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
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 22 Total census: 24 No regulatory insufficiencies were cited during the onsite infection control survey or the investigation of Complaint #94486-C, Complaint #96765-C, and Complaint #97332. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program fror People with Dementia.	A 000		
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 by: Based on interview and record review the Program failed to complete criminal, child, and dependent adult abuse background checks prior to employment for 1 of 8 staff reviewed (Staff F). Findings follow:	A 400	Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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	Continued From page 1 Record review on 8-3-21 of Staff F's file revealed a hire date of 1-25-21. A Single Contact License and Background Check was completed 8-2-21. No criminal, child, and dependent adult abuse background checks completed prior to employment could be located. The Administrative Assistant confirmed these findings on 8-5-21 at 11:18 a.m.	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 Program failed to submit an evaluation to the Department of Human Services (DHS) for 2 of 2 staff reviewed with a criminal history (Staff A and Staff G). Findings follow: 1. Record review of Staff A's file revealed a hire date of 11-11-19. A Single Contact License and Background Check completed 10-29-19 revealed a criminal history. No evaluation from DHS could be located. A Single Contact License and Background Check completed 12-3-19 revealed a criminal history. An evaluation from DHS	A 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 415	Continued From page 2 approved her employment to the Program on 12-16-19, 5 weeks after beginning employment. 2. Record review of Staff G's file on 8-2-21 revealed a hire date of 3-30-2020. A Single Contact License and Background Check completed 3-25-2020 revealed a criminal history. No evaluation from DHS could be located. The Administrative Assistant confirmed these findings on 8-5-21 at 11:18 a.m.	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 interview and record review the Program failed to evaluate each tenant's functional, cognitive, and health status within 30 days of occupancy for 3 of 4 tenants reviewed (Tenant #1, Tenant #2, and Tenant #3). Findings follow: Record review of tenant files on 8-10-21 revealed the following: 1. Tenant #1 was admitted on 2-28-21. No 30 day evaluation could be located. 2. Tenant #2 was admitted on 11-24-2020. No 30	A 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 3 day evaluation could be located. 3. Tenant #3 was admitted on 11-28-2020. No 30 day evaluation could be located. On 8-12-21 at 9:45 a.m. the Registered Nurse confirmed these findings.	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 evaluate functional, cognitive, and health status as needed for significant change for 2 of 4 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. Review of tenant files on 8-10-21 revealed the following: a. Tenant #1's Progress Notes dated 6-15-21 documented he began hospice services. Hospice clinical notes dated 6-10-21 revealed he was	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 4 admitted to hospice on 6-10-21. No functional, cognitive, and health assessments could be located after he was admitted to hospice care. b. Tenant #2's Progress Notes revealed the following: *12-1-2020 noted conversation with spouse and explained Tenant #2 exceeded level of care as he required 2-3 staff for transfers. *1-11-21 noted conversation with Tenant #2's physician about wound on right hip. The physician verbally ordered a referral to a wound care clinic. *2-5-21 noted conversation with spouse and recommended hospice care. *7-30-21 noted Tenant #2 returned from the hospital with a catheter for one week to monitor urine. No comprehensive evaluations for these significant changes in health status could be located. 2. On 8-11-21 at 12:34 p.m. the Licensed Practical Nurse confirmed Tenant #2 was admitted to hospice care on 2-17-21. On 8-12-21 at 9:45 a.m. the Registered Nurse confirmed these findings.	A 145		
A 155	481-69.23(1)b Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation	A 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 155	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program admitted and/or retained 2 of 2 tenants reviewed who required routine two-person assistance with standing, transfer, or evacuation (Tenant #1 and Tenant #2). Findings follow: Record review of tenant files on 8-10-21 revealed the following: 1. Tenant #1 was admitted on 2-28-21. The Functional, Cognitive, and Health Status assessment completed 2-27-21 revealed he required two staff to transfer using a gait belt. The Service Plan dated 3-9-21 revealed he required the assistance of two staff for transfers. Progress Notes dated 4-28-21 revealed a communication with the physical therapist (PT) provider that Tenant #1 would be discharged on 5-20-21 for lack of progress. Hospice clinical notes revealed the following: *6-10-21 documented Tenant #1 was admitted to hospice services on 6-10-21. *6-15-21 revealed he required 2-3 staff for transfers. On 8-10-21 at 12:34 p.m. the Licensed Practical Nurse confirmed Tenant #1 received PT from 3-14-21 through 5-21-21 and was admitted to hospice care on 6-10-21. On 8-12-21 the Registered Nurse (RN) stated she completed an in home assessment and Tenant #1's spouse stated she could transfer him by herself. The RN stated she failed to attempt to transfer him herself to confirm this and initiated PT immediately after admission when he required	A 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 155	Continued From page 6 the assistance of two staff for transfers. Tenant #1 exceeded criteria when he required the assistance of two staff for transfers. 