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
	S0445	A. BUILDING: _____ B. WING _____	C 07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STIRLINGSHIRE OF CORALVILLE MC	1140 KENNEDY PARKWAY CORALVILLE, IA 52241

(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: 19 Total census of Assisted Living Program for People with Dementia: 19 Regulatory insuffiencies were cited during the investigation of Complaints #111997-C, #113995-C and Incidents #112609-I, #112824-I , #113143-I, and #111744-I .	A 000	The Plan of Correction is attached.	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to follow established policies and procedures related to door alarms and missing person/elopement for 2 of 2 tenants reviewed who had eloped (Tenant #3 and Tenant #4), completion of incident reports for 1 of 1 tenants reviewed who had a fall with a fracture (Tenant #5) and safety checks which potentially affected all tenants in memory care (census of 19). Findings follow: 1. Review of Tenant #3's record on 7/13/23 revealed an incident report indicated on 5/6/23 at 10:00 a.m. Tenant #3 entered through the front	A 150		

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entrance door to the attached general population assisted living. Tenant #3 went towards the memory care unit and into the spa where he had a fall. No injuries were noted.

An Incident Investigation Report dated 5/8/23 indicated on 5/6/23 at 11:00 a.m. the Executive Director was notified that Tenant #3 entered the building through the front main entrance. Tenant #3 continued to the spa area, fell and had no injuries. Tenant #3 was redirected back to the memory care unit. The report indicated Tenant #3 had exited the memory care stairwell door at 9:51 a.m. Tenant #3 walked down the stairs, outside of the building, walked up the hill and back into the building (attached general population assisted living). Video footage reviewed showed Staff A clear the alarm but not follow the policy and procedure. All staff were verbally re-educated about the policy and a meeting was scheduled for 5/25/25. Corrective action was provided to Staff A.

When interviewed on 7/18/23 the Executive Director revealed on camera it looked like Tenant #3 exited the stairwell door, walked around the building and came in the front entrance door. Staff at the front entrance radioed back to the memory care unit staff. Tenant #3 had a fall outside of memory care door but did not sustain any injuries. Tenant #3 was dressed appropriately for the weather and had his walker. When the alarm sounded, Staff A went to the electronic wandering monitoring system on the wall and reset it. She did not open the door that was alarming and did not start a head count. The Executive Director confirmed Staff A did not follow the policy for door alarms.

Further record review revealed Staff A was given

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a Performance Deficiency Notice dated 5/9/23. The form indicated Staff A failed to follow policy for the alarmed door. It indicated Tenant #3 exited the door and Staff A cleared the door a minute later and failed to complete a physical check of the area.

Review of Tenant #3's file revealed he was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. The service plan dated 2/24/23 indicated Tenant #3 had an electronic wandering monitoring device and had a current or history of wandering but it not jeopardize his safety. A Progress Note dated 5/10/23 indicated on 5/6/23 at 11:00 a.m. the Executive Director was notified Tenant #3 entered the building through the front door, he went into the spa and had a fall without injuries. Video footage revealed he exited the unit via the rear stairwell door at 9:51 a.m. He went down the stairs and exited the building on the lower level. He was observed using the sidewalk and up the front drive and entered the front entrance door at 10:09 a.m. Tenant #3 was dressed appropriately for the weather wearing pants, shirt, jacket and tennis shoes. The primary care provider (PCP) and family were made aware.

Continued record review revealed a fax was sent to the PCP dated 5/8/23 (two days post elopement and fall) regarding a fall Tenant #3 had in a bathroom on 5/6/23 at 10:15 a.m. The notification to the PCP did not include notification of the elopement that occurred prior to the fall on 5/6/23 at 10:15 a.m.

When observed on 7/18/23 at 1:30 p.m. the possible area Tenant #3 traveled during the elopement was observed. The rear stairwell door

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had a 15 second delayed egress alarm and an electronic wandering monitoring system. After exiting the stairwell door there were stairs that went up to the second floor and stairs that went down to the lower level. The stairs to the lower level had two flights of stairs with a landing between the flights and each flight of stairs had approximately 9 to 10 stairs. After traveling down the stairs to the lower level there was a door that exited the building to exterior. That door was not alarmed. There was a sidewalk that went from the exit door, crossed in front of the door for the underground parking, and went up the hill, parallel to the parking lot. The sidewalk went to the front main entrance door. The video footage was not available for review at the time of the investigation and the elopement was not witnessed; however, possible terrain Tenant #3 traveled included sidewalks, parking lot and grassy area. Upon entering the building there was a reception area to right and a hallway to memory care to the right (after the front desk). A door marked labeled SPA was observed outside of the memory care unit in the hallway of the attached general population assisted living. The approximate number of steps taken from the memory care stairwell door to the front main entrance foyer was 265 steps, the distance was 0.18 of a mile, and the time taken to travel was approximately two minutes at a brisk pace via a phone pedometer.

The State Climatologist provided the following weather conditions in Coralville on 5/6/23 at 9:51 a.m.: the temperature was 66 degrees, relative humidity was 60%, winds were from the south, southeast, at 11 miles per hour and there was no precipitation and there were clear skies.

Review of video footage from the incident was

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requested and was not available at the time of the investigation. Per the timeframe provided in the internal investigation and in Tenant #3's file, he left the memory care unit from 9:51 a.m. and entered the front door (main entrance to attached general population assisted living) at 10:09 a.m. Tenant #3 had a fall at about 10:15 a.m., which occurred outside of the memory care unit. The time Tenant #3 was out of memory care was approximately 24 minutes.

2. Review of Tenant #4's file on 7/13/23 revealed an incident report dated 5/21/23 indicating at 3:30 a.m. Tenant #4 came out and sat in the chair by the stairwell door. The electronic wandering monitoring alarm was going off as he was near the exit door as he was wearing an electronic wandering monitoring device. Staff kept resetting the alarm and offered to take him to the bathroom but he declined. At 5:57 a.m. the alarm came through the phone and staff thought it was due to Tenant #4 sitting by the door. At 6:00 a.m. other staff reported the exit door alarm was going off in the back. Staff asked who was sitting there and then staff completed a head count. Staff went upstairs (attached general population assisted living) and found Tenant #4 being escorted out of another tenant's apartment by the tenant's family member. Staff took Tenant #4 back to the memory care unit.

Continued record review revealed an Incident Investigation Report dated 5/21/23 indicating first shift staff arrived and heard the stairwell door alarming. Staff started a head count and noted Tenant #4 was not there. Staff went upstairs (attached general population assisted living) and found him leaving an apartment. Tenant #4 had been seated by the door and the stairwell door kept alarming due to the electronic wandering

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monitoring device. Staff was in another tenant's apartment when the door alarmed and staff thought it was alarming due to the electronic wandering monitoring device and Tenant #4's proximity to the door. When first shift arrived they started a head count and located Tenant #4.

When interviewed on 7/11/23 at 11:16 a.m. Staff B said when she came in on first shift the stairwell door alarm was going off. She heard it when she was walking down the hallway. She said there was an agency staff sitting there who said she had just checked everyone and it was after 6:00 a.m. and she had to go. Staff B checked the door but did not see anyone. She checked a tenant's apartment and then a head count was started. Tenant #4 was found in the general population assisted living in a tenant's apartment. He did not have any injuries.

When interviewed on 7/11/23 at 3:41 p.m. Staff D said at 6:00 a.m. she heard the door going off on her way to the memory care unit. Third shift was walking around and had not done a head count. There were two third shift staff working. She started searching but did not find anyone. Tenant #4 walked back to the memory care unit with another staff.

When interviewed on 7/11/23 at 12:55 p.m. Staff E said when first shift staff arrived they could hear the door alarm sounding. Two third shift staff was sitting there, one Program staff and one agency staff. Staff noticed a chair with a spot on it. Staff went outside to look and staff searched inside. Tenant #4 was located in a tenant's apartment on the second floor (attached general population assisted living). Tenant #4 did not have any injuries. His pants were soiled with urine.

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When interviewed on 7/11/23 Staff F said she was working with agency staff. There was a chair in the hallway and Tenant #4 was seated in the chair. At 5:45 a.m. Tenant #4 was seated there by the stairwell door and she went to assist another tenant. She said with Tenant #4 sitting there the noise from the electronic wandering monitoring alarm had been going off all night. She heard the alarm. She did have her phone and heard it go off but thought it was the electronic wandering monitoring alarm since he was sitting there and had been setting it off. Tenant #4 exited at 5:51 a.m.. First shift staff came in and told her it was the door alarm that was alarming. They checked the apartments and did not find Tenant #4. He was found on second floor (attached general population assisted living). A tenant's family member was in the apartment and said he had just come into the apartment. Staff F took him back down the stairs to memory care. Tenant #4 did not have any injuries and did not have a walker with him.

When interviewed on 7/18/23 the Executive Director said Tenant #4 exited the stairwell door and went upstairs to second floor. When first shift arrived a head count was completed. Third shift staff was helping another tenant and she did not believe third shift staff heard the door alarm. He went into a tenant apartment on the second floor (attached general population assisted living) and the family member recognized him and called for assistance via the pendant. Staff responded and Tenant #4 was redirected to memory care.

