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
	S0401	A. BUILDING: _____ B. WING _____	C 06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT INDIAN CREEK ALP/D	325 COLLINS ROAD SE CEDAR RAPIDS, IA 52403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 16 TOTAL Census of Assisted Living Program for People with Dementia: 16 An onsite infection control survey was completed and no regulatory insufficiencies were identified. The investigation of Complaints #96602-C, #96606-C and #96677-C and the recertification visit to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program were completed. The following regulatory insufficiencies were identified:	A 000		
A 270	481-67.5(2)f(1) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be	A 270		

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A 270	Continued From page 1 administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff administering medications completed a department-approved medication aide or medication manager course and passed the approved medication aide or manager examination prior to administering medications. This pertained to 1 of 2 staff reviewed that administered medications (Staff F). Findings follow: 1. Record review on 5-26-21 revealed Staff F's training documents did not include a certificate of completion for a medication aide or medication manager. 2. When interviewed on 6-2-21 at 3:15 p.m. Staff F confirmed he administered medications. 3. When interviewed on 6-2-21 at 4:17 p.m. the Director of Health and Wellness confirmed Staff F administered medications; however, had not completed the course.	A 270	POC 8/26/21	
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program:	A 285		

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A 285	Continued From page 2 (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications as prescribed. This pertained to 1 of 2 discharged tenants reviewed (Tenant #4). Findings follow: 1. Record review on 6-2-21 revealed Tenant #4 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #4 received medications administered by the Program. Tenant #4 was discharged on 3-27-21. Tenant #4's February 2021 medication administration records (MARs) reflected the following orders: -Quetiapine 100 milligram (mg) tablet, one tablet orally at bedtime along with 1.5 of 50 mg tablets. It was administered from 2-1-21 to 2-25-21 at 6:00 p.m. -Quetiapine 50 mg tablet, 1.5 tablets (75 mg) orally at bedtime, along with 100 mg tablet. It was administered from 2-1-21 to 2-25-21 at 6:00 p.m. -Quetiapine 100 milligram (mg) tablet, one tablet orally at bedtime along with 1.5 of 50 mg tablets. It was administered from 2-26-21 to 2-28-21 at 8:00 p.m. -Quetiapine 50 mg tablet, 1.5 tablets (75 mg) orally at bedtime, along with 100 mg tablet. It	A 285		

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was administered from 2-26-21 to 2-28-21 at 8:00 p.m.

-Trazodone 50 mg tablet, 1/2 tablet (25 mg) orally at bedtime. It was administered from 2-1-21 to 2-25-21 at 6:00 p.m.

-Trazodone 50 mg tablet, 1/2 tablet (25 mg) orally at bedtime. It was administered from 2-26-21 to 2-28-21 at 8:00 p.m.

Continued record review revealed a Physician Communication document reflected physician orders for Quetiapine 175 mg at bedtime and Trazodone 25 mg at bedtime, dated 10-2-20. There were no orders found to reflect the medication time change from bedtime to 6:00 p.m. for either Quetiapine or Trazadone. The medications listed above were documented as administered at 6:00 p.m. from 2-1-21 to 2-25-21, despite the order for the medications to be administered at bedtime.

2. Record review revealed Tenant #4's March 2021 MARs reflected the following:

-Quetiapine 100 milligram (mg) tablet, one tablet orally at bedtime along with 1.5 of 50 mg tablets. It was administered at 8:00 p.m. on 3-1-21 and then again from 3-16-21 to 3-26-21.

-Quetiapine 50 mg tablet, 1.5 tablets (75 mg) orally at bedtime, along with 100 mg tablet. It was administered from at 8:00 p.m. on 3-1-21 and then again from 3-16-21 to 3-26-21.

-Quetiapine 100 milligram (mg) tablet, one tablet orally at bedtime along with 1.5 of 50 mg tablets. It was administered at 7:00 p.m. from 3-2-21 to

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A 285	Continued From page 4 3-15-21. -Quetiapine 50 mg tablet, 1.5 tablets (75 mg) orally at bedtime, along with 100 mg tablet. It was administered from at 7:00 p.m. from 3-2-21 to 3-15-21. -Sertraline 50 mg tablet, one tablet orally every evening. It was administered at 6:00 p.m. from 3-1-21 to 3-15-21. -Sertraline 50 mg tablet, one tablet orally every evening. It was administered at 8:00 p.m. from 3-16-21 to 3-26-21. -Trazodone 50 mg tablet, 1/2 tablet (25 mg) orally at bedtime. It was administered at 8:00 p.m. on 3-1-21 and then again from 3-16-21 to 3-26-21. -Trazodone 50 mg tablet, 1/2 tablet (25 mg) orally at bedtime. It was administered at 7:00 p.m. from 3-2-21 to 3-15-21. Continued record review revealed a Physician Communication document reflected physician orders for Quetiapine 175 mg at bedtime and Trazodone 25 mg at bedtime dated 10-2-20. A Physician Communication document reflected a physician order for Sertraline 50 mg every evening was dated 11-25-19. There were no orders found that reflected the medication time change for Quetiapine, Sertraline or Trazadone medications from 3-1-21 to 3-19-21. Further record review revealed a Physician's Order Sheet, dated 3-19-21, reflected the following orders signed by the physician, dated 3-19-21: -Quetiapine 100 mg tablet, one tablet orally at	A 285		

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bedtime along with 1.5 of the 50 mg tablets. The time ordered was 8:00 p.m. A handwritten entry next to it reflected 7:00 p.m.