2. Tenant #2 was admitted on 11-24-2020. Review of Tenant #2's Progress Notes revealed the following: *12-1-2020 noted conversation with spouse and explained Tenant #2 exceeded level of care as he required 2-3 staff for transfers. *1-5-21 revealed PT/OT evaluation was scheduled for 1-18-21. *2-5-21 revealed discontinuation of PT due to lack of progress as he continued to require two staff for transfers and noted conversation with spouse that recommended hospice care. On 8-10-21 at 12:34 p.m. the Licensed Practical Nurse confirmed Tenant #2 received PT from 1-18-21 through 2-3-21 and was admitted to hospice care on 2-17-21. Tenant #2 exceeded criteria when he required the assistance of two staff for transfers. On 8-12-21 at 9:45 a.m. the RN stated she explained to Tenant #2's spouse he exceeded level of care and his spouse stated she would look into hospice care. The RN stated she failed to document this information.	A 155		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.	A 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 360	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days of occupancy and as needed with significant change for 3 of 4 tenants reviewed (Tenant #1, Tenant #2, and Tenant #3). Findings follow: Record review of tenant files on 8-10-21 revealed the following: 1. Tenant #1 was admitted on 2-28-21. Review of Tenant #1's Progress Notes dated 6-15-21 documented he started hospice services. Hospice clinical notes dated 6-10-21 revealed he was admitted to hospice on 6-10-21. No functional, cognitive, and health assessments could be located after he was admitted to hospice care. No updated service plan completed within 30 days of occupancy or for the admission to hospice care could be located. 2. Tenant #2 was admitted on 11-24-2020. Review of Tenant #2's Progress Notes revealed the following: *12-1-2020 noted conversation with spouse and explained Tenant #2 exceeded level of care as he required 2-3 staff for transfers. *1-11-21 noted conversation with Tenant #2's physician about wound on right hip. The physician verbally ordered a referral to a wound care clinic. *2-5-21 noted conversation with spouse and recommended hospice care. *7-30-21 noted Tenant #2 returned from the hospital with a catheter for one week to monitor	A 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 360	Continued From page 8 urine. No updated service plan completed within 30 days of occupancy or for the significant changes in health status could be located. 3. Tenant #3 was admitted on 11-28-2020. No updated service plan completed within 30 days of occupancy could be located. On 8-12-21 at 9:45 a.m. the Registered Nurse confirmed these findings.	A 360		
A 405	481-69.26(4)c Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans to include outside service providers for 2 of 4 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: Record review of tenant files on 8-10-21 revealed the following: 1. Tenant #1's Progress Notes revealed the following:	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 405	Continued From page 9 *6-15-21 documented he signed on for hospice services. *4-28-21 documented a communication with the physical therapist (PT) provider that discharge of services would occur 5-20-21 for lack of progress. Hospice clinical notes dated 6-10-21 revealed he was admitted to hospice on 6-10-21. Hospice Clinical Notes dated 6-15-21 revealed he required 2-3 staff for transfers and received a hospice aide to help with showers two times per week. No updated service plan indicating hospice or PT services could be located. 2. Tenant #2 was admitted on 11-24-2020. Review of Tenant #2's Progress Notes revealed the following: *12-1-2020 noted conversation with spouse and explained Tenant #2 exceeded level of care as he required 2-3 staff for transfers. *1-5-21 revealed PT/OT evaluation was scheduled for 1-18-21. *1-11-21 noted conversation with Tenant #2's physician about wound on right hip. The physician verbally ordered a referral to a wound care clinic. *1-22-21 revealed communication with the family that requested previous PT notes to see if they could help with current PT. *2-5-21 revealed discontinuation of PT due to lack of progress as he continued to require two staff for transfers and noted conversation with spouse that recommended hospice care. No updated service plan indicating hospice or PT services could be located.	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 405	Continued From page 10 On 8-12-21 at 9:45 a.m. the Registered Nurse confirmed these findings.	A 405		