A review of Tenant #4's file revealed he was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #4's service plan dated 4/24/23 indicated he had an electronic wandering monitoring device and a

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history of wandering that did not jeopardize his safety. A Progress Note dated 5/22/23 indicated on 5/21/23 third shift staff noted Tenant #4 woke up at 3:30 a.m. and sat by the rear stairwell door. Staff reported the alarm was consistently going off due to Tenant #4's electronic wandering monitoring device but he had not tried to exit. First shift entered the unit at 5:58 a.m. and noted the door alarm was sounding. They completed a head count and Tenant #4 was missing. Staff went out the door to look for him and went to the second floor. A family member of a tenant on second floor was escorting him out of the apartment. He did not have injuries but his protective undergarment was soiled. Video footage reviewed showed the exit door was alarmed at 5:57 a.m., at 6:09 a.m. Tenant #4 was observed walking down the second floor hallway and entered a tenant's apartment (attached general population assisted living). Staff located Tenant #4 at 6:10 a.m. and he was taken back to memory care.

Review of a door alarm record document indicated on 5/21/23 (east fire exit door) the door alarmed at 5:57 a.m. and was reset at 6:09 a.m. (11 minutes).

On 7/18/23 at 1:30 p.m. the possible area Tenant #4 traveled was observed. The rear stairwell door had a 15 second delayed egress alarm and an electronic monitoring wandering device alarm. After exiting the stairwell door there were stairs that went up to the second floor and down to the lower level. There were two flights of stairs to get to the second floor with a landing in between and approximately 8 to 9 steps in each flight of stairs. There was a door that went into the second floor hallway of the attached general population assisted living. The door was not alarmed or

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coded. The apartment Tenant #4 was escorted from was located on second floor. The approximate number of steps taken from the memory care stairwell door to the door outside of the apartment he was found was 58 steps via a phone pedometer.

Observations on 7/18/23 at 1:30 p.m. and 2:25 p.m. revealed the electronic wandering monitoring alarm and rear memory care stairwell alarm were both checked and were audible. The audible sound appeared to be different for each type of alarm.

Review of video footage from the incident was requested but was not available at the time of the investigation. Per the timeframe provided in the internal investigation and Tenant #4's file, he was out of the memory care unit from 5:57 a.m. and staff located him at 6:10 a.m. coming out of a second floor apartment. The approximate time gone from the memory care unit was 13 minutes.

3. Review of the Program's Alarmed Door For Locked Memory Care Unit policy and procedure indicated all doors that went to the outside were alarmed or coded. If a door alarmed staff were to "immediately" complete a check of the physical area that was outside of the door that alarmed to ensure none of the tenants were outside the door. Staff would then complete a physical check of each tenant inside the building to ensure none of the tenants had exited through the door. If additional assistance was needed, other staff would be called to assist.

The Program's Missing Person and Elopement policy and procedure indicated upon locating a missing tenant the nurse would contact the PCP and report the condition of the tenant and follow

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A 150	Continued From page 9 orders provided. In summary, staff did not follow the door alarm policy and procedure related to the elopements with Tenant #3 and Tenant #4. Staff responded to the door when it alarmed for Tenant #3; however, failed to check outside of the door and physical area and reset the alarm within one minute. Regarding Tenant #3 staff also failed to notify of the PCP of the elopement per the Missing Person and Elopement policy and procedure. Staff did not respond to the stairwell door alarm when Tenant #4 eloped, and staff were found sitting when first shift arrived and heard the door alarm. Staff did not follow the door alarm policy and procedure. 4. Review of Tenant #5's file on 7/13/23 revealed an incident report indicating on 3/13/23 at 8:45 p.m. Tenant #5 had an unwitnessed fall with her walker. Tenant #5 was found yelling in the hallway. She was found lying on her left side on the floor of the memory care floor outside of the nursing station. Bleeding was present on the right side of her forehead and there was small skin tear near her wrist. A Progress Note dated 3/14/23 revealed Tenant #5 had an unwitnessed fall on 3/13/23. Tenant #5 was transferred to the hospital and received 5 to 10 sutures in the right side of her forehead. She had redness/abrasion surrounding the area that was the size of a tennis ball. Tenant #5 also sustained a humerus fracture and was to wear a sling. Tenant #5 could not ambulate with her walker due to the fracture. She was also found to have a urinary tract infection and was prescribed antibiotics. A clinic note dated 3/28/23 indicated Tenant #5	A 150		

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was seen for orthopedic trauma follow up. Tenant #5 had a fall on 3/13/23 and sustained a left proximal humerus fracture. The note indicated it sounded like she slipped in the hallway wearing socks. She was seen in the hospital and placed in a sling.

Continued record review revealed an Incident Investigation Report was not completed related to Tenant #5's unwitnessed fall, with injuries, including a humerus fracture.

When interviewed on 7/18/23 the Executive Director said she was not involved with Tenant #5's fall and she was only aware of the fall from Tenant #5's family member (it was prior to the Executive Director's start date). She confirmed an Incident Investigation Report was not completed related to Tenant #5's fall on 3/13/23.

Further record review revealed the Program's Incident Report policy and procedure indicated any incident with unknown or suspicious origin would have follow up including the completion of the Incident Investigation Report by the nurse or designee.

5. Record review of Safety Checks documents from 6/12/23 to 7/10/23 reflected staff were to complete safety checks hourly and it included a count of all tenants, staff's initials and if a tenant was not in memory care unit and the reason. Review of the safety checks reflected omissions on the following dates: 6/15/23, 6/17/23, 6/19/23, 6/20/23, 6/21/23, 6/24/23, 6/25/23, 6/26/23, 6/27/23, 6/29/23, 6/30/23, 7/2/23, 7/9/23 and 7/10/23. There were no safety check documents provided for the following dates: 6/18/23, 7/1/23 and 7/6/23.

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A 150	Continued From page 11 Continued record review revealed the ALP Monitoring Entrance Form reflected the Program had 19 tenants and all 19 tenants had a GDS score of 4 or greater, which indicated moderate cognitive decline. All tenants had cognitive impairment. When interviewed on 7/18/23 the Executive Director said the memory care unit had one hour safety checks and the it was expected the safety checks were signed off when it happened. The Program's Staffing policy and procedure indicated when the Program served people with cognitive disorder or dementia the Program would follow a system in lieu of a personal emergency response system (PERS) that addressed how the Program would respond to emergency needs of the tenants. The system would be individualized for each tenant as needed.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, services, and treatment that were adequate and appropriate for 6 of 6 current tenants (Tenants #1, #2, #3, #4, #5 and #6) and 1 of 2 discharged tenants (Tenant	A 160		

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C1) reviewed. Findings follow:

1. When interviewed on 7/11/23 at 11:16 a.m. Staff B said Tenant C1 was checked and changed in bed and staff could not get him up. He was incontinent of bladder and bowel. Tenant C1 was bed bound for about two weeks and maybe got out of bed once. Bed baths were given and he was changed in bed. He was aggressive at the end and he would hit, kick and bite. She said he was on hospice for a while and then was taken off of hospice. She said there were no oral swabs or sponges for his mouth and the last two days she used a towel to wipe the matter from his mouth. Tenant C1 grimaced with pain and had knee pain. The day before he was sent out he had trouble swallowing. When staff checked and changed him he seemed to have a lot of pain. She said the last two days before he went out he was clearly in more pain. His breathing was rattling and he had a white gooey matter in his teeth. Vital signs could not be obtained. The nurse was notified and could hear him breathing over the phone and she said to have staff call the POA. Staff called Tenant C1's power of attorney (POA) and he was sent out to the hospital.

When interviewed on 7/11/23 at 12:22 p.m. Staff C said staff repositioned Tenant C1 in bed. She said he was bed bound for about two weeks. He was on hospice and then was taken off of hospice. Tenant C1 was in a lot of pain. He was checked and changed in bed for toileting needs. She said before hospice helped with oral cares but she was not sure now. She said staff wiped his mouth with a rag and his mouth was very dry. On the day he was sent out he was making a gargling noise like he could not clear fluid and his mouth was very crusty. The nurse was called and he was sent out to the hospital. She said

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Tenant C1 was not really responsive on the last day and he could not open up his mouth for staff to clean it.

On 7/11/23 at 3:41 p.m. Staff D said it took three people to get Tenant C1 up at the end. Staff repositioned him every 30 minutes to one hour. He was changed in bed and had a lot of pain in his knee. He was really aggressive at the end. The day before he was sent to the hospital there was noise with his breathing that had not been heard before.

When interviewed on 7/11/23 at 12:55 p.m. Staff E said Tenant C1 had a decline and did not come out of his apartment. He went on hospice. Staff changed him, wiped his mouth and changed in clothes all in bed. She said the morning he was sent out staff had gone in his apartment and noted his breathing was different. Staff called the nurse and she could hear him breathing. The nurse said to call the POA and he was sent to the hospital

On 7/11/23 Staff F said Tenant C1 had a change in condition. He went out to the hospital and when he returned he took two to three people to transfer, he was checked and changed in bed and staff fed him. When staff slid things under him he made facial expressions of pain. Staff repositioned him, unless he refused.

