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 03/07/2024

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 impairment: 0 Number of tenants with cognitive impairment: 14 Total census: 14 The following regulatory insufficiencies were cited during the investigation of 118974-C, 117278-I, 115633-I and the recertification visit conducted to determine compliance with certification rules for a Dementia-Specific Assisted Living Program.	A 000		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide a sufficient number of staff to meet the needs of 4 of 4 tenants reviewed (Tenant #1, Tenant #2, Tenant #3 and Tenant #4). Findings include: 1) Record review on 3/5/24 revealed a Service Plan for Tenant #1 dated 10/16/23 and updated on 2/22/24. Tenant #1's service plan identified he would receive housekeeping services to include daily bed-making and trash removal. Tenant #1 was dependent on staff to complete all of his housekeeping tasks. Tenant #1 required staff assistance with episodes of incontinence. Staff	A 325	The Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0445	A. BUILDING: _____ B. WING _____	C 03/07/2024

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 325	Continued From page 1	A 325		

were to check his incontinence brief twice daily for cleanliness. Tenant #1 had a history of hiding his dirty briefs and staff were to ensure his room was clean and briefs were disposed each shift.

A review of monthly task logs for Tenant #1 from 11/1/23 - 2/21/24 revealed staff were to document when they made Tenant #1's bed and took out his trash. Staff did not document they removed garbage from Tenant #1's room or made his bed from 11/1/23 - 2/21/24. There was no task reminding staff to assist Tenant #1 with toileting and ensure his room was clean.

2) Tenant #2 had a service plan dated 10/9/23. Staff were to provide Tenant #2 toileting assistance every two hours and twice during the night. Staff were to take out Tenant #2's trash and make his bed three times daily.

A review of monthly task logs for Tenant #2 from 11/1/23 - 2/29/24 revealed staff did not document the completion of trash removal or bed making. Staff documented they assisted Tenant #2 to the restroom once daily 25 days in November, 2023; once daily on 18 days in December, 2023; once daily for 17 days in January, 2024 and once daily for 17 days in February, 2024. Staff were supposed to assist Tenant #1 to the bathroom twelve times each day. Staff documented task not completed on the majority of the entries when they did not assist Tenant #1 to the bathroom.

3) Tenant #3 had a service plan dated 2/5/2024. Tenant #3 required the assistance of one person to go to the bathroom. Tenant #1 required assistance with ambulation and transfers. She got up from her wheelchair on her own at times but staff were to encouraged Tenant #3 to ask for assistance. Staff were to make Tenant #3's bed

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 03/07/2024

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 325	Continued From page 2	A 325		

and remove trash from her apartment three times daily.

A review of the February, 2024 task log for Tenant #3 revealed staff did not document removing her garbage from the apartment or making her bed any day. There was not a task for staff to document assisting her to the bathroom.

4) A review of task sheets for Tenant #4 for the months of November, 2023 - February, 2024 revealed staff were instructed to remove her trash three times daily and make her bed three times a day every day. Staff did not document completing these tasks at all.

On 3/4/24 at 1:20 PM, Staff D reported there was not a housekeeper through the whole summer until January, 2024. The caregivers did their best to keep things clean, but it was embarrassing. Maintenance could have deep cleaned the carpet. There was a terrible urine smell coming out of the carpet. Staff B reported she and other staff got sick from the urine smell and the fragrance spray they used.

She reported there were four tenants' apartments with strong smells. Tenant #1 started to hide soiled incontinence briefs and was urinating in trash cans. She thought Tenant #2 urinated on the floor as once she went into his apartment and the floor was sticky. Things were much better now there is a housekeeper.