-Quetiapine 50 mg tablet, 1.5 tablets (75 mg) orally at bedtime along with 100 mg tablet. The time ordered was 8:00 p.m. The handwritten entry next to it reflected 7:00 p.m.

-Sertraline 50 mg tablet, take one tablet every evening and a handwritten entry next to the time indicated 6:00 p.m.

-Trazadone 50 mg tablet, take 1/2 tablet (25 mg) orally at bedtime. The time ordered was 8:00 p.m. A handwritten entry next to it reflected 7:00 p.m.

3. When interviewed on 6-3-21 Staff G revealed the Former Director of Health and Wellness changed Tenant #4's bedtime and supper medications. The orders could be changed in the electronic MAR system without an order. She said supper medications were at 5:00 p.m. and could be given from 4:00 p.m. to 6:00 p.m. Bedtime medications were from 7:00 p.m. to 10:00 p.m. She said Tenant #4's family was involved with the medication time changes. They were trying to find a balance for Tenant #4 not being agitated and being sleepy.

In summary, Tenant #4 received medications administered by the Program. The February and March 2021 MARs reflected various time changes for the Quetiapine, Sertraline and Trazadone; however, no orders were found for the time changes until 3-19-21. On 3-19-21 Tenant #4's physician signed a Physician Order Sheet that included handwritten entries reflecting

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A 285	Continued From page 6 medication time changes; however, Tenant #4's medications were not given as prescribed prior to the signed Physician Order Sheet. After the Physician Order Sheet was signed on 3-19-21, which included handwritten time changes, the medications were not given at the times reflected on the orders from 3-19-21 until Tenant #4 was discharged. Tenant #4 did not receive medications as prescribed.	A 285		
A 340	481-67.9(4)a 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: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document a review to ensure staff were sufficiently trained within 60 days of the new registered nurse's (RN) hire date. This pertained to 3 of 3 staff that were hired prior to the new RN's date of hire (Staff D, E and F). Findings follow: 1. Record review revealed the ALP/ADS/EGH Monitoring Entrance Form indicated the Director	A 340		

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A 340	Continued From page 7 of Health and Wellness, hired on 3-1-21, was the current delegating nurse. 2. Record review on 5-26-21 of Staff D's training documents revealed a hire date of 1-13-21. A Caregiver Orientation Checklist completed on 1-13-21 for Staff D by Staff G, a licensed practical nurse (LPN). A Student Practicum Certification document was provided with care tasks including medication administration and treatments dated 4-1-21. The training was completed by Staff G (LPN). Staff D did not have nurse delegated training completed by the current delegating RN within 60 days of the nurse's hire date. 3. Record review on 5-26-21 of Staff E's training documents revealed a hire date of 8-3-20. Staff E had nurse delegated training on activities of daily living completed by the Former Director of Health and Wellness dated 9-7-20. A Student Practicum Certification document was provided with care tasks including medication administration and treatments dated 2-28-21. The training was completed by Staff G, LPN. Staff E did not have nurse delegated training completed by the current delegating RN within 60 days of the nurse's hire date. 4. Record review on 5-26-21 of Staff F's training documents revealed a hire date of 1-6-21. A Caregiver Orientation Checklist completed on 1-6-21 for Staff F by Staff G, a LPN. A Student Practicum Certification document was provided with care tasks including medication administration and treatments dated 2-18-21 and 2-19-21. The training was completed by Staff G (LPN). Staff F did not have nurse delegated training completed by the current delegating RN within 60 days of the nurse's hire date.	A 340		

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A 340	Continued From page 8 5. When interviewed on 6-2-21 at 4:17 p.m. the Director of Health and Wellness confirmed all the nurse delegation documents for the staff listed above were provided.	A 340		
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 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 by the Program's registered nurse (RN), within 30 days of employment. This pertained to 3 of 3 staff reviewed hired after the RN was employed (Staff A, B and C). Findings follow: 1. Record review on 5-26-21 of Staff A's training documents revealed a hire date of 4-1-21. A Caregiver Orientation Checklist was completed on 4-8-21 for Staff A by Staff G, a licensed practical nurse (LPN). Staff A did not have nurse delegated training completed by the delegating RN within 30 days of employment. 2. Record review on 5-26-21 of Staff B's training documents revealed a hire date of 4-8-21. A Caregiver Orientation Checklist was completed on 4-26-21 for Staff B by another unlicensed caregiver. Staff B did not have nurse delegated	A 345		

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A 345	Continued From page 9 training completed by the delegating RN within 30 days of employment. 3. Record review on 5-26-21 of Staff C's training documents revealed a hire date of 3-16-21. A Caregiver Orientation Checklist was completed on 4-2-21 for Staff C by Staff G, a LPN. Staff C had training on medication administration dated 4-2-21, completed by Staff G, LPN. Staff C did not have nurse delegated training completed by the delegating RN within 30 days of employment. 4. When interviewed on 6-3-21 at 4:17 p.m. the Director of Health and Wellness confirmed all the nurse delegation documents for the staff listed above were provided.	A 345		
A 410	481-67.19(3)b Record Checks 67.19(3)b Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to submit a maiden name when the single contact repository (SING) was used. This pertained to 1 of 6 staff reviewed (Staff E). Findings follow:	A 410		