When interviewed on 7/11/23 Staff G said the last time she worked with him, about two to three weeks prior to him going out, he was bed bound. She said she went in to give morning medications on the day he was hospitalized but was unable to give them. Tenant C1 made gargling noises. She said either the nurse or Executive Director was called. Tenant C1's POA was called and he was

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A 160	Continued From page 14 sent out to the hospital. On 7/12/23 at 10:00 a.m. the Director of Nursing (DON) said when she started in early June Tenant C1's baseline was independent with his walker, he came out for meals and he self-toileted with help with changing his brief. He was hospitalized later in June. When he returned to the program he had a functional decline. Tenant C1 was admitted to hospice on 6/21/23. He was a max assist of two staff. Tenant C1 was bed bound and staff changed him in bed. He went to an appointment and returned with several procedures planned and was told he could not stay on hospice during that time. Tenant C1's POA revoked hospice services on 6/30/23 as he was scheduled for a computerized tomography (CT) scan on 7/3/23. On 7/3/23 Tenant C1 was dressed but was in bed. Staff could not safely transfer him from bed to wheelchair. The POA was upset Tenant C1 was not in his wheelchair and canceled the CT appointment. On 7/3/23 the DON said Tenant C1 was alert to self, very weak and was agitated. There were no breathing issues noted on 7/3/23. On 7/4/23 at 10:00 a.m. staff contacted her regarding Tenant C1 breathing differently. She could hear his rattling breathing. Tenant C1 was transferred to the hospital and the POA sent a message that he was admitted to palliative care. Tenant C1 died on 7/5/23. She said regarding his pain he refused morphine sulfate 90% of the time when on hospice. After hospice was revoked he had Tylenol and over the counter medication for pain. She said most of his pain was in his left knee and when he repositioned. She said Tenant C1's skin was very fragile and staff were careful when rolling him. She faxed the primary care provider (PCP) regarding medications and his skin but did not receive anything back. She said staff had	A 160		

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verbalized when they tried to change him he was combative.

Review of Tenant C1's file on 7/10/23 and 7/11/23 indicated Tenant C1 was admitted on 4/21/23 and was discharged (death) on 7/5/23. The Progress Notes indicated the following:

a. On 6/2/23 it was noted while at an appointment on 6/1/23, Tenant C1's POA talked to them about the wound on the left posterior elbow. A new order was received for mepitel dressing for 10 days, to be changed every two to three days.

b. On 6/2/23 Tenant C1's POA reported a small blister on the top of his right foot. It was noted Tenant C1 had edema and wore compression hose. The POA also reported Tenant C1 had a diaper rash on his buttocks. A fax was sent to the PCP.

c. On 6/6/23 new orders were received for a treatment for the blister on Tenant C1's right foot and also Desitin for the rash on his buttocks.

d. On 6/8/23 it was noted the skin tear on the left elbow was healing.

e. On 6/9/23 the tenant had an elevated heart rate and blood pressure and was sent to the hospital.

f. On 6/13/23 Tenant C1's POA sent a message on 6/11/23 that he had sigmoid diverticulitis. A dietician at the hospital had called and said they were evaluating him for malnutrition and wanted to know if there had been any weight loss or issues with eating.

g. On 6/16/23 it was noted Tenant C1 returned from the hospital on 6/15/23.

h. On 6/20/23 it was noted Tenant C1 had a major decline noted on 6/19/23. It took two people to and quite a bit of time to transfer him. He did not eat the day before and appeared very weak. Tenant C1's POA elected for hospice

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services to be started.
i. On 6/23/23 it was noted Tenant C1 was a max assist of two staff for all transfers and cares. Tenant C1 was wheelchair bound, was not eating, declined oral medications and required extensive assistance for activities of daily living. Tenant C1 was in a lot of pain. When staff attempted to turn him to clean him up, he yelled out. It was noted Tenant C1 was practically bed bound.
j. On 6/26/23 Tenant C1's POA indicated he had elected to have several planned cardiac procedures after an appointment. They spoke with the hospice nurse who informed them he would not be able to stay on hospice while the procedures were completed.
k. On 7/5/23 it was noted that on 7/4/23 the nurse was notified Tenant C1 had trouble breathing and hear Tenant C1 struggling to breath over the phone. Tenant C1 was transported to the hospital. A message was sent from the POA at 6:00 p.m. that indicated Tenant C1 would be admitted to the palliative care floor and would not be returning.

A hospice document indicated hospice services were revoked on 6/30/23. A fax was sent to the PCP dated 6/30/23 indicating hospice services were revoked and asked if liquid morphine had been ordered by hospice and could be given for pain or if another pain medication could be ordered. It was noted he often refused oral medications and liquid medications would be helpful. Tenant C1's POA also asked about over the counter medication medications for pain relief (lidocaine patches and Icy Hot) and orders were requested for those medications. The fax also indicated Tenant C1 had a history of skin tears and a standing order to treat them was requested.

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June 2023 medication administration records (MARs) reflected three doses of morphine sulfate, 0.25 milliliters (ml) every four hours as needed, was administered on 6/24/23, 6/25/23 and 6/27/23. No other doses were documented as administered. The MARs reflected no doses administered of the Desitin External Cream as ordered. The MARs reflected no treatments completed for the foot blister on the right foot. There were no doses of acetaminophen 325 mg, two tablets by mouth every four hours as needed, documented as administered. There was one documented completion of the treatment to the left elbow, Mepilex which was to be changed every three days, on 6/8/23. The July 2023 MARs reflected morphine sulfate, 0.25 ml every four hours as needed was on the MAR; however, was not documented as administered. There were no doses of acetaminophen 325 mg, two tablets by mouth every four hours as needed, documented as administered. There were no documented doses of Desitin or the treatment of the right foot blister documented as completed on the July 2023 MAR. The MARs for June and July reflected oral medications were documented as administered despite Tenant C1 refusing oral medications.

Hospital records (7/4/23-7/5/23) indicated Tenant C1 had progressive confusion. Tenant C1 was hospitalized with similar symptoms from 6/10/23 to 6/15/23. Per Tenant C1's POA he continued to decline post discharge. He was unable to walk or take care of himself, required two to three people to move, lift and transfer. Three days prior to his admission to the hospital he stopped eating and drinking. One day prior to admission he had a secretion that he was unable to clear. The hospital records indicated he was living in memory care unit prior to the hospitalization and

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his POA felt it that he exceeded the ability of the Program for them to continue to care for him. The hospital notes indicated Tenant C1 had multiple skin tears and dirty wound dressings. He was also "Covered in fecal matter and urine" and no oral cares were being done. The physical examination upon arrival to the ED indicated his appearance was unkempt, poor oral hygiene and a thick plaque noted to the lower teeth, and multiple skin tears and ecchymosis to the upper extremities. The records indicated he had chronic subdural hemorrhage, failure to thrive, dehydration, acute kidney injury and hypernatremia. It was noted Tenant C1 had severe arthritis of the left knee, and any movement of the lower extremity could result in pain (pre-medication was needed prior to moving). Tenant C1 was admitted to palliative care. The records indicated his primary cause of death was cardiopulmonary arrest. Conditions that contributed to his death were acute hypoxic respiratory failure and acute kidney injury.

When interviewed on 7/12/23 at 10:00 a.m. the DON said she was told from corporate staff that when someone was on hospice they could stay until they passed, no matter the level of care. She educated staff that it was a lot of work. She said staff was meeting his needs.

In summary, Tenant C1 exceeded the level of care to be retained and as his care needs increased the Program failed to meet his needs and provide adequate care, services and treatment for him. That included pain management, treatment and dressing of skin tears and blisters, assessment of skin tears, interventions related to combativeness during changing or repositioning and lack the provision of toileting and oral cares as evidenced by his

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condition upon admission to the hospital on 7/4/23.

2. When interviewed on 7/11/23 at 3:41 p.m. Staff D said it was dependent on who was working regarding if oral hygiene cares were completed. On 7/11/23 at 12:55 p.m. Staff E said when staff arrived on first shift, tenants were sometimes soaked in urine from third shift, depending on who was working. It occurred about twice per week.

Review of tenant records between 7/10/23 and 7/13/23 revealed the following :
- Tenant #1's Monthly Task Logs from May to July 2023 reflected scheduled tasks were documented as task not completed (TNC) for dressing and bathing assistance.
- Tenant #2's Monthly Task Logs from May to July 2023 reflected scheduled tasks were documented as TNC for dressing and bathing assistance.
- Tenant #3's Monthly Task Logs from May to July 2023 reflected scheduled tasks were documented as TNC for bathing, dressing, and laundry assistance.
- Tenant #4's Monthly Task Logs from May to July 2023 reflected scheduled tasks were documented as TNC for grooming, dressing, toileting, bathing, laundry and bed preparation.
- Tenant #5's Monthly Task Logs from May to July 2023 reflected scheduled tasks were documented as TNC for dressing, toileting, bathing, and bed preparation.
- Tenant #6's Monthly Task Logs from May to July 2023 reflected scheduled tasks were documented as TNC for grooming, dressing, toileting, laundry, bathing, and bed preparation.
- Tenant C1's Monthly Task Logs from May to July 2023 reflected scheduled tasks were

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A 160	Continued From page 20 documented as TNC for hygiene, dressing, laundry, bathing, bed preparation, and toileting. - Tenant C2's Monthly Task Logs for March and April 2023 reflected scheduled tasks were documented as TNC for safety checks, hygiene and grooming, dressing, and bathing. When interviewed on 7/18/23 the Executive Director confirmed all task logs for the tenants listed above were provided.	A 160		
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 complete evaluations as needed with significant change for 1 of 1 tenants reviewed with weight loss (Tenant #6). Findings follow: On 7/11/23 at 11:16 a.m. Staff B said Tenant #6	A 145		

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had a low appetite, weight loss, and had refused a lot of meals. She said he was sad/depressed. She believed the nurse was aware.