On 3/4/24 at 3:30 PM, Staff A recalled housekeeping was a concern but now they were pretty much okay. They didn't have a housekeeper for too long. Families complained. The spouse of a tenant moved her husband out because of concerns with housekeeping. Staff A

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 03/07/2024

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 325	Continued From page 3 reported there were 9 tenants' apartments which had an odor. The odor resulted from dirty toilets which were not cleaned, poop in the shower, poop on the actual mattress and urine on the floors. On 3/5/24 at 2:45 the Executive Director reported there was a period of time when there was not a housekeeper. The staff were not able to maintain the standards they expected at the program. During a tour of the program at the same time, no housekeeping issues were found.	A 325		
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 program retained 1 of 4 tenants reviewed who, despite interventions, was physically aggressive towards tenants and staff (Tenant #1). Findings include: On 3/5/24 and 3/6/24 review of Tenant #1's progress notes and information received from the Corporate Nurse on revealed the following information:	A 160		

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 03/07/2024

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 160	Continued From page 4 Tenant #1 was admitted to the program on 2/8/23 at the age of 75. Episodes of physical aggression towards tenants and staff included: - On 5/20/23, staff heard a tenant yelling and when they responded found Tenant #1 with his hands on Tenant #5's throat. Neither tenant had injuries or red marks. The program notified Tenant #1's primary care provider (PCP) about the incident but no new orders were noted. - On 7/8/23, Tenant #1 and former Tenant C1 came out of an apartment with their hands on each other. Tenant #1 had his hands around Tenant C1's neck. Tenant C1 had a scratch on his neck which was bleeding. Tenant #1 had blood on his hands, but no open cuts or sores. - On 8/30/23, Tenant #1 was laying in another tenant's bed (the other tenant was not present). Tenant #1 became aggressive when staff approached him and started to hit and kick the staff members. Tenant #1 went to the hospital for an evaluation but returned with no new orders. - On 9/9/23, staff heard tenants speaking loudly in the living room. When staff entered the living room they found Tenant #1 and former Tenant C2 on the floor. Staff believed Tenant #1 wanted to sit down on the couch where Tenant C2 was seated and Tenant C2 did not want him there. Tenant C2 sustained a skin tear. - On 9/15/23, staff heard Tenant #1 and Tenant #4 yell at each other. Tenant #4 grabbed Tenant #1's neck and Tenant #1 pushed Tenant #4 causing her to fall. Tenant #4 sustained a left femoral neck fracture requiring surgery and three screws as well as a wrist fracture. Tenant #4 spent 1.5 weeks in a skilled nursing facility following the surgery. - Tenant #1 allowed staff to help him to the	A 160		

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 03/07/2024

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 160	Continued From page 5	A 160		

restroom on 9/18/23. Tenant #1 became verbally and physically aggressive in the middle of cares. Staff held on to Tenant #1's arm to prevent him from hitting and then Tenant #1 tried to bite staff. When staff let go of his arms, Tenant #1 hit staff on the side of his face.

- Tenant #1 went to the emergency room on 10/14/23 for an increase in behaviors. Tenant #1 had hit staff members.
- Tenant #1 attacked former Tenant C3 on 11/5/23. The tenants were found on the floor in the hallway. Tenant #1 had Tenant C3 in a headlock. Tenant #1 had Tenant C3's finger in his mouth and was biting it. Tenant C3 went to the emergency room and received sutures to his finger. Tenant #1's spouse came to sit with Tenant #1 in the afternoon and evening to keep him calm.
- On 1/9/24, staff notified the DON Tenant #1 grabbed and twisted the wrists of staff. Tenant #1 pushed staff against the wall, held them in a corner and would not let them go.
- The DON documented on 1/16/24 Tenant #1 was having increased behaviors and being physical towards others. Tenant #1 yelled at Tenant #4 and grabbed her around the head.
- Staff documented Tenant #1 was displaying aggression and agitation on 2/1/24.
- Staff assisted Tenant #1 with a shower on 2/2/24. Tenant #1 refused to take the shower and then threw things in his room. He punched, kicked and bit at staff. The DON could not de-escalate Tenant #1 so they called the police. Tenant #1 went to the emergency department (ED). Orders received from the ED identified staff should utilize Tenant #1's Seroquel, which he was ordered to take on an as needed basis. The DON notified the ED Tenant #1's outbursts were sudden and therefore they were unable to give the medication for prevention.

