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
	570617	A. BUILDING: _____ B. WING _____	C 09/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORRIDOR CROSSING PLACE	136 36TH AVENUE SW CEDAR RAPIDS, IA 52404

(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
R 000	Initial Comments The following deficiency was cited during the investigation of investigations 92736-C, 92760-C and 92740-I.	R 000		
R 368	481-57.11(5)d Personnel 57.11(5) Supervision and staffing. d. Staff shall be aware of and provide supervision levels based on the present needs of the residents in the staff"s care. The facility shall document the supervision of residents who require more than general supervision, as defined by facility policy. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document and provide proper supervision levels for 1 of 3 residents reviewed (Resident #2). Findings follow: Record review on 8/17/20 revealed an Incident Report for Resident #2 dated 8/4/20. According to the Incident report, Staff A was giving medication to residents in the memory care unit while Staff B put Resident #2 close to the table, locked the brakes, and left to go on break. Staff A continued to pass medication to the residents. Staff A then heard a moan, turned around and found Resident #2 laying on her side on the floor close to the table and wheelchair. She was noted to have	R 368	✓ 12/22/20 Plan of Correction is attached DD — 12/16/20	

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

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R 368	Continued From page 1 lacerations and bleeding to the left side of her face/temple area. Staff A called the Nurse Manager and Resident #2 was assessed. Emergency Medical Services (EMS) was called and Resident #2 was transported to the hospital via ambulance. Resident #2 received a CT scan on 8/4/20 at the hospital. The scan found a moderate amount of scattered acute subarachnoid hemorrhaging bilaterally. There were several acute facial bone fractures including along the left zygomatic arch, left maxillary sinus, left superior orbital wall (in 2 separate areas) and lateral orbital wall on the left. Resident #2 died on 8/12/20 according to a Certificate of Death. Her immediate cause of death was listed as multiple blunt force injuries to her head/face due to, or as a consequence of, a fall. The place of the injury was listed as the facility. Staff A was interviewed on 8/17/20 at 2:05 PM and reported she was covering the memory care unit on 8/4/20 when Staff B took a break. Staff A recalled Resident #2 was seated and facing an outside door. Two other residents were arguing and then Staff A heard Resident #2 moan and gurgle. She turned around and found Resident #2 on the floor. Staff A said she didn't understand how Resident #2 was able to get from the table she was seated to the other table where she fell as she didn't know the resident could stand up. Staff A described herself as a new employee (hire date of 6/25/20). Staff A said the Nurse Manager later told her she had seen Resident #2 walk on the camera system the facility had. Staff A said if she had known Resident #2 could walk, she would have positioned herself closer to the resident but had believed Resident #2 was wheelchair bound. Staff A stated she had never	R 368		

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R 368	Continued From page 2 seen Resident #2 walk and had not provided cares to this resident. Staff A stated she did not know if the wheelchair brakes were on or off at the time. On 8/18/20 at 2:15 PM, Staff B recalled she put Resident #2 up to the table in the dining room in her wheelchair with the brakes on. She then went on break. Staff B was not present when the fall occurred. When she realized Resident #2 had fallen, she ran to see what happened. Staff B was surprised when she arrived back in the dining room to see Resident #2's wheelchair pushed to the side of the table and the resident laying by a table approximately five feet away from the table she had been seated at. Staff B had never seen Resident #2 get up from her wheelchair if it was pushed up to the table. She had seen her push herself up from the couch before so she made sure she sat by Resident #2 on the couch to ensure she did not get up as she was a fall risk. On 8/18/20 at 1:10 PM Staff D stated when Resident #2 was admitted to the facility in the fall of 2019 she didn't walk very much, however then something sparked and the resident wanted to get up and walk. Staff D estimated the resident got up and walked without waiting for staff assistance about twice a week. She was aware Resident #2 had a tendency to get up and wander, especially if she was anxious or bored. Staff D stated the Nurse Manager was aware Resident #2 would get up and wander because she told staff not to leave Resident #2 unattended in the dining room. She said she would have pushed Resident #2's wheelchair up to the table and locked the brakes because the resident had a tendency to get up and wander. She added that as many times as Resident #2 had gotten up, she had never fallen and hurt herself before. Staff D	R 368		

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R 368	Continued From page 3 had provided the training to Staff A. Both staff were Medication Aides. Staff D said she didn't provide hands on training to Staff A for each resident, but made her aware of each residents' needs. She said she believed she had gone through each residents' ISP (Individual Service Plan) with Staff A, although she did not specifically recall doing so with Resident #2. Staff D said the service plans were online and had told Staff A where to find the service plans and the important information in them. Staff D also reviewed a training packet with Staff A, although this would not have been specific to Resident #2. Staff D stated she had reviewed Resident #2's specific care needs with Staff A, including her ability to walk, not to leave her unattended and to give her something to do. She said she trained everyone the same way. On 8/18/20 at 12:55 PM, Staff E reported when she entered Resident #2's room, she was usually in bed but sometimes would be sitting up. On the days when the resident was sitting up, she would likely be on the go. Staff E described times when she would turn around in Resident #2's room and find she had moved across her room or out into the hall on her own. The resident hung onto the railing when walking in the hall. Staff E reported when she woke Resident #2 up, she tried to keep her eyes on her or she would just be gone. There had been times she took another resident to the restroom while Resident #2 was sitting in a recliner in the dining room. Sometimes the resident was still in her chair and other times she had moved elsewhere without staff assistance. Staff E stated the actions of getting up without warning may have decreased to some extent over the previous few weeks but Resident #2 still did it. Staff E reported these activities to the Residential Aide or OMT (oral med tech) on shift.	R 368		