On 7/11/23 at 12:22 p.m. Staff C said Tenant #6 had weight loss and had protein shakes and snacks. She was pretty sure the nurse was aware.

On 7/11/23 at 3:41 p.m. Staff D said Tenant #6 had weight loss and he was eating a protein bar and now was refusing the bar. The nurse was aware.

On 7/11/23 at 12:55 p.m. Staff E said Tenant #6's weight loss could be seen visually. It could be observed in his skin. She was pretty sure one of the nurses was informed.

On 7/11/23 Staff F said Tenant #6 had a lot of weight loss. Tenant #6 had protein bars and shakes and was accepting of it at first.

When interviewed on 7/11/23 Staff G said Tenant #6 had weight loss and he had a rash in his mouth.

2. Review of Tenant #6's file on 7/17/23 and 7/18/23 revealed he was admitted on 3/20/23. The Program provided one documented weight since admission, which was 169 pounds on 5/2/23. Weights were obtained during the review of Tenant #6's file and were gathered from medical appointment records and hospital records. A Clinic Note with an encounter date of 3/22/23 indicated his weight was 181 pounds. An After Visit Summary (post hospitalization) dated 7/17/23 indicated his weight was 122 pounds. From 3/22/23 to 7/17/23 Tenant #6 sustained a 59 pound weight loss in approximately four

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A 145	Continued From page 22 months. Progress Notes indicated the following: a. On 4/17/23 a call was received from a nurse at the primary care provider's (PCP) office. The lab results indicated chronic protein malnutrition. It was noted a fax would be sent for high protein snacks, shakes and to encourage protein intake at meals b. On 4/23/23 orders were received on 4/17/23 for a high protein diet and supplement shakes at meals. c. On 5/1/23 it was noted Tenant #6 was leaning to the side and yelling. His grips were unequal. He became diaphoretic, 911 was called and he was transported to the hospital. d. On 5/2/23 Tenant #6 was discharged from the hospital. Hospital diagnoses included mild hypotension, acute kidney injury, lactic acidosis, altered mental status, pseudohypontremia, hypomagnesemia, hypophospatemia and acute hypoxic respiratory failure. e. On 6/2/23 during a dental appointment it was noted there was a concern he had a yeast infection in his mouth. The PCP was notified. A new order was received for Nystatin Solution Swish and Swallow, four times daily until symptoms resolved. f. On 7/12/23 it was noted Tenant #6 had an appointment on 7/11/23. At the appointment it was noted Tenant #6 had a 30 pound weight loss since April. He was also hypotensive. Tenant #6 was sent to the emergency department from the appointment. He was admitted for altered mental status and possible sepsis. Tenant #6 was receiving intravenous fluids and antibiotics. g. On 7/17/23 it was noted Tenant #6 was discharged back to the Program. h. On 7/24/23 it was noted a 90 day nurse review was completed.	A 145		

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A 145	Continued From page 23 3. Hospital records (7/11/23 to 7/17/23) indicated Tenant #6 went to a cardiology appointment on 7/11/23 and had significant mental status decline since the last time his spouse had seen him. It was also noted he had hypotension, significant weight loss since last seen and a decline in his mental status. The Program confirmed he had decreased oral intake. The Discharge Summary indicated active hospital problems included altered mental status, sepsis with acute organ dysfunction and septic shock. It was suspected that the altered mental status was due to dehydration due to poor oral intake versus sepsis. A clear source was not identified. 4. Continued record review revealed evaluations were last completed on 4/23/23 when 30 day evaluations were completed. Evaluations were not completed as needed with Tenant #6's significant weight loss, with the infection in Tenant #6's mouth and treatment or with the hospitalization on 5/1/23. Evaluations were not completed with significant change when Tenant #6 returned from the hospital on 7/17/23. 5. When interviewed on 7/12/23 at 10:00 a.m. the DON confirmed the standard of practice was to complete change of condition assessments within 24 hours. When interviewed on 7/18/23 the Executive Director confirmed all evaluations for the tenant listed above were provided.	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	A 155		

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A 155	Continued From page 24 retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow admission and retention criteria for 1 of 1 former tenants reviewed who required a minimum of two person assist with transfers (Tenant C1). Findings follow: 1. When interviewed on 7/11/23 at 11:16 a.m. Staff B said Tenant C1 was checked and changed in bed as staff could not get him up. He was incontinent of bladder and bowel. Tenant C1 was bed bound for about two weeks and maybe got out of bed once. Bed baths were given and he was changed in bed. He was aggressive at the end and hit, kicked and bit. Tenant C1 grimaced with pain. When staff checked and changed him he seemed to have a lot of pain. On 7/11/23 at 12:22 p.m. Staff C said staff repositioned Tenant C1 in bed. She said he was bed bound for about two weeks. He was on hospice and then was taken off of hospice. Tenant C1 was in a lot of pain. He was checked and changed in bed for toileting needs. When interviewed on 7/11/23 at 3:41 p.m. Staff D said it took three people to get Tenant C1 up at the end. Staff repositioned him every 30 minutes to one hour. He was changed in bed and had a lot of pain in his knee. He was really aggressive at the end.	A 155		

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A 155	Continued From page 25 During an interview on 7/11/23 at 12:55 p.m. Staff E said Tenant C1 had a decline and did not come out of his apartment. He went on hospice. Staff changed him, wiped his mouth and changed his clothes in bed. When interviewed on 7/11/23 Staff F said Tenant C1 had a change in condition. He went out to the hospital and when he returned he took two to three people to transfer, he was checked and changed in bed and staff fed him. When staff slid things under him he made facial expressions of pain. Staff repositioned him, unless he refused. When interviewed on 7/11/23 Staff G said the last time she worked with him, about two to three weeks prior to him going to the hospital, he was bed bound. When interviewed on 7/12/23 at 10:00 a.m. the Director of Nursing (DON) said when she started in early June Tenant C1's baseline was independent with his walker, he came out for meals and he self-toileted with help with changing his brief. He was hospitalized later in June. When he returned to the program he had a functional decline. Tenant C1 was admitted to hospice on 6/21/23. He was a max assist of two staff at that time. Tenant C1 became bed bound and staff changed him in bed. He went to an appointment and returned with several procedures planned and was told he could not stay on hospice during that time. Tenant C1's POA revoked hospice services on 6/30/23 as he was scheduled for a computerized tomography (CT) scan on 7/3/23. On 7/3/23 Tenant C1 was dressed and a clean brief but was in bed. Staff could not safely transfer him from bed to wheelchair. The POA was upset Tenant C1 was not in his wheelchair and canceled the CT	A 155		

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appointment. On 7/3/23 the DON said Tenant C1 was alert to self, was very weak and was agitated. There were no breathing issues noted on 7/3/23. On 7/4/23 at 10:00 a.m. staff contacted her regarding Tenant C1 breathing differently. She could hear his rattling breathing. Tenant C1 was transferred to the hospital and the POA sent a message that he was admitted to palliative care. Tenant C1 died on 7/5/23. She said staff had verbalized when they tried to change him he would be combative. She stated she was told from corporate staff that when someone was on hospice they could stay until they passed, no matter the level of care.

2. Review of Tenant C1's file on 7/10/23 and 7/11/23 indicated Tenant C1 was admitted on 4/21/23 and was discharged (death) on 7/5/23. The Progress Notes indicated the following:
a. On 6/20/23 it was noted Tenant C1 had a major decline noted on 6/19/23. It took two people to and quite a bit of time to transfer him. Tenant C1 did not eat the day before and appeared very weak. Tenant C1's POA elected for hospice services to be started.
b. On 6/23/23 Tenant C1 was a max assist of two staff for all transfers and cares. It was noted Tenant C1 was practically bed bound.
c. On 6/26/23 Tenant C1's POA indicated Tenant C1 had elected to have several planned cardiac procedures after an appointment. They spoke with the hospice nurse who informed them he would not be able to stay on hospice while the procedures were completed.
d. On 7/5/23 it was noted that on 7/4/23 the nurse was notified Tenant C1 had trouble breathing and the nurse could hear Tenant C1 struggling to breath over the phone. Tenant C1 was transported to the hospital. A message was sent from the POA at 6:00 p.m. that indicated

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A 155	Continued From page 27 Tenant C1 would be admitted to the palliative care floor and would not be returning. 3. Hospital records (7/4/23-7/5/23) indicated Tenant C1 had progressive confusion. Tenant C1 was hospitalized with similar symptoms from 6/10/23 to 6/15/23. Per Tenant C1's POA he continued to decline post discharge. He was unable to walk or take care of himself, required two to three people to move, lift and transfer. The hospital records indicated he was living in memory care unit prior to the hospitalization and his POA felt it that he exceeded the ability of them to continue to care for him. 4. When interviewed on 7/18/23 the Executive Director confirmed a 30 day written notice was not given regarding Tenant C1; however, it had been discussed. She confirmed the Program had not applied for a waiver of administrative rule for exceeding level of care related to Tenant C1.	A 155		
A 160	481-69.23(1)c(1) 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: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 160		