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 03/07/2024

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 160	Continued From page 6 - Tenant #1 pushed other tenants on 2/17/24 but did not push them to the ground. He punched, kicked, hit and bit staff. Tenant #1 was cursing at staff. The police arrived and had to handcuff Tenant #1 as they could not calm him down. Tenant #1 was striking, punching, kicking and attempting to spit at police. Tenant #1 went to the ED but returned to the program that evening. The DON notified Tenant #1's spouse he needed 1:1 supervision. A private caregiver was hired. - Tenant #1's caregiver told the DON he became aggressive on 2/19/24, 2/20/24 and 2/21/24. Tenant #1 grabbed her wrists and arms but calmed with re-direction. Interventions by the Program included: - On 9/18/23 the DON contacted the tenant's PCP (primary care provider) and asked for a plan to help manage Tenant #1's behaviors. The PCP wrote an order to complete blood work for Tenant #1 and to do a urinalysis with culture. All tests were within normal limits. The program updated Tenant #1's service plan on 9/18/23. Interventions were added for staff to keep Tenant #1 engaged through the day and perform hourly safety checks. If he began to act in an aggressive manner, staff were to remove other tenants from the area. Staff were to redirect or distract Tenant #1 to keep his behavior from escalating by offering him food, movement or a call to his family. - On 9/21/23 the Registered Nurse (RN) spoke with the PCP on 9/21/23 and discussed giving Tenant #1 a 30-day discharge notice (this was not officially issued). - Tenant #1 went to the emergency room on 10/14/23 for an increase in behaviors due to hitting staff members. The doctor at the emergency room did not prescribe new medication as Tenant #1 did not display negative	A 160		

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 03/07/2024

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 160	Continued From page 7 behaviors while there. The DON updated his plan on 10/16/24 to add interventions for staff to remove Tenant #1 to a quiet room or activity to prevent overstimulation as he did not like yelling or loud noises. - On 11/6/23 Tenant #1's spouse reported she would talk with her husband's neurologist about starting him on Seroquel for behaviors after incident on 11/5/23. Staff were educated to keep a close eye on Tenant #1 and notify the nurse of any signs or symptoms of aggression. The doctor wrote a prescription for Seroquel twice daily and as needed. - The DON discussed Tenant #1's actions with the neurologist when he called the program for a copy of the tenant's medications. - The DON updated Tenant's service plan on 2/22/24 following reports of aggression to the private caregiver. Staff were encouraged to have Tenant #1 read the Bible or have it read to him. They were to ensure his door was open as he did not like to be in a room alone with a closed door. The program provided a 30-day discharge notice to Tenant #1 and his guardian on 2/22/24. The DON and Executive Director confirmed these findings on 3/4/24 at 2:20 PM. They reported they were trying to work with Tenant #1 and his family to find an intervention which worked to control his behaviors.	A 160		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance	A 395		

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 03/07/2024

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 395	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to include identified needs and preferences for services in the service plan for 2 of 4 tenants reviewed (Tenant #2, Tenant #3). Findings include: Record review of staff communication notes identified the following entries: - On 12/1/23, Tenant #3 was being pushed around a lot by Tenant #2 (in her wheelchair). - On 12/2/23, Tenant #2 was helping Tenant #3 a lot. - On 12/20/23, Tenant #2 was all over Tenant #3. Tenant #3 was pushing Tenant #2 away from her. - On 12/22/23, Tenant #2 was bothering Tenant #3 a lot. - On 1/6/24, staff documented Tenant #2 always wanted to be with Tenant #3. - On 1/22/24, Tenant #2 was very touchy with Tenant #3. - On 1/29/24, Tenant #3 returned from a visit to the Emergency Department. Staff wrote a note to the other employees to keep Tenant #2 away from Tenant #3. - On 3/4/24, Tenant #2 kept following Tenant #3. On 3/4/24 at 3:30 PM, Staff A reported Tenant #2 was close with a former female tenant. Tenant #3 moved into the former tenant's apartment. Tenant #3's family didn't want her to have boyfriends. When staff tried to redirect Tenant #2 from Tenant #3, he became aggressive. Once Tenant #3 had a bruise on her arm from Tenant #2 grabbing her arm. Tenant #2 kissed and hugged on Tenant #3 and she tried to get away from him. Tenant #2 was in Tenant #3's bed once but she wasn't in the	A 395		

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 03/07/2024

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 395	Continued From page 9	A 395		

apartment. Tenant #2 had taken his clothes and hung them up in Tenant #3's room. She was told Tenant #2 attempted to take Tenant #3 to the toilet once. Tenant #3's family made it clear they didn't want any men near her.

