he refused twice and on the third attempt he kicked one of the staff in the face. -On 2-2-21 it was noted Tenant #3 was aggressive with staff and some tenants the night prior. -On 2-18-21 it was noted an order was received to crush Tenant #3's medications. -On 2-24-21 it was noted Tenant #3 used a wheelchair for mobility when unsteady. -On 2-26-21 it was noted staff had taken Tenant #3 to the bathroom and he pushed a staff up	A 350		

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A 350	Continued From page 17	A 350		

against the wall and she had to call for assistance

-On 3-10-21 it was noted Tenant #3 was aggressive with cares the night prior.

-On 3-15-21 it was noted on 3-14-21 Tenant #3 refused assistance with toileting and cares and did not eat much supper. He spit out his medications in pudding on staff's hair and clothes, while he grabbed and twisted staff's arm. When staff removed his anti-embolism hose he kicked staff.

-On 3-18-21 it was noted Tenant #3 was sent to the hospital and returned with a new order for Amoxicillin for a UTI.

-On 3-18-21 it was noted one to one daily care was set up with an outside home health agency to increase the safety for Tenant #3.

-On 3-19-21 it was noted Tenant #3 had two falls that morning and was sent to the hospital. Tenant #3 was admitted for pneumonia.

-On 3-22-21 it was noted Tenant #3 returned from the hospital and was placed on hourly safety checks during the day and 30 minute safety checks at bedtime.

-On 3-25-21 it was noted Tenant #3 exposed himself to a female tenant.

-On 3-25-21 it was noted Tenant #3 was offered his medications and he spit them in the staff's face.

Continued record review revealed service plans were updated on 3-23-21 and 3-29-21. The service plan was not updated as needed prior to

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A 350	Continued From page 18 the 3-23-21 and 3-29-21 updated services. The service plan provided by the Program prior to the 3-23-21 service plan was dated 10-28-20. 4. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and the Director of Health and Wellness confirmed all of the service plan available for the tenants listed above were provided.	A 350		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed eight hours of dementia-specific education within 30 days of hire. This pertained to 3 of 6 staff reviewed (Staff A, C and D). Findings follow: 1. Record review on 3-30-21 of Staff A's training documents revealed Staff A was hired on 2-15-21 and did not have eight hours dementia-specific education completed within 30 days of hire. 2. Record review on 3-30-21 of Staff C's training documents revealed Staff was hired on 3-10-20 and did not have eight hours of dementia-specific education completed within 30 days of hire.	A 545		

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A 545	Continued From page 19 3. Record review on 3-30-21 of Staff D's training documents revealed Staff D was hired on 3-9-20 and did not have eight hours of dementia-specific education completed within 30 days of hire. 4. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness confirmed no additional dementia specific education was located for the staff listed above.	A 545		
A 565	481-69.30(5) Dementia Specific Education for Personnel 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program did not provide dementia-specific training including hands-on training. This pertained to 2 of 6 staff reviewed (Staff C and E). Findings follow: 1. Record review on 3-30-21 of Staff C's training documents revealed a hire date of 3-10-20. The Program provided two certificates of completed dementia training for Staff C. One certificate documented Staff C completed a two hour case study. The other certificate documented Staff C completed four hours of hands-on dementia training. Both certificates were dated 3-15-21 and both certificates were signed by the Former Director of Health and Wellness.	A 565		

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A 565	Continued From page 20 Continued record review revealed the Program provided a termination date of 1-25-21 for the Former Director of Health and Wellness. The two certificates of completed dementia training for Staff C provided by the Program reflected dates of 3-15-21 and signatures of the Former Director of Health and Wellness, who had not been employed by the Program nearly two months prior to the dates on the certificates. The dates of the certificates could not be reconciled by the Program when requested. There was no accurate documentation provided for the completion of hands-on dementia training within 30 days of Staff C's hire date. 2. Record review on 3-30-21 of Staff E's training documents revealed a hire date of 10-12-20. The Program provided two certificates of completed dementia training for Staff E. One certificate reflected Staff E completed a two hour case study dated 10-21-20 and the certificate was signed by the Former Director of Health and Wellness. The second certificate provided by the Program indicated Staff E completed a four hour hands-on dementia training dated 2-25-20. The certificate was signed by the Former Director of Health and Wellness. Continued record review revealed time card records reflected Staff E did not work on 10-21-20, when it was documented Staff E completed a two hour case study. Additionally, the four hour hands-on dementia training was dated 2-25-20, nearly eight months before Staff E was hired. The dates of the certificates could not be reconciled by the Program when requested. There was no accurate documentation provided for the completion of hands-on dementia training within 30 days of Staff E's hire date.	A 565		