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A 160	Continued From page 28 Program failed to follow admission and retention criteria for 1 of 1 former tenants reviewed who was a danger to self and others (Tenant C2). Findings follow: 1. Review of Tenant C2's file on 7/11/23 reflected he was discharged on 5/10/23. Incident reports indicated the following: a. On 8/26/22 Tenant C2 ran into the dining room and threw himself on the floor. He cut his chin and staff attempted to stop the bleeding but were not successful. Tenant C2 was taken to the hospital and received sutures. b. On 9/13/22 Tenant C2 threw himself on the floor, and after assisted up by staff, threw himself back on the floor. Tenant C2 sustained an abrasion to his knee after repeatedly falling. c. On 10/16/22 another tenant started swinging at staff. Tenant C2 walked by, saw the other tenant's behavior and punched the other tenant two to three times which caused his glasses to come off. d. On 1/17/23 another tenant fell in memory care. Tenant C2 was observed standing close to the tenant. Video footage revealed the other tenant walked up to the counter and grabbed the silverware. Tenant C2 stood up and pushed the other tenant. e. On 2/15/23 another tenant reported Tenant C2 hit her in the mouth. f. On 2/21/23 staff held the door open for Tenant C2 to come back to the memory care unit. Tenant C2 punched staff in the left side of her chest. g. On 4/2/23 staff heard screaming from the living room and responded. A female tenant was crying and said that Tenant C2 had hit her in the chest. h. On 4/22/23 Tenant C2 sat on the couch where another tenant was seated. The two tenants had	A 160		

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a verbal exchange and Tenant C2 hit the other tenant in the mouth. It caused an open cut and bleeding to the other tenant. Tenant C2 was sent out to the hospital for a geriatric psychological evaluation and returned that evening with no new orders.

i. On 4/30/23 it was noted Tenant C2 hit a private caregiver hard in the chest and called her a name.

A review of Progress Notes indicated the following:

a. On 5/1/23 after the incident on 4/30/23 (see description above) Tenant C2 was sent to the hospital and was admitted.

b. On 5/2/23 Tenant C2 hit hospital staff.

c. On 5/5/23 Tenant C2 remained in the behavioral health unit.

d. On 5/8/23 Tenant C2 transferred to a higher level of care.

2. When interviewed on 7/11/23 at 11:16 a.m. Staff B said soon after she started at the building Tenant C2 punched her in the chest as she attempted to redirect him. Tenant C2 also had altercations with other tenants, including Tenant #1, who he punched in the lip and chest. He also hit Tenant #2.

When interviewed on 7/11/23 at 12:22 p.m. Staff C said Tenant C2 had been physical with other tenants a few times. There was an incident when Tenant C2 punched Tenant #2. Tenant C2 walked away and staff found Tenant #2 with blood on his face. Tenant #2 was sent out to the hospital.

3. Record review revealed Tenant C2 was given a 30 day notice to transfer dated 4/26/23, effective 5/26/23. Tenant C2 was discharged on

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A 160	Continued From page 30 5/10/23. The Incident Investigation Form dated 4/24/23 indicated one to one staffing would be provided until Tenant C2 was discharged. In summary, Tenant C2 was discharged at the time of the investigations; however, he had documented physical behaviors towards himself, other tenants, and staff for months prior to being discharged, including behaviors that caused injuries. Tenant C2 exceeded the level of care related to being a danger to himself and to others related to the incidents noted above and he exceeded the level of care prior to the 30 day notice issued on 4/26/23.	A 160		
A 320	481-69.25(1)o Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record) This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete incident reports as needed for 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. When interviewed on 7/11/23 at 11:16 a.m. Staff B said Tenant C1 had a skin tear on his hand and a bandage was put on it. Staff B did not know what the skin tear was from.	A 320		

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A 320	Continued From page 31 During an interview on 7/11/23 at 12:22 p.m. Staff C said in the past few days, Tenant C1 had open skin tears on both arms that were wrapped up with gauze. She said Tenant C1 dug his nails into his skin. She said the nurse was aware of his arm. When interviewed on 7/11/23 at 3:41 p.m. Staff D said towards the end Tenant C1 was really aggressive, and staff had to hold his hands in order to change him. It was not forceful in any way. Tenant C1 pulled his arm back as staff had ahold of it. Staff D said Tenant C1's skin was weaker every day and it was bleeding a lot. On 7/11/23 Staff F said towards the end Tenant C1 was aggressive and had skin tears on his arms and hand. She said Tenant C1 did not want to be changed. When interviewed on 7/12/23 at 10:00 a.m. the Director of Nursing said Tenant C1's skin was very fragile and staff were careful when rolling him. She faxed the PCP (primary care provider) regarding medications and about his skin issues but did not receive anything back. 2. Review of Tenant C1's file on 7/10/23 and 7/11/23 revealed an After Visit Summary (AVS) dated 6/1/23 (Interventional Radiology) indicating he was seen for a placement of a retrievable interior vena cava (IVC) filter below the level of the renal veins. A nursing note indicated Tenant C1 was seen for a IVC filter placement and the power of attorney (POA) voiced concerns with Tenant C1's left posterior elbow injury. The injury started from a hematoma a week ago from a fall. A wound nurse was messaged and recommended a mepitel dressing for 7 to 10	A 320		

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days, and to change the dressing every two to three days. The dressing was applied at the appointment and dressings were sent with Tenant C1. An image of the wound was sent with the AVS.

Continued record review revealed hospital records (7/4/23-7/5/23) indicated had multiple skin tears and ecchymosis on his upper extremities upon admission. The hospital records indicated Tenant C1 had chronic wounds, dirty dressings and skin tears. There were pictures included that showed a wound on the left hand and pictures of the skin on the left and right arms. The hospital records indicated Tenant C1 died on 7/5/23.

Review of hospital records (7/4/23-7/5/23) revealed the tenant had multiple skin tears and ecchymosis on his upper extremities upon admission. The hospital records indicated Tenant C1 had chronic wounds, dirty dressings and skin tears.

3. Further record review revealed incident reports were completed for Tenant C1 on 5/17/23 and 5/18/23 for falls. Neither incident report documented an injury to the left elbow. At a clinic appointment the POA voiced concerns regarding the injury to the posterior left elbow and said it had occurred about a week prior. An incident report was not completed related to the injury. Review of all of Tenant C1's incident reports from admission to discharge did not reveal an incident report completed related to skin tears, injuries to the skin, or injuries of unknown etiology. . Incident reports were not completed related to skin injuries of unknown etiology for Tenant C1.

4. When interviewed on 7/18/23 the Executive

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A 320	Continued From page 33 Director confirmed all incident reports for the tenant listed above were provided.	A 320		
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 to identified the needs of 5 of 6 current (Tenants #1, #3, #4, #5 and #6) and 2 of 2 discharged (Tenant C1, C2) tenants reviewed. Findings follow: 1. Review of Tenant #1's file on 7/12/23 revealed incident reports dated 2/15/23, 4/2/23 and 4/19/23 indicating altercations with other tenants. The service plan dated 3/9/23 reflected Tenant #1 did not have any behavioral issues. The service plan failed to identify issues that occurred between Tenant #1 and other tenants as indicated in incident reports. When interviewed on 7/11/23 at 11:16 a.m. Staff B said Tenant #1 required toileting assistance every hour. She was incontinent of urine and occasionally of stool.	A 350		

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A 350	Continued From page 34 On 7/11/23 at 12:22 p.m. Staff C said she assisted Tenant #1 with toileting about every two hours. When interviewed on 7/11/23 at 3:41 p.m. Staff D said Tenant #1 was assisted with toileting every 30 minutes to one hour. She was incontinent of urine and sometimes stool. The tenant's service plan reflected she required minimal assistance with toileting and staff provided cues or prompts. The service plan was not updated to reflect the toileting needs of Tenant #1. 2. Review of Tenant #3's file on 7/13/23 revealed an incident report indicating on 5/6/23 at 10:00 a.m. the tenant entered through the front entrance door of the attached general population assisted living. Tenant #3 went towards the memory care unit and into the spa where he had a fall. No injuries were noted. Progress Notes indicated the following: a. On 5/19/23 staff reported a large excoriation on Tenant #3's buttocks. A nurse assessment revealed the groin, genitals, and buttocks were extremely excoriated. Tenant #3 had an order for Nystatin. b. On 5/24/23 Tenant #3's power of attorney (POA) took him to urgent care over the weekend for the rash on his groin. A new order was received for miconzole powder twice daily and to discontinue Nystatin powder. c. On 6/8/23 it was noted the 14 day course of the miconzole powder to the groin was completed. The POA requested the order be continued twice daily, as it helped with the rash. A fax was sent to request it be continued.	A 350		