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R 368	Continued From page 4 On 8/17/20 at 1:25 PM Staff F said she had seen Resident #2 unlock her wheelchair on her own and try to take off. On her active days staff had to watch her constantly. Staff F stated Resident #2 shook and staggered so she always sat by the resident during her shift. She believed it was important to make sure Resident #2's brakes were locked when she was seated in her wheelchair. On 8/17/20 at 1:42 PM, Staff G reported she made sure Resident #2's wheelchair brakes were engaged when she took the resident to the dining room table. Staff G stated Resident #2 was not strong or stable enough to stand and walk on her own were she to try and do so. On 8/18/20 at 2:00 Staff H reported she had seen Resident #2 stand up from her wheelchair and shuffle her feet but not walk away as staff stopped her. Staff H reported she always locked Resident #2's wheelchair brakes for safety as she was weak. On 8/18/20 at 1:35 PM, Staff I reported she rarely utilized the wheelchair as Resident #2 preferred to walk with the assistance of the gait belt. Staff I had not seen Resident #2 get up from a seated position unassisted from a regular chair. If Resident #2 used a wheelchair, Staff I made sure the brakes were locked when assisting Resident #2 to the table in the dining room. The facility policy on Staffing/Personnel stated the Community shall employ sufficient trained staff to be available to meet identified resident needs. The level of staff assistance provided would be adapted to changing needs based on assessments conducted related to residents'	R 368		

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R 368	Continued From page 5 service plans. According to a 90-day review completed for Resident #2 on 7/1/20, there were no changes in ADLs (activities in daily living) or staff assistance provided for her during that time period. Resident #2 had a service plan dated 7/1/20. In the area of eating/meals, Resident #2 was noted to need assistance from the Resident Assistant (RA) to eat in the dining room. The RA was to encourage Resident #2 to drink fluids throughout the day, cue her with eating and drinking, remind her to go to meals and report any changes in her ability to eat or drink to the nurse. Resident #2 was noted to have severe memory loss due to a diagnosis of dementia which caused difficulty with recall and retaining information. Resident #2 had ongoing support in the area of mobility as she wished to remain safe at all times and did not want to have any falls. She was noted to have a history of falls and was at risk for falls due to her severe dementia. Resident #2 was to have an RA assist her with a gait belt and a walker when she ambulated. Resident #2 was also to receive an escort from activities and the dining room. Resident #2 was to utilize a wheelchair when moving long distances. The service plan did not address the need for staff to be aware of Resident #2 getting up unexpectedly from a seated position. The service plan did not address if the wheelchair brakes should be locked or unlocked as it was a right's restriction, according to the Nurse Manager. The Nurse Manager confirmed these findings in an interview on 9/8/20. She stated she knew Resident #2 had gotten up without assistance and staff were trained to watch for this as it happened sporadically, however it was not included in the resident's service plan. The Nurse	R 368		

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R 368	Continued From page 6 Manager confirmed the service plan did not address if the wheelchair brakes should be locked or unlocked as she believed locking the brakes was a right's restriction. She added it would not be considered as restriction if staff were with the resident during the time the brakes were locked.	R 368		

Corridor Crossing Place

✓ 12/22/20

December 11, 2020
Corridor Crossing Place
136 36th Avenue SW
Cedar Rapids, Iowa 52404

Iowa Department of Inspection & Appeals
Deb Dixon
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

To Whom It May Concern,

Incident/Complaint Investigation Intake #'s:
Incident #92740-I Supervision/Safety – Substantiated
Complaint #92760-C Supervision/Safety - Substantiated
Complaint #92736-C Supervision/Safety - Substantiated

Please consider this our plan of correction for the deficiencies cited during 8/17/2020-9/8/2020 incident/complaint investigation, with the **Final Results, Corridor Crossing Place, Cedar Rapids, IA** completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 481 and Iowa Administrative Code, chapter 57.

Personnel 481-57.11(5)d
R368
481-57.11(5)d Personnel

57.11(5) Supervision and staffing.

d. Staff shall be aware of and provide supervision levels based on the present needs of the residents in the staff's care. The facility shall document the supervision of residents who require more than general supervision, as defined by facility policy. (I, II, III)

1. **Step-by-step description of method(s) used to correct the system level problem which caused the deficiencies. The Plan of correction must provide information which assures the intent of the regulation, as evidenced by the examples, is corrected. A statement that the correction has been made for the specific examples cited is not acceptable.**

✓ 12/16/20

a. Upon move in and with every comprehensive assessment, the nurse will assess and document on the Individualized Service Plan resident needs when requiring more than general supervision.
b. Nurse has reviewed all current residents and updated ISPs for all residents identified as requiring more than general supervision.
c. Nurse will provide a list of current residents upon the hire of new nursing staff. New nursing staff will be informed of each residents' individualized needs by reviewing each residents' ISP and will be signed and dated by the new nursing staff and staff member providing the training prior to caring for residents independently.

2. **State the method(s) to be used to maintain and monitor compliance. Indicate the position or positions responsible for monitoring the correction to prevent the deficiencies reoccurrence. State your anticipated frequency of monitoring.**
    a. Nurse Manager or designee will review all ISPs of residents requiring assistance with transfers or ambulation with nursing staff for changes in the needs of general supervision for appropriateness for 4 weeks, and then as needed as determined by the Nurse Manager ongoing.
    b. Nurse Manager or designee will ask a minimum of 5 nursing staff questions regarding 3 residents identified needs documented on residents' ISP to verify knowledge weekly for 4 weeks, and then as needed as determined by the Nurse Manager ongoing.

3. **A realistic date of correction by month, date, and year.**
    a. The community will be in compliance by 1/8/2020.

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 regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Sincerely,

Lisa Urbanek, Nurse Manager of Corridor Crossing Place