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A 410	Continued From page 10 1. Record review on 5-26-21 of Staff E's training documents revealed a hire date of 8-3-20. The Request and Acknowledgement to Conduct Registry and Record Check document provided information for Staff E's background check and included her current last name and a maiden name. 2. Continued record review revealed a criminal history background check and abuse registries background check was completed via SING on 7-27-20 and revealed no records were found. The background check for the abuse registries background check and criminal history background check, under Other Last Name, did not reflect Staff E's maiden name. 3. When interviewed on 6-3-21 at 8:52 a.m. the Executive Director confirmed there were no additional background checks for Staff E.	A 410		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to	A 135		

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A 135	Continued From page 11 a scored cognitive screening tool. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete cognitive evaluations prior to tenant occupancy. This pertained to 1 of 2 tenants admitted since 10-1-20 to current (Tenants #3). Finding follows: 1. Record review on 6-1-21 of Tenant #3's file revealed Tenant #3 was admitted on 10-26-20. Tenant #3 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. A Grand Living at Indian Creek Evaluation was completed on 10-22-20 and reflected it a pre-evaluation. The evaluation had a section for the SPMSQ; however, it was not completed. 2. When interviewed on 6-2-21 at 4:17 p.m. the Director of Health and Wellness confirmed all evaluations for the tenants listed above were provided.	A 135		
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.	A 140		

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A 140	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days. This pertained to 1 of 2 tenant reviewed that was admitted from 10-1-20 to current (Tenant #3). Findings follow: 1. Record review on 6-1-21 of Tenant #3's file revealed Tenant #3 was admitted on 10-26-20. Tenant #3 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Cognitive, health and functional evaluations were not completed within 30 days of taking occupancy. 2. When interviewed on 6-2-21 at 4:17 p.m. the Director of Health and Wellness confirmed there were no additional evaluations for Tenant #3.	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:	A 145		

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A 145	Continued From page 13 Based on interview and record review the Program failed to complete evaluations with a change in condition. This pertained to 2 of 5 tenants reviewed (Tenants #1 and #4). Findings follow: 1. Record review on 6-1-21 of Tenant #1's file revealed Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Progress Notes dated 5-5-21 indicated Tenant #1 was admitted to hospice. Continued record review revealed a Long Term Care Facility Visit encounter date of 5-12-21 indicated Tenant #1 received hospice services, had issues with urinating in public areas, had a poor appetite and had lost a significant amount of weight, 19 pounds per staff report. Further record review revealed the Master Assessment document, dated 3-31-21, was the most recent evaluation was completed. It was completed for increased bladder incontinence, increased assistance needed with toileting, weight loss and a recent fall. Evaluations were not completed as needed with significant change, including with the addition of hospice services. 2. Record review on 6-2-21 of Tenant #4's file revealed a Master Assessment document dated 3-11-21 indicated the reason for the assessment was changes to the service plan. The document included an evaluation of function and health; however, a cognitive evaluation, a GDS, was not completed with a change of condition. 3. When interviewed on 6-2-21 at 4:17 p.m. the Director of Health and Wellness confirmed all evaluations for the tenants listed above were	A 145		

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A 145	Continued From page 14 provided.	A 145		
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 by: Based on interview and record review the Program failed to update service plans as needed, failed to develop service plans based on evaluations and failed to have service plans reflect the service needs of the tenants. This pertained to 5 of 5 tenants reviewed (Tenants #1, #2, #3, #4 and #5). Findings follow: 1. Record review on 6-1-21 of Tenant #1's file revealed Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Progress Notes indicated the following: -On 2-22-21 it was noted Tenant #1 urinated in a drawer. -On 4-14-21 it was noted on 4-12-21 staff reported Tenant #1 got out of bed and went room to room and woke everyone up on third shift. Staff tried to redirect Tenant #1 back to his apartment and he tried to hit her. Tenant #1 went into another tenant's apartment and tried to hit him while he slept.	A 350		

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A 350	Continued From page 15 -On 4-19-21 it was noted Tenant #1 urinated in the common area. Staff redirected Tenant #1 back to his apartment and tried to assist with changing his soiled clothes. Tenant #1 tried to hit both staff. -On 5-5-21 it was noted Tenant #1 was admitted to hospice. Continued record review revealed a Long Term Care Facility Visit encounter date of 5-12-21 indicated Tenant #1 received hospice services, had urinary issues with urinating in public areas, had a poor appetite and had lost a significant amount of weight, 19 pounds per staff report. Further record review revealed a Service Plan Agreement, dated 4-11-21. The service plan was not updated to reflect hospice services after the services were initiated. The service plan also did not reflect Tenant #1's weight loss and behaviors, including urinating in common areas and physical behaviors. 2. Record review on 6-1-21 of Tenant #2's file revealed Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. Progress Notes indicated the following: -On 4-21-21 it was noted Tenant #2's doctor was informed Tenant #2's behaviors were escalating and a verbal order was received to send Tenant #2 to the emergency department (ED) via ambulance. -On 4-21-21 it was noted the ED was informed of Tenant #2's behaviors and upcoming surgery.	A 350		

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A 350	Continued From page 16 -On 5-13-21 it was noted Tenant #2 would be discharged back to the Program. Medication changes included: Clonazepam 0.5 milligram (mg), one tablet at bedtime, Escitalopram 10 mg one tablet daily and Propranolol 20 mg, one tablet twice daily. Continued record review revealed the Master Assessment document dated 5-11-21 reflected it was completed for a change of condition related to a hospitalization for transurethral resection of the prostate (TURP) surgery completed on 5-5-21 and adult psych for a medication review. Further record review revealed the Service Plan Agreement dated 6-1-21, weeks after Tenant #2's returned to the building post hospitalization from a TURP procedure and medication adjustment. The service plan dated 6-1-21 also failed to reflect a history of behaviors and interventions. 3. Record review on 6-1-21 revealed Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. When interviewed on 6-1-21 at 11:38 a.m. Staff I said Tenant #3 had a new behavior (hitting), which occurred twice in the last two weeks. Continued record review revealed a Resident Incident Report, dated 5-3-21 at 11:50 a.m., indicated Tenant #3 kicked her legs back and forth, not allowing another tenant to pass through to sit in a chair. During the incident another tenant came to help and was kicked twice by Tenant #3. Further record review revealed the Service Plan Agreement, dated 3-22-21, failed to reflect Tenant	A 350		