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A 350	Continued From page 35 Continued record review revealed a document with a skin care routine for Tenant #3 that included to use wipes after incontinence of stool and with toileting, and to not use toilet paper, soap or washcloths. Staff were to apply topical creams and powders, toilet Tenant #3 frequently and change the protective undergarment when soiled. The document indicated if possible to leave open to air or wear cotton undergarments for part of the day. It also indicated not to use steroid creams on the area as it would make the yeast grow quicker, to shower using only water on the perineal area and to rinse off all layers of the skin products daily. Tenant #3's service plan dated 2/24/23 reflected a history of wandering that did not jeopardize safety. The service plan was not updated post elopement to reflect Tenant #3 had left the building and any needed interventions for his safety. The service plan reflected Tenant #3 had a history of skin impairment; however, did not reflect the groin and perineal area rash and treatment. The service plan reflected Tenant #3 was independent with toileting. The service plan did not reflect toileting assistance or the skin care routine as indicated above. 3. Review of Tenant #4's file on 7/13/23 revealed an incident report dated 5/21/23 indicating at 3:30 a.m. Tenant #4 came out and sat in the chair by the stairwell door. The electronic wandering monitoring alarm was going off as he was near the exit door and was wearing an electronic wandering monitoring device. Staff kept resetting the alarm and offered to take him to the bathroom and he declined. At 5:57 a.m. the alarm came through the phone and staff thought it was due to Tenant #4 sitting by the door. At 6:00 a.m. other staff reported the exit door alarm was going off in	A 350		

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the back. Staff asked who was sitting there and then staff completed a head count. Staff went upstairs (attached general population assisted living) and found Tenant #4 being escorted out of another tenant's apartment by the tenant's family member. Staff took Tenant #4 back to the memory care unit.

Progress Notes reflected the following:
a. On 6/5/23 Tenant #4's POA took him to urgent care due to blood in his urine.
b. On 6/13/23 results were received from the 6/12/23 urology appointment. New orders were received for doxycycline for seven days and tamsulosin. The primary care provider (PCP) recommended 60 ounces of water per day, vitamin C, cranberry and a probiotic (no orders were received). The PCP office was called and informed input and output was not tracked in assisted living but fluids would be encouraged and that an order would be needed for the vitamin C, cranberry and probiotic.
c. On 6/22/23 the antibiotic was completed
d. On 6/28/23 Tenant #4 continued to have hematuria, even though he was treated for a urinary tract infection (UTI). Tenant #4's POA was updated and the urology office was informed.
e. On 7/6/23 it was noted Tenant #4 was seen in urology for prolonged hematuria.

Tenant #4's service plan dated 4/24/23 reflected a history of wandering that did not jeopardize safety. The service plan was not updated post elopement to reflect Tenant #4 had left the memory care unit and any needed interventions for his safety. The service plan also reflected a history of UTIs; however, did not reflect Tenant #4 had hematuria.

4. Review of Tenant #5's file on 7/13/23 revealed

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Progress Notes indicated the following:
a. On 3/14/23 it was documented Tenant #5 had an unwitnessed fall on 3/13/23. Tenant #5 was transferred to the hospital and received 5 to 10 sutures in the right side of her forehead. She had redness/abrasion surrounding the area that was the size of a tennis ball. Tenant #5 also sustained a humerus fracture and was to wear a sling. Tenant #5 could not ambulate with her walker due to the fracture.
b. On 3/15/23 a change of condition was completed related to the left arm fracture. The service plan was updated.
c. On 3/30/23 Tenant #5 had an appointment (orthopedics) to follow up from falls on 3/27/23 and 3/13/23. No new orders were received.
d. On 4/24/23 new orders were received for physical therapy (PT) and occupational therapy (OT).
e. On 5/1/23 a new order was received to crush medications.
f. On 5/9/23 it was noted Tenant #5 fell on 5/7/23 and was transported to the hospital. She was diagnosed with a UTI, cellulitis and hypokalemia.

Continued record review revealed therapy documentation stating Tenant #5 was discharged from PT on 6/23/23 and discharged from OT on 6/28/23. A clinic document dated 3/28/23 indicated Tenant #5 was to remain non-weight bearing on the left upper extremity. It indicated the sling was for comfort, she could dangle her arm and work on pendulums.

When interviewed on 7/18/23 at 10:25 a.m. the Executive Director. Tenant #5 was not using the sling at the current time. She said when she started in early April she did not recall her using it at that time either. She confirmed there was no order found to discontinue the sling

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A 350	Continued From page 38 Tenant #5's service plans were dated 3/15/23 and 5/15/23. The 3/15/23 service plan reflected the use of the arm sling. The 5/15/23 service plan still reflected the use of sling; despite no longer being used. In April orders were received for OT, PT and crushed medications. The service plan was updated to reflect those changes; however, it was not updated until 5/15/23. The service plan dated 5/15/23 reflected Tenant #5 had a history of skin impairments and breakdown. The service plan was not updated to reflect Tenant #5 had cellulitis and the treatment. The service plan was also not updated to reflect Tenant #5's discharge from OT/PT. 5. When interviewed on 7/11/23 at 11:16 a.m. Staff B said Tenant #6 had a low appetite, weight loss, and he refused a lot of meals. She said he was sad/depressed. She believed the nurse was aware. On 7/11/23 at 12:22 p.m. Staff C said Tenant #6 had weight loss and was receiving protein shakes and snacks. She was pretty sure the nurse was aware. When interviewed on 7/11/23 at 3:41 p.m. Staff D said Tenant #6 had weight loss. He was receiving a protein bar but was now refusing it. The nurse was aware. During an interview on 7/11/23 at 12:55 p.m. Staff E said Tenant #6's weight loss could be seen visually. It could be observed in his skin. She was pretty sure one of the nurses was informed. When interviewed on 7/11/23 Staff F said Tenant #6 had a lot of weight loss. Tenant #6 had protein bars and shakes and was accepting of it at first.	A 350		

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A 350	Continued From page 39 On 7/11/23 Staff G said Tenant #6 had weight loss and he had a rash in his mouth. Review of Tenant #6's file on 7/17/23 and 7/18/23 revealed he was admitted on 3/20/23. The Program provided one documented weight since admission, which was 169 pounds on 5/2/23. Weights were obtained during the review of Tenant #6's file and were gathered from medical appointment records and hospital records. A Clinic Note with an encounter date of 3/22/23 indicated his weight was 181 pounds. An After Visit Summary (post hospitalization) dated 7/17/23 indicated his weight was 122 pounds. From 3/22/23 to 7/17/23 Tenant #6 sustained a 59 pound weight loss in approximately four months. Progress Notes indicated the following: a. On 4/17/23 a call was received from a nurse at the primary care provider's (PCP) office. The lab results indicated chronic protein malnutrition. It was noted a fax would be sent for high protein snacks, shakes and to encourage protein intake at meals b. On 4/23/23 orders were received on 4/17/23 for a high protein diet and supplement shakes at meals. c. On 5/1/23 it was noted Tenant #6 was leaning to the side and yelling. His grips were unequal. He became diaphoretic, 911 was called and he was transported to the hospital. d. On 5/2/23 Tenant #6 was discharged from the hospital. Hospital diagnoses included mild hypotension, acute kidney injury, lactic acidosis, altered mental status, pseudohypontremia, hypomagnesemia, hypophospatemia and acute hypoxic respiratory failure. e. On 6/2/23 during a dental appointment it was noted there was a concern he had a yeast	A 350		

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infection in his mouth. The PCP was notified. A new order was received for Nystatin Solution Swish and Swallow, four times daily until symptoms resolved.

f. On 7/12/23 it was noted Tenant #6 had an appointment on 7/11/23. At the appointment it was noted Tenant #6 had a 30 pound weight loss since April. He was also hypotensive. Tenant #6 was sent to the emergency department from the appointment. He was admitted for altered mental status and possible sepsis. Tenant #6 was receiving intravenous fluids and antibiotics.

g. On 7/17/23 it was noted Tenant #6 was discharged back to the Program.

h. On 7/24/23 it was noted a 90 day nurse review was completed.

Continued record review revealed the service plan was last updated on 4/23/23 (30 day service plan). The service plan reflected protein shakes and snacks, however, did not reflect Tenant #6's weight loss, or the infection in his mouth and treatment The service plan was also not updated as needed with the continued significant weight loss and infection in mouth and treatment. An updated service plan was requested after Tenant #6's return from the hospital (7/17/23) but the service plan had not been completed at that time. The service plan was not updated as needed and did not reflect the service needs of Tenant #6.