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 ensure comprehensive nurse reviews were completed every 90 days or as needs changed for 2 of 4 tenants reviewed (Tenant #1 and Tenant #2. Findings follow: Record review of tenant files on 8-5-21 revealed the following: 1. Tenant #1's Progress Notes dated 4-28-21 revealed a communication with the physical therapist (PT) provider that documented discharge of services would occur 5-20-21 for lack of progress. No comprehensive nurse review could be found for the start and stop of PT services.	A 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 11 On 8-10-21 at 12:34 p.m. the Licensed Practical Nurse confirmed Tenant #1 received PT from 3-14-21 through 5-21-21. 2. Tenant #2's Progress Notes dated 1-5-21 revealed PT/OT evaluation was scheduled for 1-18-21. Notes dated 1-22-21 revealed communication with the family that requested previous PT notes to see if they could help with current PT. Notes dated 2-5-21 revealed discontinuation of PT due to lack of progress as he continued to require two staff for transfers. No comprehensive nurse review could be found for the start and stop of PT services. On 8-10-21 at 12:34 p.m. the Licensed Practical Nurse confirmed Tenant #2 received PT from 1-18-21 through 2-3-21.	A 430		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide annual in-service training on food protection for 2 of 7 staff reviewed that handled food (Staff A and Staff E). Findings follow: Record review of staff files revealed the following:	A 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 465	Continued From page 12 1. Staff A completed safe food handling on 1-26-20 but no annual training on food protection could be located. 2. Staff E completed safe food handling on 3-12-19 but no annual training on food protection could be located. On 8-5-21 at 12:05 p.m. the Executive Director confirmed these findings.	A 465		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide 8 hours of dementia training within 30 days of employment for 8 of 8 staff reviewed (Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff G, and Staff H.). Findings follow: Record review of staff files on 8-2-21 revealed the following: 1. Staff A was hired 11-11-19. No dementia training within 30 days of employment could be located.	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 545	Continued From page 13 2. Staff B was hired 2-3-20. No dementia training within 30 days of employment could be located. 3. Staff C was hired 12-5-19. No dementia training within 30 days of employment could be located. 4. Staff D was hired 3-31-20. No dementia training within 30 days of employment could be located. 5. Staff E was hired 2-7-19. One hour of dementia training was completed on 2-8-19. No further dementia training within 30 days of employment could be located. 6. Staff F was hired 1-25-21. One hour of dementia training was completed on 1-26-21. No further dementia training within 30 days of employment could be located. 7. Staff G was hired 3-30-20. No dementia training within 30 days of employment could be located. 8. Staff H was hired 5-26-20. One hour of dementia training was completed on 6-14-2020. No further dementia training within 30 days of employment could be located. On 8-5-21 at 11:18 a.m. the Administrative Assistance confirmed these findings.	A 545		
A 556	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education	A 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 556	Continued From page 14 b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide 8 hours of dementia training annually for 2 of 8 staff reviewed (Staff C and Staff E). Findings follow: Record review of staff files on 8-2-21 revealed the following: 1. Staff C was hired 12-5-19 and completed 4.75 hours of annual dementia training. 2. Staff E was hired 2-7-19 and completed 1.5 hours of annual dementia training. On 8-5-21 at 11:18 a.m. the Administrative Assistance confirmed these findings.	A 556		
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:	A 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 565	Continued From page 15 Based on interview and record review the Program failed to provide hands-on dementia training within 30 days of employment for 8 of 8 staff reviewed (Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff G, and Staff H.). Findings follow: Record review of staff files on 8-2-21 revealed the following: 1. Staff A was hired 11-11-19. No hands-on dementia training completed within 30 days of employment could be located. 2. Staff B was hired 2-3-2020. No hands-on dementia training completed within 30 days of employment could be located. 3. Staff C was hired 12-5-19. No hands-on dementia training completed within 30 days of employment could be located. 4. Staff D was hired 3-31-2020. No hands-on dementia training completed within 30 days of employment could be located. 5. Staff E was hired 2-7-19. No hands-on dementia training completed within 30 days of employment could be located. 6. Staff F was hired 1-25-21. No hands-on dementia training completed within 30 days of employment could be located. 7. Staff G was hired 3-30-2020. No hands-on dementia training completed within 30 days of employment could be located. 8. Staff H was hired 5-26-2020. No hands-on dementia training completed within 30 days of	A 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0379	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN MEMORY CAI	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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 565	Continued From page 16 employment could be located. On 8-5-21 at 11:18 a.m. the Administrative Assistance confirmed these findings.	A 565		