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A 565	Continued From page 21 3. Interviews completed on 4-6-21 and 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness indicated the termination date of the Former Director of Health and Wellness provided was confirmed to be accurate and Staff E had not worked previously at the Program. When asked to reconcile the dates of the certificates noted above, indicated the certificates questioned were found in a filing cabinet.	A 565		
A 680	481-69.33(7) Transportation 481-69.33(231C) Transportation. When transportation services are provided directly or under contract with the program: 69.33(7) Each vehicle shall have a first-aid kit, fire extinguisher, safety triangles and a device for two-way communication. This REQUIREMENT is not met as evidenced by: Based on observation and interview the Program failed to maintain required safety equipment in a vehicle used to transport tenants. This potentially affected all tenants (census of 19). Findings follow: 1. When observed on 3-30-21 at approximately 12:50 p.m. the Program's sport utility vehicle (SUV), did not have a first-aid kit, fire extinguisher or safety triangles. 2. When interviewed on 3-30-21 at approximately 12:50 p.m. Staff H revealed the SUV was used approximately three times per week to transport	A 680		

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A 680	Continued From page 22 tenants and Staff H confirmed the SUV did not have the above safety items. 3. An interview on 4-8-21 at 2:30 p.m. with the Executive Director and Director of Health and Wellness revealed the equipment was placed in the vehicle and corrected the day it was observed.	A 680		

Keystone Place at Forevergreen ok
Plan of Correction
August 3, 2021

A150- Program Policies and Procedures 481-67.2(3)

Findings:

1. Program failed to follow its policy and procedure related to medications.

Plan of Correction:
1. All tenants receiving medication administration by the Program will have medications administered in accordance with physician or third party health care provider orders.

2. The Program has amended its' Medication Needs of Tenants/Medication Management Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 1).

3. All Health and Wellness staff will be retrained with respect to the new Medication Needs of Tenants/Medication Management Policy and Procedure dated August 2, 2021. Retraining will be completed by September 1 2021.

4. The Medications Needs of Tenants/Medication Management Policy and Procedure dated August 2, 2021 includes procedures at items (9) and (11) which will add a review of the MAR to medications received by the program. The Director of Health and Wellness has completed retraining of all registered nurses as to the new procedures.

5. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures.

A 345 – Staffing Medication Records 481-67.9(4)b

Findings:

1. Program failed to properly complete and document training completed for newly hired staff within 30 days of employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include a checklist for Orientation Training. The Orientation Training includes nurse delegation procedures.

2. The Program has amended its' Staff Training Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 2).

3. The Director of Operations shall conduct audits of the personnel files including verification of training and documentation of training at the intervals set forth on the Staff Training Policy and

Procedure and ensure that any training is completely on a timely basis in accordance with regulatory requirements and the policy and procedure.

4. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes item for review of staff files for appropriate documentation.

A 380 – Staffing 481-67.9

Findings:

1. Program failed to properly complete and document dependent adult abuse training for staff within 6 months of employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include a checklist for Dependent Adult Abuse Training within 6 months of employment and each 3 years thereafter. The Orientation Training includes nurse delegation procedures.

2. The Program has amended its' Staff Training Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 2).

3. The Director of Operations shall conduct audits of the personnel files including verification of training and documentation of training at the intervals set forth on the Staff Training Policy and Procedure and ensure that any training is completely on a timely basis in accordance with regulatory requirements and the policy and procedure.

4. A new Director of Operations was hired with experience regarding personnel training and proper documentation of personnel files.

5. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes an item for review of personnel files to ensure appropriate documentation of training.