6. When interviewed on 7/11/23 at 11:16 a.m. Staff B said Tenant C1 was checked and changed in bed as staff could not get him up. He was incontinent of bladder and bowel. Tenant C1 was bed bound for about two weeks and got out of bed possible one time. Bed baths were given and he was changed in bed. He was aggressive at the end and hit, kicked and bit staff. She said he was on hospice for awhile and then was taken off of

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A 350	Continued From page 41 hospice When interviewed on 7/11/23 at 12:22 p.m. Staff C said staff repositioned Tenant C1 in bed. She said he was bed bound for about two weeks. He was on hospice and then was taken off of hospice. Tenant C1 was in a lot of pain. He was checked and changed in bed for toileting needs. When interviewed on 7/11/23 at 3:41 p.m. Staff D said it took three people to get Tenant C1 up at the end. Staff repositioned him every 30 minutes to one hour. He was changed in bed and had a lot of pain in his knee. He was really aggressive at the end and would grab his feces. On 7/11/23 at 12:55 p.m. Staff E said Tenant C1 had a decline and did not come out of his apartment. He went on hospice. Staff performed peri-care, changed his clothes and wiped his mouth all in bed. When interviewed on 7/11/23 Staff F said Tenant C1 had a change in condition. He went out to the hospital and when he returned he took two to three people to transfer, he was checked and changed in bed and staff fed him. On 7/11/23 Staff G said the last time she worked with him, about two to three weeks prior to him going to the hospital, he was bed bound. When interviewed on 7/12/23 at 10:00 a.m. the Director of Nursing (DON) said when she started in early June Tenant C1's baseline was independent with his walker. He came out for meals and self-toileted with help in changing his brief. He was hospitalized in June. When he returned to the program he had a functional decline. Tenant C1 was admitted to hospice on	A 350		

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6/21/23. He was a max assist of two staff. Tenant C1 was bed bound and staff changed him in bed. He went to an appointment and returned with several procedures planned and was told he could not stay on hospice if procedures were going to be completed. Hospice services were revoked on 6/30/23.

Review of Tenant C1's file on 7/10/23 and 7/11/23 indicated he was admitted on 4/21/23 and was discharged (death) on 7/5/23. Progress Notes indicated the following:

a. On 6/2/23 it was noted while at an appointment on 6/1/23, Tenant C1's POA talked to them about the wound on the left posterior elbow. A new order was received for mepitel dressing for 10 days, to be changed every two to three days.

b. On 6/2/23 Tenant C1's POA reported Tenant C1 had a small blister on the top of his right foot. It was noted Tenant C1 had edema and wore compression hose. The POA also reported Tenant C1 had a diaper rash on his buttocks. A fax was sent to the PCP.

c. On 6/6/23 new orders were received for a treatment for the blister on the right foot and Desitin for the rash on his buttocks.

d. On 6/8/23 it was noted the skin tear on the left elbow was healing.

e. On 6/9/23 Tenant C1 had an elevated heart rate and blood pressure and was sent to the hospital.

f. On 6/13/23 it was noted Tenant C1's POA sent a message on 6/11/23 stating that the tenant had sigmoid diverticulitis. A dietician at the hospital had called and said they were evaluating him for malnutrition and wanted to know if there had been any weight loss or issues with eating.

g. On 6/16/23 it was noted Tenant C1 returned from the hospital on 6/15/23.

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A 350	Continued From page 43 h. On 6/20/23 it was noted Tenant C1 had a major decline noted on 6/19/23. It took two people to transfer him and it took quite a bit of time. Tenant C1 did not eat the day before and appeared very weak. His POA elected for hospice services to be started. i. On 6/23/23 it was noted Tenant C1 was a max assist of two staff for all transfers and cares. Tenant C1 was wheelchair bound, was not eating, declined oral medications and required extensive assistance for activities of daily living. Tenant C1 was in a lot of pain. When staff attempted to turn him to clean him up, he yelled out. It was noted Tenant C1 was practically bed bound. j. On 6/26/23 the POA indicated Tenant C1 had elected to have several planned cardiac procedures after an appointment. They spoke with the hospice nurse who informed them they would not be able to stay on hospice while the procedures were completed. k. On 7/5/23 it was noted that on 7/4/23 the nurse was notified Tenant C1 had trouble breathing and the nurse could hear the tenant struggling to breathe over the phone. Tenant C1 was transported to the hospital. A message was sent from the POA at 6:00 p.m. that indicated Tenant C1 would be admitted to the palliative care floor and would not be returning. Continued record review revealed a hospice document indicated hospice services were revoked on 6/30/23. Hospital records (7/4/23-7/5/23) indicated Tenant C1 had progressive confusion. Tenant C1 was hospitalized with similar symptoms from 6/10/23 to 6/15/23. Per Tenant C1's POA he continued to decline post discharge. He was unable to walk or take care of himself, required two to three people to move, lift and transfer. Three days prior to his	A 350		

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admission he stopped eating and drinking and one day prior to admission he had a secretion that he was unable to clear.

Tenant C's service plans were dated 5/28/23, 6/23/23 and 7/10/23 (print date and effective date; signed on 6/30/23). The service plan was not updated to reflect the skin tear on the left elbow and treatment. The service plan also did not reflect the blister and treatment on the foot or rash on Tenant C1's buttocks and treatment. The notes referenced compression hose. Compression hose were not included on the service plan.

The service plan was updated 6/23/23 to reflect hospice services and an increase in cares; however, a significant increase in his cares was noted but the service plan did not reflect the care needs as indicated above. The service plan was updated after 6/23/23 with a service plan print date and effective date 7/10/23 (signed on 6/30/23). The service plan reflected hospice services despite hospice services being revoked on 6/30/23. The service plans dated 6/23/23 and 7/10/23 (6/30/23) did not reflect Tenant C1's current level of care and services needed as indicated above.

8. Review of Tenant C2's file on 7/11/23 reflected he was discharged on 5/10/23. Incident reports indicated the following:
a. On 10/16/22 another tenant started swinging at staff. Tenant C2 walked by and saw the other tenant's behavior and punched the other tenant two to three times causing his glasses to come off.
b. On 1/17/23 another tenant fell in memory care. Tenant C2 was observed standing close to the tenant. Video footage revealed the other

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A 350	Continued From page 45 tenant walked up to the counter and grabbed the silverware. Tenant C2 stood up and pushed the other tenant. c. On 2/15/23 another tenant reported Tenant C2 hit her in the mouth. d. On 2/21/23 staff held the door open for Tenant C2 to come back to the memory care unit. Tenant C2 punched staff in the left side of her chest. e. On 4/2/23 staff heard screaming from the living room and responded. A female tenant was crying and said that Tenant C2 had hit her in the chest. f. On 4/22/23 Tenant C2 sat on the couch where another tenant was seated. The two tenants had a verbal exchange and Tenant C2 hit the other tenant in the mouth. It caused an open cut and bleeding to the other tenant. Tenant C2 was sent out to the hospital for a geriatric psychological evaluation and returned that evening with no new orders. g. On 4/30/23 Tenant C2 hit a private caregiver hard in the chest and called her a name. The service plan dated 12/28/22 reflected Tenant C2 had occasional behaviors and a history of behaviors including those verbally and physically improper. Staff was to separate tenants if it was noted there was any agitation. Staff was to report any worsening of behaviors. The service plan did not reflect the behaviors as noted above towards tenants, staff and private caregivers. 9. When interviewed on 7/18/23 the Executive Director confirmed all service plans for the tenants listed above were provided.	A 350		
A 420	481-69.27(1)a Nurse Review	A 420		

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A 420	Continued From page 46 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: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to make appropriate interventions or referrals related to changes tenants' change of condition for 1 of 1 current tenants reviewed with weight loss (Tenant #6) and 1 of 1 discharged tenants with wounds (Tenant C1). Findings follow: 1. Review of Tenant C1's file on 7/10/23 and 7/11/23 revealed during a medical appointment on 6/1/23 Tenant C1's Power of Attorney (POA) voiced concerns over a left posterior elbow inury sustained from a fall a week prior. A wound nurse recommended mepitel dressing for 7 to 10 days, change the dressing every two to three days. The dressing was applied at the appointment and dressings were sent with Tenant C1. Hospital records (7/4/23 and 7/5/23) indicated the tenant had multiple skin tears and ecchymosis on his upper extremities upon admission to the	A 420		

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A 420	Continued From page 47 hospital on 7/4/23. When interviewed on 7/12/23 at 10:00 a.m. the Director of Nursing (DON) said Tenant C1's skin was very fragile and staff were careful when rolling him. She faxed the PCP regarding medications and his skin but did not receive anything back. Continued record review revealed there were no referrals or interventions related to Tenant C1's wounds and treatment. The only skin treatment documented was the order for the posterior left elbow treatment which was not a referral or intervention initiated by the Program; however, was brought up by the POA at a non-related medical appointment. A fax was sent to the PCP dated 6/30/23 for a history of skin tears and a standing order to treat was requested; however, the fax did not indicate Tenant C1 had current skin tears. Tenant C1 was admitted to the hospital on 7/4/23 and hospital records indicated multiple skin tears and ecchymosis on his hands and upper extremities. The hospital records also indicated the dressings were soiled. Tenant C1's file lacked any documentation of the skin issues or referrals or interventions to treat the wounds. Nurse reviews were not completed as needed for Tenant C1, which included appropriate referrals and interventions related to his skin tears and ecchymosis. For more information, please see the deficiency under 67.3(2) Tenant Rights. 2. During an interview on 7/11/23 at 11:16 a.m. Staff B said Tenant #6 had a low appetite, weight loss, and refused a lot of meals. She said he was	A 420		

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sad/depressed. She believed the nurse was aware.

On 7/11/23 at 12:22 p.m. Staff C said Tenant #6 had weight loss and was to be given protein shakes and snacks. She was pretty sure the nurse was aware.

On 7/11/23 at 3:41 p.m. Staff D said Tenant #6 had weight loss. He had been eating a protein bar but now was refusing the bar. She indicated the nurse was aware.

When interviewed on 7/11/23 at 12:55 p.m. Staff E said Tenant #6's weight loss could be seen visually. It could be observed in his skin. She was pretty sure one of the nurses was informed.