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A 350	Continued From page 17 #3's behaviors or interventions. 4. Record review on 6-2-21 revealed a Service Plan Agreement, dated 3-12-21, to reflect a changes in services. The service plan was not based on the cognitive evaluation when the service plan update was completed, as a cognitive evaluation was not completed when the service plan was updated 3-12-21. 5. Record review on 6-2-21 revealed Tenant #5 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #5 was discharged on 11-12-20. Progress Notes indicated the following: -On 8-9-20 it was noted Tenant #5 was upset and thought staff gave her a poisonous banana and called her family and said someone was trying to poison her. -On 10-22-20 it was noted the nurse explained to Tenant #5 what her medications were and why she was taking them. If that had not been done, Tenant #5 would have refused all her medications. It was the second time Tenant #5 had done that in two weeks. -On 10-26-20 it was noted Tenant #5 had stayed in her apartment a lot and had not socialized with her neighbors. -On 10-29-20 it was noted Tenant #5 had approached staff several times about a white basket full of laundry that had not been seen by staff. She said someone took it and wanted staff to call housekeeping or someone to find it.	A 350		

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A 350	Continued From page 18 -On 11-3-20 it was noted Tenant #5 was upset staff was in other tenant apartments and assisting with cares. Tenant #5 said staff should be out in the common area getting coffee for her and others. Continued record review revealed Tenant #5's Service Plan Agreement dated 9-3-20 failed to reflect Tenant #5's behaviors and interventions. 6. When interviewed on 6-2-21 at 4:17 p.m. the Director of Health and Wellness confirmed all service plans in the time period requested for the tenants listed above were provided.	A 350		
A 365	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans within 30 days of taking occupancy. This pertained to 1 of 2 tenants reviewed that was admitted from 10-1-20 to current (Tenant #3). Findings follow: 1. Record review on 6-1-21 of Tenant #3's file revealed Tenant #3 was admitted on 10-26-20. Tenant #3 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. A service plan was not developed within 30 days of taking occupancy.	A 365		

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A 365	Continued From page 19 2. When interviewed on 6-2-21 at 4:17 p.m. the Director of Health and Wellness confirmed the service plans available for Tenant #3 were provided.	A 365		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews as needed and every 90 days. This pertained to 2 of 5 tenants reviewed (Tenants #4 and #5). Findings follow: 1. Record review revealed a Resident Incident Report, dated 3-10-21 at 4:00 p.m., for Tenant #4 indicated staff reported redness, a possible rash like area to the tenant's upper right side of his back. Tenant #4 was unable to tell staff what occurred. The area was on Tenant #4's right upper side of the back. A reddened area approximately 3 x 3 inches was noted across the shoulder blade. There were no witnesses. The	A 430		

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Director of Health and Wellness was notified at 4:00 p.m. on 3-10-21. Family was notified on 3-10-21 at 11:00 a.m. The report was completed on 3-12-21 at 11:07 a.m. by Staff G. The report indicated an investigation was being completed related to the injury of unknown origin.

Continued record review of Tenant #4's file revealed diagnoses included: dementia with Lewy bodies and Tenant #4 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #4's service plan dated 3-12-21 indicated Tenant #4 was a one-person assist with a gait belt for transfers. The Master Assessment document dated 3-11-21 indicated Tenant #4 had a reddened area on the right side of his back and light yellowing bruising noted around Tenant #4's waist area.

Further record review revealed Progress Notes indicated the following:

-On 3-8-21 at 7:55 p.m. it was noted "Upper right back big red rash-it looks like an allergic reaction."

-On 3-10-21 at 4:46 p.m. it was noted Tenant #4's spouse asked that the Director of Health and Wellness check Tenant #4. His eyes had redness and the spouse wanted his primary care provider notified.

-On 3-11-21 at 12:25 p.m. it was noted a telehealth visit was completed with Tenant #4's family present. They discussed the yellow bruising to the back and reddened area to the right upper back and redness to the eyes. A chest x-ray was recommended.

-On 3-12-21 at 10:39 a.m. it was noted chest

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A 430	Continued From page 21	A 430		

x-rays results were received and it was recommended that a chest x-ray be completed in two weeks.

-On 3-19-21 at 10:56 a.m. it was noted "This is dated 3/8/21, first time coming up on this nurse Wisdom 2 Act is 3/19/21 at 10:56. This has been assessed." That entry was charted by the Former Assistant Director of Nursing (ADON).