A 400 – Record Checks 481-67.19(3)

Findings:

1. Program failed to complete background checks with the Iowa Department of Public Safety prior to employment.

2. Program failed to complete evaluation by the Iowa Department of Human Services to determine if employment was prohibited for a person considered for employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include checklist items for background checks with the Iowa Department of Public Safety and record checks with the Iowa Department of Human Services.

2. The Program has amended its Staffing Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 3) to include restrictions (i) on inputting newly hired personnel into the payroll processing system and (ii) placing any newly hired personnel on the schedule for work prior to completion of the Department of Public Safety background check and the Department of Human Services record check to confirm eligibility for employment.

3. At any time the Director of Operations conducts audits of the personnel files, the Director of Operations shall ensure that documentation of record checks is maintained in personnel files.

4. A new Director of Operations was hired with experience regarding personnel record checks and proper documentation of personnel files.

5. The Community has developed and implmented a written Quality Assurance Checklist as a control measure with designation of responsibilities to ensure ongoing compliance with the Community's policies and procedures. The Quality Assurance Checklist includes an item for review of personnel files to ensure appropriate documentation of record checks.

A 140 – Evaluation of Tenant 481-6.22(2)

Findings:

1. Program failed to complete evaluations upon a significant change of tenant's condition.

Plan of Correction:

1. The Program has updated its Evaluation of Residents Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 4). The updated policy includes a list (which is not comprehensive) of changes to a tenant's condition that would be considered a significant change and necessitate an evaluation.

2. The Director of Health and Wellness will ensure that all Health and Wellness staff are retrained in the updated Evaluation of residents Policy and Procedure by September 1 2021.

3. All Health and Wellness staff are required to report to the nurse on duty any identified and needed significant changes via an incident report or documentation in the electronic charting system.

A 350 – Service Plans 481-69.26(1)

Findings:

1. Program failed to complete service plans as needed and failed to develop service plans to reflect the identified needs of tenants.

Plan of Correction:

1. The Program has updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 5). The updated policy includes a list (which is not comprehensive) of changes to a tenant's condition that would be considered a significant change and necessitate an evaluation and service plan change.

2. The Director of Health and Wellness will ensure that all Health and Wellness staff are retrained in the updated Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure by September 1 2021.

3. All Health and Wellness staff will be retrained by September 1, 2021 on the Community's electronic charting system which includes automated alerts for resident assessments.

4. As a quality assurance measure, the Community has created and is using an excel file, Schedule Assessment Tool, which identifies upcoming assessments to ensure resident service plans are updated timely following evaluations. The Schedule Assessment Tool is reviewed on a weekly basis by the Executive Director and the Director of Operations.

A 545 – Dementia Specific Education for Personnel 481-69.30(1)

Findings:

1. The Program failed to ensure staff completed 8 hours of dementia-specific training within 30 days of employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include a checklist for Orientation Training which also includes dementia specific training as a training item.

2. The Program has amended its Staff Training Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 2) to further outline rquirements for dementia spcific training.

3. The Director of Operations shall conduct audits of the personnel files including verification of training and documentation of training at the intervals set forth on the Staff Training Policy and Procedure which include the requirement for initial and ongoing dementia specific training and ensure that any training is completely on a timely basis in accordance with regulatory requirements and the policy and procedure.

A 565 – Dementia Specific Education for Personnel

Findings:

1. The Program failed to provide dementia-specific training including hands-on training.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include a checklist for Orientation Training which also includes dementia specific training as a training item.

2. The Program has amended its Staff Training Policy and Procedure as of August 2, 2021 (a copy of which is attached as Exhibit 2) to further outline rquirements for dementia spcific training including required available training methods.

3. The Director of Operations is responsible to ensure that the methods for dementia specific training as set forth in the Staff Training Policy and Procedure as of August 2, 2021 are available at the Community.

A 680 – Transportation

Findings:

1. The Program failed to maintain required safety equipment in a vehicle used to transport tenants.

Plan of Correction:

1. As of April 8, 2021, all vehicles utilized to transport residents contained required safety equipment including a first aid kit, fire extinguisher and safety triangles.

2. The job descriptions of the Director of Facilities and the Life Enrichment Director include within the job duties requirements to assess vehicles that transport residents to confirm required safety equipment is onboard prior to utilization of the vehicles.