On 7/11/23 Staff F said Tenant #6 had a lot of weight loss. Tenant #6 had protein bars and shakes and was accepting of it at first.

When interviewed on 7/11/23 Staff G said Tenant #6 had weight loss and he had a rash in his mouth.

Review of Tenant #6's file on 7/17/23 and 7/18/23 revealed he was admitted on 3/20/23. The Program provided one documented weight since admission, which was 169 pounds on 5/2/23. Weights obtained during the review of Tenant #6's file were gathered from medical appointment records and hospital records. A Clinic Note with an encounter date of 3/22/23 indicated his weight was 181 pounds. An After Visit Summary (post hospitalization) dated 7/17/23 indicated his weight was 122 pounds. From 3/22/23 to 7/17/23 Tenant #6 sustained a 59 pound weight loss.

Nurses Notes indicated the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0445	A. BUILDING: _____ B. WING _____	C 07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STIRLINGSHIRE OF CORALVILLE MC	1140 KENNEDY PARKWAY CORALVILLE, IA 52241

(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 420	Continued From page 49 a. On 4/17/23 a call was received from a nurse at the primary care provider's (PCP) office. The lab results indicated chronic protein malnutrition. It was noted a fax would be sent for high protein snacks, shakes and to encourage protein intake at meals b. On 4/23/23 orders were received on 4/17/23 for a high protein diet and supplement shakes at meals. c. On 5/1/23 it was noted Tenant #6 was leaning to the side and yelling. His grips were unequal. Tenant #6 became diaphoretic, 911 was called and he was transported to the hospital. d. On 5/2/23 Tenant #6 was discharged from the hospital. Hospital diagnoses included mild hypotension, acute kidney injury, lactic acidosis, altered mental status, pseudohypontremia, hypomagnesemia, hypophospatemia and acute hypoxic respiratory failure. e. On 7/12/23 it was noted Tenant #6 had an appointment on 7/11/23. At the appointment it was noted Tenant #6 had a 30 pound weight loss since April. Tenant #6 was also hypotensive. Tenant #6 was sent to the emergency department from the appointment. f. On 7/17/23 Tenant #6 was discharged back to the Program. g. On 7/24/23 a 90 day nurse review was completed. Hospital records (7/11/23 to 7/17/23) indicated Tenant #6 went to a cardiology appointment on 7/11/23 and had significant mental status decline since the last time his spouse had seen him. It was also noted he had hypotension and the nurse practioner noted Tenant #6 had significant weight loss since was last seen. He was sent to the hospital. The Program confirmed he had decreased oral intake. The Discharge Summary indicated active hospital problems included	A 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0445	A. BUILDING: _____ B. WING _____	C 07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 420	Continued From page 50	A 420		

altered mental status, sepsis with acute organ dysfunction and septic shock. It was suspected that the altered mental status was due to dehydration due to poor oral intake versus sepsis. A clear source was not identified.

Continued review of Tenant #6's file revealed no referrals or interventions related to his significant weight loss. On 4/17/23 protein supplements were ordered; however, it the nurse at the PCP's office who called and said Tenant #6's labs indicated chronic protein malnutrition. It was not a referral or recommendation by the Program. Only one weight was provided by the Program from admission, which was on 5/2/23. On 7/11/23 at a medical appointment it was noted Tenant #6 had a 30 pound weight loss since the last appointment, had a decline in his mental status and was hypotensive. Tenant #6 was sent to the hospital. The Program had not made any recommendations or referrals regarding Tenant #6's weight loss. Nurse reviews were not completed as needed for Tenant #6, which included appropriate interventions and referrals related to his weight loss.

3. When interviewed on 7/31/23 at the Director of Nursing confirmed all nurse reviews were provided for the tenants listed. She said she had not been made aware of the weight loss and refusals to eat for Tenant #6 and was not aware of the current skin tears for Tenant C1; however, was aware of the fragile nature of his skin. She confirmed the above finding.

Plan of Correction for Stirlingshire of Coralville MC
In Response to
Final Complaint/Incident Investigation
Dated 7/10/2023-7/31/2023
Investigation #111712-I, #111744-I, #111997-C, #112609-I, #112824-I, #113143-I, and #113995-C

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Regulatory Insufficiency: Program Policies and Procedures: 481-67.2(3)

67.2(3)-The program shall follow the policies and procedures established by the program.

1. **Elements detailing how the program will correct the insufficiency.**
   a. The program will follow the policies and procedures established by the program.
2. **What measures will be taken to ensure the problem does not recur.**
   a. Education for all nursing staff will be completed by 10/31/2023. Education will include review of program policies and procedures-specifically the elopement and alarmed door policy and memory care safety check protocol.
3. **How the program plans to monitor performance to ensure compliance.**
   a. Executive Director and or designee will periodically conduct elopement drills.
   b. Regional Nurse and or designee will periodically audit supporting documentation for completion during visits to community.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. 10/31/2023

Regulatory Insufficiency: Tenant Rights 481-67.3(2)

481-67.3 Tenant Rights. All tenants have the following rights:

67.3(2) To receive care, treatment and services which are adequate and appropriate.

1. **Elements detailing how the program will correct each regulatory insufficiency.**
   a. Education for all nursing staff will be completed on ADL charting and completion of scheduled tasks.
2. **What measures will be taken to ensure the problem does not recur.**

a. DON, Regional Nurse, and or designee to perform random audits of monthly task log to ensure that scheduled ADL's are charted

3. **How the Program plans to monitor performance to ensure compliance.**
    a. DON, Regional Nurse, and or designee to perform random audits of monthly task log to ensure that scheduled ADL's are documented.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. 10/31/2023

Regulatory Insufficiency: Evaluation of Tenant 481-69.22(3)

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.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Assessments and service plans will be created and kept updated to reflect residents' individual needs.
2. **What measures will be taken to ensure the problem does not recur.**
    a. Education with DON/ADON will be completed with Regional Nurse and/or designees on resident requirements on assessments.
3. **How the program plans to monitor performance to ensure compliance.**
    a. The DON, Regional Nurse and/or designee will complete random audits of resident assessments and service plans to ensure accuracy and compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. The regulatory insufficiency will be corrected by 10/31/2023.

Regulatory Insufficiency: Criteria for Admission / Retention of Tenants 481-69.23(1)c(1)

69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who:

c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression.

5. **Elements detailing how the program will correct each regulatory insufficiency.**
    a. Assessments and service plans will be created and kept updated to reflect residents' individual needs.
6. **What measures will be taken to ensure the problem does not recur.**
    a. Education with DON/ADON will be completed with Regional Nurse and/or designee on resident requirements on assessments.
7. **How the Program plans to monitor performance to ensure compliance.**

a. The DON, Regional Nurse and/or designee will complete random audits of resident assessments and service plans to ensure accuracy and compliance.

8. **The date by which the regulatory insufficiency will be corrected.**
    a. The regulatory insufficiency will be corrected by 10/31/2023.

Regulatory Insufficiency: Tenant Documents 481-69.25(1)

69.25(1) Documentation for each tenant shall be maintained by the program and shall include:

o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record)

1. **Elements detailing how the program will correct the insufficiency.**
    a. The program will follow the policies and procedures established by the program.
2. **What measures will be taken to ensure the problem does not recur.**
    b. Education for all nursing staff will be completed by 10/31/2023. Education will include review of program policies and procedures-specifically incident reports.
3. **How the program plans to monitor performance to ensure compliance.**
    a. DON and or designee will review incident report policy during staff meetings at minimum twice a year.
    b. Regional Nurse and or designee will periodically audit supporting documentation for completion during visits to community.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. 10/31/2023

Regulatory Insufficiency: Service Plans 481-29.26(1)

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.

1. **Elements detailing how the program will correct each regulatory insufficiency.**
    a. Service plans will be created to reflect residents individual care needs per program policy and within regulatory compliance.
2. **What measures will be taken to ensure the problem does not recur.**
    a. Education with DON/ADON will be completed by the Regional Nurse and/or designee regarding service plans.
3. **How the Program plans to monitor performance to ensure compliance.**
    a. The Regional Nurse and/or designee will complete random audits of resident service plans to ensure accuracy and compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. The regulatory insufficiency will be corrected by 10/31/2023.

Regulatory Insufficiency: Nurse Review 481-69.27(1)a

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:

a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders

1. **Elements detailing how the program will correct the insufficiency.**
    a. Assessments will be created and completed to reflect residents individual care needs per program policy and within regulatory compliance.
    b. Physician order sheets to be sent, reviewed, and signed by tenants provider whom program manages and administers medications for per program policy and within regulatory compliance.
2. **What measures will be taken to ensure the problem does not recur.**
    a. Education with DON/ADON will be completed by the Regional Nurse and/or designee regarding assessments.
    b. Education with DON/ADON will be completed by the Regional Nurse and/ or designee regarding physician order sheets.
3. **How the Program plans to monitor performance to ensure compliance.**
    a. The Regional Nurse and/or designee will complete random audits of resident assessments to ensure accuracy and compliance.
    b. The Regional Nurse and/or designee will complete random audits of resident physician order sheets.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. The regulatory insufficiency will be corrected by 10/31/2023

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