

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0390	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/27/2022
NAME OF PROVIDER OR SUPPLIER VINTAGE HILLS RETIREMENT COMMUNITY AL		STREET ADDRESS, CITY, STATE, ZIP CODE 604 EAST HILLCREST AVENUE INDIANOLA, IA 50125		
(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 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 impairment: 36 Number of tenants with cognitive impairment: 0 Total census: 36 No regulatory insufficiencies were cited during the investigation of Incident #105897-I. The following regulatory insufficiencies were cited during the investigation of Complaints #106641-C, 106640-C, 106992-C and 107861-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program.	A 000		
A 525	481-69.29(3) Staffing 69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure all personnel including contract/agency staff were appropriately trained to meet the tenant needs. This potentially affected 36 of 36 tenants and specifically effected 1 of 1 sample tenant who received morphine (Tenant #1). Finding follows:	A 525	1. Onsite orientation process in place for Vintage Hills employees who are passing medications to have thier Medication Managers certificate prior to admininistering medications to tenants. 2. Onsite orientation process to ensure all agency staff have thier Medication Managers Certificate prior to administering medications to tenants. 3. Audit of all current employee and agency files for required Medication Managers certificateto be completed by 1/9/2023.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 525	Continued From page 1 1. Record review on 9/20/22 revealed no training documentation for 6 of 6 contract/agency staff reviewed. When interviewed the Regional Assisted Living Director-Iowa said the Program had a procedure for training agency staff but the documentation of this training could not be located for staff who had worked since June 2022. Further record review revealed that 51 agency staff had worked at the Program since 8/1/22. When interviewed on 9/20/22 the Regional Assisted Living Director- Iowa confirmed the Program failed to consistently ensure contract/agency staff received the required training. 2. Record review on 9/26/22 revealed Tenant #1 received hospice services. Review of Tenant #1's medication administration record (MAR) noted staff had administered .25 ml (5mg) Morphine SUL SOL 100/5 ml. The MAR directed administration to be sublingual every two hours for pain or shortness of breath. When interviewed on 9/27/22 the AL Health Specialist confirmed four staff had administered morphine sublingually to Tenant #1. He said two of the four staff had been delegated or received training on oral/sublingual medications. The AL Health Specialist confirmed the Program failed to ensure all staff who administered the morphine had received the appropriate training.	A 525		