2. Record review of the Program's internal investigation related to the injury of unknown origin for Tenant #4 indicated the event was possible fall with injury. The investigation was started on 3-10-21 at 7:00 p.m. the event date and time were unknown. The report indicated on 3-8-21 a direct care staff completed a Wisdom 2 Act alert regarding a possible abrasion on his right shoulder. A nurse saw the Wisdom 2 Act on 3-10-21 and it was evaluated by a nurse and she thought it was a rash. On 3-10-21 the Executive Director received a phone call from Tenant #4's family, who was upset about a red area on Tenant #4's back. A meeting was set up for 3-11-21. On 3-11-21 at 7:00 a.m. the Director of Health and Wellness assessed the area and she observed a red area on his upper right shoulder and some yellow bruising on his right waist area. A telehealth visit was completed and x-rays were ordered. On 3-12-21 x-ray results were received and it was recommended for a two week follow up for a repeat chest x-ray. The rib series showed a "possible non-displaced anterior lateral left 10 rib fracture." The internal investigation indicated Tenant #4's the etiology of Tenant #4's injury could not be determined. Therapy staff indicated Tenant #4 would not have been able to get himself off the floor by himself and no staff reported falls with Tenant #4 in the past 30 days. The investigation determined Tenant #4 was not

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abused and and staff did not intentionally cause the injury to Tenant #4. It was determined there was delay in the assessment. The initial report of a "rash type" area for Tenant #4 was made on 3-8-21 by a direct care staff. A nurse did not assess the area until 3-10-21.

3. Continued record review revealed the Program's Investigation Questionnaire-Associate (staff questions) were reviewed related to the investigation regarding Tenant #4 and indicated the following:

-Staff H indicated she provided care to Tenant #4 on 3-8-21 and noticed a red area and put a Wisdom 2 Act in (alert to nursing) and reported it. Staff H said it looked like a rash and was red.

-Staff G indicated on 3-10-21 she noticed an area on Tenant #4's right upper shoulder that looked like he was developing a rash. When she looked at it she did not see anything.

-Staff F indicated last night (3-10-21) he noticed a red area and said it looked like a rash. He saw it when he took Tenant #4 to the bathroom.

-The Former ADON indicated on 3-11-21 the Director of Health and Wellness told her today that there was a red area that looked like a rash and bruising where the gait belt was.

4. When interviewed on 6-1-21 at approximately 12:10 p.m. Staff G, licensed practical nurse, revealed staff called her and sent a picture of the area of Tenant #4's back/shoulder. In the picture it looked like a rash. The next day she assessed the area and it looked like petechiae. There were no blisters and it looked like broken blood vessels. There was no purple or bruising.

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A 430	Continued From page 23 When interviewed on 6-2-21 at 3:15 p.m. Staff F revealed he helped Tenant #4 to the bathroom and noticed a rash, red area with bumps. It looked like a heat rash. He thought it was rash and maybe soap had irritated it. When interviewed on 6-2-21 at 2:04 p.m. the Executive Director said it was first reported by Staff H on 3-8-21 and the nurse did not see it. Staff H and the Former ADON were no longer employed by the Program and were contacted for an interview; however, did not return a call for an interview. In summary, Staff H noticed a red area on Tenant #4's shoulder on 3-8-21 and sent an alert to nursing. The area was not assessed by nursing staff promptly after notification by Staff H. The incident report indicated it was assessed on 3-10-21. The Master Assessment document dated 3-11-21 reflected it was assessed. Tenant #4 had a reddened area and light bruising noted around the waist. An x-ray of the area indicated a possible non-displaced fracture of the 10th rib. In addition to delayed assessment of Tenant #4's injury of unknown etiology, Tenant #4's family was also not made of aware of injury or area of concern when it was first observed by staff. A nurse review was not completed as needed for Tenant #4. 5. Record review on 6-2-21 of Tenant #5's file revealed Tenant #5 was admitted on 3-9-20 and was discharged on 11-12-20. Tenant #5 received cares and assistance with medications. Tenant #5 did not have a 90 day nurse review. 6. When interviewed on 6-2-21 at 4:17 p.m. the	A 430		

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A 430	Continued From page 24 Director of Health and Wellness confirmed all nurse reviews were provided in the time period requested for the tenants listed above.	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 ensure staff, who served food, completed orientation on safe food handling prior to handling food. This pertained to 4 of 5 staff who served food (Staff B, D, E and F). Findings follow: 1. Record review on 5-26-21 of Staff B's training documents revealed a hire date of 4-8-21. Staff B did not have an orientation on safe food handling. 2. Record review on 5-26-21 of Staff D's training documents revealed a hire date of 1-13-21. Staff D did not have an orientation on safe food handling. 3. Record review on 5-26-21 of Staff E's training documents revealed a hire date of 8-3-20. Staff E did not have an orientation on safe food handling. 4. Record review on 5-26-21 of Staff F's training	A 465		

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A 465	Continued From page 25 documents revealed a hire date of 1-6-21. Staff F had a food safety training dated 4-6-21; however, Staff F did not have a food safety training prior to handling food as it was completed three months after hire. 5. When interviewed on 6-2-21 at 2:04 p.m. the Executive Director confirmed all the staff listed above served food and all food safety training was provided for the staff listed above.	A 465		
A 500	481-69.28(6)f Food Service 69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. The department will not require the program to be licensed as a food establishment if the program limits food activities to the following: f. Warewashing may be done in the program's kitchen as long as the program utilizes a commercial dishwasher and documents daily testing of sanitizer chemical ppm and proper water temperatures. Verification by the department of these practices may be conducted during on-site visits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to utilize commercial dishwashers for warewashing and failed to document daily testing of sanitizer chemicals parts per million and water temperatures. This potentially affected all tenants (census of 16).	A 500		

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GRAND LIVING AT INDIAN CREEK ALP/D	325 COLLINS ROAD SE CEDAR RAPIDS, IA 52403