The Willows of Marshalltown

To: Iowa Department of Inspections & Appeals

From: Jennifer Stanley

CC: Linda Kellen; Deb Dixon

Date: October 11, 2021

Re: Memory Care Corrections

A400- A new hire checklist has been developed for the Administrative Assistant, Assistant Director to utilize when an individual has applied and being considered for employment. This checklist includes all the required items to ensure compliance, Criminal History Check and Child & Dependent Adult Abuse records check. The Administrative Assistant and the Assistant Director must review all employee records and approve all applicable completed records. All Willows employees working this position when the Administrative Assistant is absent, must be trained on this process. The Checklist also includes mandatory paperwork requirements for all new hires. Weekly Audits will be completed on each employee's file, each Friday of the week. There will be a weekly audit completed by the Administrative Assistant, and Approved by the Assistant Director, going through each file, each week on Friday, to ensure the background checks are completed 100% through.

Date Completed: April 8, 2021 (Checklist was already in place when findings and will continue the same process).

Persons Responsible- Administrative Assistant & Assistant Director

A415 A new hire checklist has been developed for the Administrative Assistant, Assistant Director to utilize when an individual has applied and being considered for employment. This checklist includes all the required items to ensure compliance, Criminal History Check and Child & Dependent Adult Abuse records check. The Administrative Assistant and the Assistant Director must review all employee records and approve all applicable completed records. All Willows employees working this position when the Administrative Assistant is absent, will be trained on this process. The Checklist also includes mandatory paperwork requirements for all new hires.

Date Completed: April 8, 2021 (Checklist was already in place when findings, and we will continue to use this same process). Updated Date of Checklist- September 6, 2021.

Persons Responsible- Administrative Assistant & Assistant Director

A140 Our nurses are knowledgeable in the 30-day evaluation of tenants, and currently are fully utilizing our EHR/Resident Management software (Point Click Care). The software is configured to remind and prompt the RN staff of all scheduled evaluations.

Date Completed: August 13, 2021

Persons Responsible- Director of Nursing

10/29/21

A145 Our nurses are knowledgeable in the significant change process, however, we just learned that only a RN can only complete the change of condition process.

Date Completed: August 13, 2021 (the next week, August 18, 2021, both nurses attended the IHCA DIA conference in Des Moines, Ia, studying the rules and regulations of DIA to help better understand the guidelines. The RN is the only individual completing the change of conditions. She understands that she is on call 24/7, and will be responsible for this process, even when she out of the building or on vacation.

Persons Responsible: Director of Nursing

A155 We are knowledgeable in the criteria for admissions. We understand that we cannot admit a person that is a two- assistant. There seemed to be some confusion with the spouse and our assessment, meaning, we were told that she was caring for him alone, and was able to transfer him alone.

Date completed: August 13, 2021(the RN and ED will be at assessments together and have resident walk and transfer before admission.

Persons Responsible- Director of Nursing & Executive Director

A360 All nursing staff are updating change of conditions 24-48 hours of the event of the change.

Dated Completed: August 13, 2021- All nursing staff are updating service plans with changes in tenant needs.

Persons Responsible- Director of Nursing

A405 Anytime an outside provider for the resident is scheduled, RN will update service plan with the outsiders and the services they are providing detailed to the resident's care plan. The RN will complete within 24-48 hours of change.

Date Completed: August 13, 2021- All nursing staff are updating service plans with changes within 30 days.

Persons Responsible- Director of Nursing

A430 A nurse review will be completed with all assessments. Change of conditions will completed within 24-48 hours of the change of the event.

Date Completed: August 13, 2021

Person Responsible: Director of Nursing

A465 Date Completed: August 13, 2021- A new hire checklist has been developed for the Administrative Assistant, Assistant Director to utilize when an individual has applied and being considered for employment. This checklist includes all employees to complete food handling and food safety training. This training is mandatory in Relias program, where the employee is mandatory training before 30 days of hire. The directors for each department will receive a weekly summary report from Relias from the Administrative Assistant. If the employee has not completed the training within 30 days, the employee will be removed from the schedule and will not be able to work until training is completed. Each January, every employee will be mandatory to renew the food handling/safety training. The Administrative Assistant will complete weekly employee file audits that include checking for this form. This form is also included in the new hire paperwork.

Persons Responsible: Assistant Director & Administrative Assistant

A545, A556 All employees who are hired will be required to complete Dementia Specific Education, within 30 days of hire.

Date Completed: August 13, 2021- The new hire will complete all required all annual dementia training before they start on the floor. They will work with their director on completing trainings the first 3 days of hire. The new hire is not allowed to start working until the annual training is completed.

The Administrative Assistant and Assistant Director will monitor the Relias training program to ensure new hire is 100% compliance with this training before they start working. The Administrative Assistant will complete weekly employee file audits that include checking for this form. This form is also included in the new hire paperwork. The Relias Program is schedule to email employees and supervisors of any upcoming trainings that are due, or overdue. The Administrative Assistant and the Assistant Director will monitor the Relias program each week to ensure employees are completing the annual training. The Relias program restarts the annual trainings each year of the employee start date. If for any reason an employee does not have the annual training completed by the due date, the employee is removed from the schedule and not rescheduled until the training is completed.

Person Responsible- Administrative Assistant & Assistant Director

A565 Date Completed: August 13, 2021- A new hire checklist has been developed for the Administrative Assistant, Assistant Director to utilize when an individual has applied and being considered for employment. This checklist includes all employees to complete hands-on dementia training. The directors for each department will receive a weekly summary report from Relias from the Administrative Assistant. If the employee has not completed the training within 30 days of hire, the employee will be removed from the schedule and will not be able to work until training is completed. Each January, every employee will be mandatory to renew hands on dementia training. The administrative assistant and assistant director will make sure all employees are signed off on this training.

Persons Responsible: Assistant Director & Administrative Assistant