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
	S0176	A. BUILDING: ______ B. WING ______	C 08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF MADRID HOMES	**600 NORTH KENNEDY AVENUE MADRID, IA 50156**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 30 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 34 There were no regulatory insufficiencies cited during the onsite infection control survey or the investigation of Complaint 91680-C. The following regulatory insufficiency was cited during the investigation of Complaints 92459-C and 92460-C.	A 000		
A 013	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 ensure treatment and services were adequate for 1 of 3 former tenants reviewed (Tenant C-1). Findings include: On 8/05/2020 at 12:45 p.m. record review revealed Tenant C-1 was admitted to the Program on 8/24/2019 with a diagnosis of Parkinson's	A 013	V 12/1/20 Plan of Correction is attached [signature]	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 013	Continued From page 1 disease, hypertension and dementia. Tenant C-1's weight on admission was noted at 151.1 pounds. During the 30 day nurse review dated 9/23/19 his weight was noted at 153 pounds. On 12/20/2019 following an appointment the tenant's PCP (primary care provider) noted Parkinson's Associated Psychosis with orders to start 12.5 mg Quetiapine every night at bedtime for agitation. Further orders included to discontinue ½ tab (10 mg) Simvastatin tab 20mg every night at bedtime and consider moving the tenant to ICF level of care. There was nothing noted in the tenant's progress notes concerning the PCP's recommendations to move to a higher level of care. A nurse review was completed on 1/26/20 due to a significant change in Tenant C-1's mental health condition. Tenant C-1's weight during this review was noted at 133.8 pounds. The difference of 19.2 pounds in four months when compared to the 9/23/19 weight was not noted as a concern during this review. The review noted cognitive decline since his last assessment. On 4/27/20 a quarterly nurse review was completed and noted Tenant C-1's weight at 130.2 pounds. This demonstrated the continued loss of weight dating back to admission. Tenant C-1's loss of weight had not been picked up on or addressed. On 6/04/20 a nurse review for a significant change in condition for increased incontinence, confusion and weight loss was completed. Tenant C-1's weight was now noted at 116.4 pounds. An order was obtained for a UA (urine analysis). He was moved to a level 3 which included additional times for staff to check on the tenant. Review of	A 013		

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A 013	Continued From page 2	A 013		

the service plan dated 6/4/20 revealed weekly weights were added due to the weight loss. There were no other additional interventions added concerning weight loss recorded on the service plan.

On 6/10/20 at 6:40 p.m. staff found Tenant C-1 lying on the floor in his living room and he was sent to the emergency room where he was diagnosed with dehydration. The tenant returned to the Program later that night with family who began to question his weight loss. Review of the emergency room instructions dated 6/10/20 revealed the tending physician felt it would be beneficial to move to a higher level of care due to his dementia. Orders were to continue current medications, drink plenty of water and follow up with his PCP in one week.

An order was requested and received on 6/10/20 for physical therapy, occupational therapy and speech therapy evaluations.

From 6/10/20 to 6/15/20 there was nothing documented in Tenant C-1's progress notes concerning his need for a higher level of care.

On 6/15/20 a follow up visit with his PCP was completed. The PCP noted weight loss and worsening confusion. She ordered protein supplements and recommended the tenant be transferred to a local nursing home where he could receive a higher level of care than in assisted living. The POA (power of attorney) was to let the PCP know what he planned to do.

The PCP's recommendations for the tenant to be transferred to local nursing home was not noted in the progress notes until 6/18/20 when received via a fax from the doctor's office.

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A 013	Continued From page 3 Progress notes review revealed supplements and snacks were taken to the Program on 6/15/19 by Tenant C-1's family. Record review revealed these supplements had not been added to Tenant C-1's service plan or noted on his Medication Administration Record. A progress note dated on 6/18/20 revealed the tenant's family was notified of his current weight and that he was accepting supplements and snacks. Supplements were also provided if he didn't eat well during meals. Another progress note on 6/18/20 indicated the Program received notes from the PCP dated 6/15/20 documenting the recommendation for a higher level of care and was waiting to hear the POA's decision. At this point the nurse wrote Tenant C-1 continued to meet criteria for Assisted Living. He was receiving services due to cognitive change. The POA would let the Program know when and if he decided to move the tenant. The Program would let the POA know when the tenant exceeded level of care. On 8/24/20 Staff B provided an email sent by family to the Program dated 6/16/20 concerning the discussion about moving Tenant C-1 to a nursing home for more care. The POA stated he would advise the Program what to do after checking with family members. No follow-up email was received according to the staff. There had been no other record of attempts from the Program to follow up with the family to discuss the need for a higher level of care between 6/16/20 and 6/21/20. On 6/21/20 at 11:00 p.m. Tenant C-1 was found on the floor in his bedroom at the foot of his bed	A 013		

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A 013	Continued From page 4 and was transported to the hospital. In the emergency room he was diagnosed with a urinary tract infection, dehydration and weight loss. He did not return to the Program. Interview with Tenant C-1's POA revealed following the fall on 6/21/20 he was transferred to the hospital. Following discharge from the hospital he was transferred to a nursing home. He passed away on 7/20/20.	A 013		

The facility denies that the facts set forth constitute a deficiency under interpretation of Federal and State law. The preparation of the following plan of correction does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged of deficiencies. The plan of correction prepared was executed solely because the provision of Federal and state law require it.

Complaint 92459-C & Complaint 92460-C

Elements detailing how the Program will correct the regulatory insufficiency:

Members of the interdisciplinary team will continue to bring concerns with any tenants' weight loss/decline in food intake to the RN Clinical Coordinator, who will continue to initiate a significant change if called for. Tenants at risk for loss will be reviewed with Dietary Manager/Dietician and appropriate interventions implemented. Interventions implemented may include increase frequency of obtaining weights and other dietary supplemental interventions. Cedars of Madrid will continue to monitor tenant weights at a minimum of every quarter with nurse assessment. All physician/hospital discharge orders making mention of consideration of placement to an alternate level of care will be reviewed by the interdisciplinary team and acted on.

Facility staff discussed Tenant C-1 decline and possible transition to higher level of care with tenant POA via email on 6-16-20, with POA to discuss further with family. Tenant C-1 was transferred to the hospital on 6-22-20. Family then contacted facility on 6-24-20 and agreed that the tenant would be transferred from the hospital to a long-term care facility.

Measures taken to ensure the problem does not recur:

Members of the interdisciplinary team will continue to bring concerns with any tenants' weight loss/decline in food intake to the RN Clinical Coordinator, who will continue to initiate a significant change if called for. Tenants at risk for loss will be reviewed with Dietary Manager/Dietician and appropriate interventions implemented. Interventions implemented may include increase frequency of obtaining weights and other dietary supplemental interventions. Cedars of Madrid will continue to monitor tenant weights at a minimum of every quarter with nurse assessment. All physician/hospital discharge orders making mention of consideration of placement to an alternate level of care will be reviewed by the interdisciplinary team and acted on.

How the Program plans to monitor performance to ensure compliance:

The Program Director, RN Clinical Director, or designee will monitor quarterly to ensure ongoing compliance with identified concerns to be addressed and corrected.

The date by which the regulatory insufficiency will be corrected:

10-29-20

✓ 12/11/20