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A 500	Continued From page 26 Findings follow: 1. When observed on 5-26-21 at approximately 1:10 p.m. the Program had two dementia units, unit #1 on first floor and unit #2 on the second floor. Each unit had a kitchen area, including a dishwasher. Staff was observed removing items from the dishwasher on unit #2, which appeared to mostly be utensils. 2. When observed on 6-2-21 at approximately 11:10 a.m. and 11:20 a.m. the kitchen areas in the two dementia units had non-commercial grade dishwashers. The dishwasher on unit #1 had silverware, glasses and a few plates when it was observed. 3. Record review on 5-25-21 revealed the Program had a current Food Service Establishment License for the Program (main kitchen). 4. When interviewed on 6-2-21 at 11:10 a.m., 11:20 a.m. and 2:04 p.m. the Executive Director revealed most of the dishes were returned to the main kitchen for washing; however, the utensils and a few dishes were washed in the dishwashers in the dementia units. A water temperature sensor was purchased about a month ago and was placed in the dishwashers to ensure the temperature was hot enough. The temperatures were not recorded.	A 500		
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	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0401	A. BUILDING: _____ B. WING _____	C 06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 545	Continued From page 27 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 complete eight hours of dementia-specific education within 30 days of employment. This pertained to 6 of 6 staff reviewed (Staff A, B, C, D, E and F). Findings follow: 1. Record review on 5-26-21 of Staff A's training documents revealed a hire date of 4-1-21. Staff A did not have eight hours of dementia-specific education within 30 days of employment. 2. Record review on 5-26-21 of Staff B's training documents revealed a hire date of 4-8-21. Staff B did not have eight hours of dementia- specific education within 30 days of employment. 3. Record review on 5-26-21 of Staff C's training documents revealed a hire date of 3-16-21. Staff C did not have eight hours of dementia-specific education within 30 days of employment. 4. Record review on 5-26-21 of Staff D's training documents revealed a hire date of 1-13-21. Staff D did not have eight hours of dementia-specific education within 30 days of employment. 5. Record review on 5-26-21 of Staff E's training documents revealed a hire date of 8-3-20. Staff E did not have eight hours of dementia- specific education within 30 days of employment.	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 545	Continued From page 28 6. Record review on 5-26-21 of Staff F's training documents revealed a hire date of 1-6-21. Staff F did not have eight hours of dementia- specific education within 30 days of employment. 7. When interviewed on 6-2-21 at 2:04 p.m. the Executive Director confirmed all dementia education for the staff listed above was provided.	A 545		

GRAND LIVING
YOUR LIFE. UNIQUELY EMBRACED.

ok

August 6th, 2021

Linda Kellen
Bureau Chief Adult/Special Services Bureau

Catie Campbell
Program Coordinator
Adult/Special Services Bureau
Health Facilities Division 515-281-3759

Re: Recertification, Investigation #96602-C, #96606-C and #96677-C and onsite infection control survey

Dear Ms. Kellen,

This letter will serve to acknowledge receipt of the 1UG411 form and associated letter dated 7/27/2021 and the statement of insufficiencies emanating from a survey conducted by the Iowa Department of Inspection and Appeals. The letter purports to give notice to the Community that it was allegedly not in substantial compliance with certain state requirements of participation and directed the Community to submit an acceptable plan of correction by August 6, 2021.

Without prejudice as to the legal sufficiency of the letter and whether it purports to advise the Community of its rights under law, the Community is, as of today's date, submitting its response to the statement of insufficiencies. Please see below the required response alleging compliance to the Recertification Survey as well as a Complaint survey ending 6/7/2021.

Insufficiency Tag Number	Corrective Action Taken for the Identified Insufficiency	Identification of others that might be affected by the insufficiency	System Measures Taken to Prevent a recurrence of the insufficiency	Monitoring of Compliance	Date of Compliance
A270-Medications	Caregivers that administer medications will complete the medication managers class prior to administering medications.	100% audit was completed to identify if any staff who are passing medications did have proof of completion of the Medication Manager course.	All new hires who plan to administer medications will be required to provide a copy of Medication Manager Certification from an approved course prior to administering any medications. If the new hire is not currently certified, they will not administer any medications until they have completed an approved medication manger course with a delegating nurse.	Employee caregiver files will be audited quarterly by the Director of Health and Wellness or Human Resources to ensure that any caregiver passing medications have the proper paperwork proof in their personnel files.	8/26/21
A285-Medications	Resident #4 no longer resides at the Community as of	On 8/3/21 a 100% audit of a residents' physician orders were reviewed to determine	Upon move in and monthly, residents who have their medications administered by this program will be reviewed	Quarterly, the Director of Health and Wellness will submit a report to the ED that	8/26/21