On 3/5/24 at 4:15 PM Staff E reported Tenant #2 seemed to be interested in Tenant #3. Tenant #2 had held Tenant #3's hands and touched her. She hadn't seen Tenant #2 kissing Tenant #3. Tenant #2 had moved his clothing into Tenant #3's apartment.

During interviews with the Director of Nursing (DON) on 3/6/24 at 8:40 AM and 1:00 PM, she stated she was aware Tenant #2 went in Tenant #3's room. The DON believed Tenant #2 tried to hold Tenant #3's hand but he did this with other tenants as well. The DON was aware Tenant #2 took his clothing into Tenant #3's room. Tenant #3's family expressed they did not want any males in their mother's room or touching her. Tenant #3 was unable to vocalize concerns due to a stroke and her inability to communicate worried them about having males access their mother's room. The DON shared with staff they should redirect Tenant #2 when they saw him holding Tenant #3's hand. The DON arranged to move Tenant #3 to an apartment closer to the staff area and away from Tenant #2.

Tenant #2 had a service plan dated 10/9/23. His service plan identified he had a history of or currently wandered but it did not jeopardize his health or the safety of others. Tenant #2 had moderate impairments and scored a 6 on the Global Deterioration Scale. The service plan did not address the issue of his inappropriate behaviors toward Tenant #3.

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 03/07/2024

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 395	Continued From page 10 Tenant #3 had a service plan dated 2/5/24. She was diagnosed with Parkinson's disease. She had a history of stroke. Tenant #3 had a moderate impairment which resulted in a disorientation to person, place time or situation even in familiar surroundings. She required supervision and oversight for safety. The service plan did not address the issues with Tenant #2 or her family's (son is power of attorney) wishes to keep men at a distance (out of her room and no touching).	A 395		

STIRLINGSHIRE
DIAL SENIOR LIVING

Plan of Correction for Stirlingshire of Coralville MC
In Response to
Recertification, Complaint Investigations, and Self Reports
Dated 4/23/3034
Investigation #115633-I, 117281-I, 118974-C
Civil Penalty Citation #10312

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: Staffing 481-67.9(1)

67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

1. **Elements detailing how the program will correct the insufficiency.**
   a. DON and/or designee provided immediate verbal education to all direct care nursing staff regarding ADL documentation
   b. Urine odor resolved in resident apartments
2. **What measures will be taken to ensure the problem does not recur.**
   a. DON and/or designee to provide education to all direct care nursing staff regarding ADL documentation.
   b. DON and/or designee to provide education to all direct care nursing staff regarding reporting urine odor, incomplete tasks, and any changes in resident condition to the nurse on duty.
3. **How the program plans to monitor performance to ensure compliance.**
   a. Executive Director, DON, and/or designee will randomly walk memory care unit to ensure no urine odor noted.
   b. DON and/or designee to randomly review ADL documentation to ensure completion
   c. Regional Nurse and/or designee will periodically audit supporting documentation for completion during visits to community.
   d. Regional Nurse and/or designee will randomly tour memory care unit to observe for urine odor
4. **The date by which the regulatory insufficiency will be corrected.**
   a. 5/10/2024

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

481-69.23(1)c(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: is dangerous to self or other tenants or staff, including but not limited to a tenant who: despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression.

1. **Elements detailing how the program will correct each regulatory insufficiency.**
   a. The program provided a 30-day discharge notice to tenant #1 and his POA on 2/22/2024
   b. Tenant #1 discharged from the program on 3/13/2024
2. **What measures will be taken to ensure the problem does not recur.**
   a. DON and/or designee to provide education to direct care nursing staff to notify on duty nurse of any resident behaviors
   b. DON and/or designee to notify the Regional Director of Nursing with any resident level of care concerns
3. **How the Program plans to monitor performance to ensure compliance.**
   a. DON and/or designee to review resident incident reports for new behaviors
   b. Regional DON to randomly review resident chart notes to observe for any level of care concerns
4. **The date by which the regulatory insufficiency will be corrected.**
   a. 5/10/2024

Regulatory Insufficiency: Service Plans 481-69.26(4)a

481-69.26(4)a – The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance

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 5/10/2024.

Sincerely,

Amy Kubik-Hasley, Executive Director

✓ 6/27/24