Insufficiency Tag Number	Corrective Action Taken for the Identified Insufficiency	Identification of others that might be affected by the insufficiency	System Measures Taken to Prevent a recurrence of the insufficiency	Monitoring of Compliance	Date of Compliance
	3/27/21 and was discharged home.	if the medications are being administered as prescribed by the physician. Any discrepancies identified were corrected at the time of discovery.	by the Director or Assistant Director of Health and Wellness or the pharmacist to conduct a medication reconciliation to include review of physician orders to ensure that medications were administered and documented as prescribed.	details the quarterly audit and accuracy of medication administration to residents in the program. All medication error reports will be reviewed and signed off by the DOHW and the Executive Director. A performance improvement plan will be created for any areas identified as needing performance improvement.	
A340-Staffing	As of 8/4/21, a new Director of Health and Wellness has been hired. By 10/3/21 the new DOHW will document a review of staff to determine if they are sufficiently trained within 60 days of the DOHW's hire.	All staff under the supervision of the Director of Health and Wellness are affected by this requirement and will need a documented review by the Program Delegating RN.	If a new Director of Health and Wellness, RN program director is hired, the RN will ensure certified and noncertified staff are competent to meet the individual needs of residents within 60 days. The new Director of Health and Wellness will take the 8-hour required Assisted Living Regulatory Class so that the RN can delegate appropriately to caregivers.	The Executive Director will check on the progression of determining and documenting competency of caregiving staff the first 60 days of the DOHW's employment to ensure staff are documented as competent by the 60th day of hire of the RN program manager.	8/26/21
A345-Staffing	As of 8/4/21, a new Director of Health and Wellness has been hired. By 9/4/21 the new DOHW will document a review of staff to determine if they are sufficiently trained within 30 days of the caregiver's hire.	All staff under the supervision of the Director of Health and Wellness are affected by this requirement and will need a documented review by the Program Delegating RN.	If a new Director of Health and Wellness, RN program director if hired, the RN will ensure certified and noncertified staff have completed delegation skills to meet the individual needs of residents. The new Director of Health and Wellness will take the 8 hour required Assisted Living Regulatory Class so that the RN can delegate appropriately to caregivers. Caregivers will complete delegations with the program RN within 30 days of the caregivers hire date.	The Executive Director will check on the progression of determining and documenting delegating authority to the caregiving staff the first 30 days of the caregivers employment to ensure staff are documented as delegated.	8/26/21

Insufficiency Tag Number	Corrective Action Taken for the Identified Insufficiency	Identification of others that might be affected by the insufficiency	System Measures Taken to Prevent a recurrence of the insufficiency	Monitoring of Compliance	Date of Compliance
A410-Record Checks	When completing a background check the employee's maiden name will also be included in the background check.	A 100% audit of all staff personnel records was completed. Any areas of background discrepancy identified in the audit were corrected at the time of discovery.	Prior to a new hire participating in the Community's general orientation, a background check for abuse registry, background check and criminal background check utilizing the employee's maiden name requested through SING using.	New hire personnel, files will be reviewed for completion by the Human Resources designee prior to staff attending General Orientation.	8/26/21
A135-Evaluation of Resident	Any resident with a moderate decline exam on the mini mental will require a Global Deterioration Scale completed 30 days after admission.	A 100% audit of all residents who were evaluated to have moderate cognitive decline to ensure that a Global Deterioration Scale was completed and used in subsequent evaluations. Any assessments needing completion were completed at the time of discovery.	All prospective residents are evaluated prior to occupancy, either before planned move in date or the day of the anticipated move in date. This evaluation includes the residents functional, cognitive and health status prior to signing the occupancy agreement and taking dwelling of a unit. If a resident is determined to have moderate cognitive decline, the evaluator will utilize the Global Deterioration Scale to determine a specific level of deterioration to assist with developing an individualized service plan for the prospective resident and to ensure eligibility into the program. If a GDS is utilized to determine cognitive decline, the GDS will be the default tool used to evaluate the resident's cognition on future evaluations, unless that resident's cognition improves to mild or none, then the standard cognitive evaluation will be utilized.	The Director of Health and Wellness/designee Will review prospective resident's evaluation to ensure that if the resident was determined to have moderate cognitive decline, that the GDS was used in place of the standard evaluation, prior to the resident moving in to the Community.	8/26/21
A140-Evaluation of a Resident	All residents will receive a 30 day evaluation and service plan.	On August 9, 2021 a 100% audit of residents who currently receive services from the program was completed to determine if any residents were in need of a 30-day evaluation.	Residents are evaluated within 30 days after move in, to determine if the level of services provided are meeting the resident's needs and continues to meet the eligibility of the program. This evaluation includes the residents functional, cognitive	The Director of Health and Wellness/designee Will audit resident evaluations that are due based on the date of move into the Community. Any residents that are	8/26/21

Insufficiency Tag Number	Corrective Action Taken for the Identified Insufficiency	Identification of others that might be affected by the insufficiency	System Measures Taken to Prevent a recurrence of the insufficiency	Monitoring of Compliance	Date of Compliance
		If a resident had not received a 30-day evaluation but had received a 90 day evaluation were noted on the audit.	and health status. If a resident is determined to have moderate cognitive decline, the evaluator will utilize the Global Deterioration Scale to determine a specific level of deterioration to assist with developing an individualized service plan for the resident and to ensure services needed are being provided. If a GDS is utilized to determine cognitive decline, the GDS will be the default tool used to evaluate the resident's cognition on future evaluations, unless that resident's cognition improves to mild or none, then the standard cognitive evaluation will be utilized.	within 30 days of move in, will be evaluated to ensure that the resident is receiving the necessary services and continues to meet the eligibility of the program.	
A145-Evaluation of a Resident	All residents with changes in conditions will be evaluated and their service plan will be updated.	A 100% audit of residents who currently receive services from the program was completed to determine if any residents were in need of a change in condition evaluation. The audit included a review of the current service plan as well as nursing notes and physician orders. Any residents identified had an assessment completed at the time of discovery.	A resident evaluation is completed when a change in condition or a significant change is identified by nursing or caregivers, to determine if the level of services provided needs to be adjusted to meet the needs of the resident. The change of condition evaluation is also completed to determine if the resident continues to meet the eligibility of the program. This evaluation includes the residents functional, cognitive and health status. If a resident is determined to have moderate cognitive decline, the evaluator will utilize the Global Deterioration Scale to determine a specific level of deterioration to assist with developing an individualized service plan for the resident and to ensure services needed are being provided. If a GDS is utilized to determine cognitive decline, the GDS will be the default	The Director of Health and Wellness/designee will monitor residents' health status by reviewing, medication changes, resident accident/incident reports, increase in service plan, and refusal or increase in services and completed WISDOM2ACT alerts. The DOHW/designee will inform the Executive Director and Business Office manager during morning stand up meetings when a change of condition has occurred.	8/26/21

Insufficiency Tag Number	Corrective Action Taken for the Identified Insufficiency	Identification of others that might be affected by the insufficiency	System Measures Taken to Prevent a recurrence of the insufficiency	Monitoring of Compliance	Date of Compliance
			tool used to evaluate the resident's cognition on future evaluations, unless that resident's cognition improves to mild or none, then the standard cognitive evaluation will be utilized. Additionally, a process called WISDOM2ACT is available for the caregiving team to alert a nurse in real time, that there is something different with a particular resident. The nurse will then evaluate and determine if there is a need for a formal change in condition evaluation to be completed.		
A350-Service Plans	The service plans will be updated based on the most recent master assessment on and reflects the residents' current needs and preferences.	8/5/21 through 8/13/21, residents who receive services from the program had their service plan reviewed and updated as needed based on the resident's most recent Master Assessment and information provided from the caregivers/family and resident.	Upon move in, 30 days after move in, quarterly and annually, each resident receiving services from the program will have a Master Assessment completed which creates the service plan for each resident. The service plan will be revised or created as needed based on the Master Assessment findings, caregiver input as well as family/resident input. When there is a change to the service plan, the Director of Health and Wellness will inform the resident/family/responsible party of the change.	The Director of Health and Wellness/designee will report to the Executive Director monthly, any significant changes in residents service plan.	8/26/21
A365-Service Plans	Master Assessment will ensure that the service plan matches the identified needs.	Master Assessment and the associated Service Plans for residents who moved in after 6/7/21 were audited to ensure a 30 day post move in Master Assessment and associated Service Plan was completed timely.	Upon move in, 30 days after move in, quarterly and annually, each resident receiving services from the program will have a Master Assessment completed which creates the service plan for each resident. The service plan will be revised or created as needed based on the Master Assessment findings, caregiver input as well as family/resident input. When there is a change to the service plan, the Director of	The Director of Health and Wellness/designee will report to the Executive Director monthly, any significant changes in residents service plan.	8/26/21

Insufficiency Tag Number	Corrective Action Taken for the Identified Insufficiency	Identification of others that might be affected by the insufficiency	System Measures Taken to Prevent a recurrence of the insufficiency	Monitoring of Compliance	Date of Compliance
			Health and Wellness will inform the resident/family/responsible party of the change.		
A430- Nurse Review	Nursing Staff will be retrained on the WISDOM2ACT policy and procedure.	100% audit of WISDOM2ACT (electronic alert notification) was completed on August 13, 2021, to determine if any identified changes in condition were reviewed by a nurse to assess and document the resident(s) and to make recommendations and referrals as appropriate.	Anytime a caregiver identifies a possible change in a resident's ability or behavior, the caregiver will complete an electronic alert form in the residents Electronic Health Record (EHR). This WISDOM2ACT alert will notify the nurse immediately via the EHR. The nurse will then follow up on the alert by assessing the identified resident to determine if any changes are needed to the plan of care/service plan. If additional follow, referrals, monitoring are necessary, the nurse will coordinate that care with the appropriate providers. The nurse will also communicate to the resident's physician, make a progress note and inform the responsible party.	Monthly, the Director of Health and Wellness will track and trend all WISDOM2ACT that were completed to determine if there is a pattern of any changes that may to be addressed.	8/26/21
A465-Food Service	Staff will be trained and oriented to safe food handling prior to serving food.	On 8/5/2021 100% audit of all Culinary staff was completed to determine if all staff had received proper food handling training. Any areas of discrepancy noted were corrected at the time of discovery.	Chef will make sure that all the employees that handle food go through food handling before they serve food to the residents.	Human Resources will audit employee files monthly to ensure completion.	8/26/21
A500-Food Service	The dishwasher in the memory care area will be removed or disabled.		Dishes will be sent to the main kitchen for cleaning.	The dishwasher in the main kitchen is commercial grade and employees will be instructed to have all dishes sent there to be cleaned.	8/26/21
A545-Dementia	Staff will receive required 8-hour dementia training	A 100% audit of Personnel Files pertaining to education	The Human Resources department will work in conjunction with other	The Human Resources Department/designee will meet with the	8/26/21

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Specific Education	with-in 30 days of employment	requirements was completed on 8/5/2021 to ensure that staff working with the Dementia Unit, had received the 8 hours of Dementia training within 30 days of hire, if a discrepancy was noted it was addressed at the time of discovery.	Department Heads to ensure that all staff that works on the Dementia Units will receive 8 additional hours of Dementia training within their 30 days of employment. The Human Resources department will track hire dates and education dates and will inform necessary department heads who and when staff should be educated prior to the 30 days expiring.	Executive Director monthly to ensure all required staff have received the necessary 8-hour Dementia education prior to the 30 days after hire expires.	

Sincerely,

Lisa Cleland

Executive Director
Grand Living at Indian Creek
325 Collins Road SE
Cedar Rapids, IA 52403