

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/27/2020
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NAME OF PROVIDER OR SUPPLIER PRIMROSE PATH AT THE KENSINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 AVE H FORT MADISON, IA 52627
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VP/29/20

(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
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A 000	<p>Initial Comments</p> <p>Assisted Living Programs for People with Dementia are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site.</p> <p>Number of tenants without cognitive disorder: 22 Number of tenants with cognitive disorder: 0 Total census: 22</p> <p>There were no deficiencies cited during the onsite infection control survey completed on 7-2-2020.</p> <p>THIS REPORT HAS BEEN AMENDED TO REFLECT THE REVISED EXIT DATE OF THE INVESTIGATIONS</p> <p>The following regulatory insufficiencies were cited during the investigation of Complaints 91759-C, 91763-C, 91765-C, 91766-C and 91774-C.</p>	A 000		
A 013	<p>481-67.3(2) Tenant Rights</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure adequate and appropriate care, treatment, and services for 3 of 6 tenants reviewed (Tenant #1, Tenant #2, and</p>	A 013	<p><i>Plan of Correction is attached</i></p>	

10/20/20

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	<p>Continued From page 1</p> <p>Tenant #3). Findings follow:</p> <p>On 7-1-20 at 9:58 a.m. Staff A recalled an incident when Tenant #1 put his arm around her shoulder, shut his door, and pulled her mask down. Staff A put the mask back on and he proceeded to touch her neck. She stated she left his room because she felt uncomfortable and reported it to the Memory Care Supervisor (MCS). She believed that incident occurred on 6-24-20 but wasn't positive. A day later she discovered Tenant #1 in his bed engaged in sexual activity with Tenant #2. She stated she did not know what to do and notified Staff D who proceeded to instruct both tenants to get dressed and go to breakfast. The incident was reported to the Memory Care Supervisor (MCS). Shortly after that a memo came out directing staff to try and keep Tenant's #1 and #2 separated. Tenant #1 now required one to one staffing in order to keep an eye on him.</p> <p>On 7-2-20 at 10:40 a.m. Staff B stated Tenant #1 had recently become "touchy, feely" with others although he had not done anything to her. On 6-24-20 she noticed Tenant #1's door closed which was unusual so she checked on him. She discovered Tenant #1 in his bed on top of Tenant #2. Neither had on pants, socks, or shoes so she asked them to get up and get dressed. Tenant #1 yelled, "Get out of here." Staff B stated she told him it was not acceptable behavior and asked him again to get up and he complied. Staff B noticed some blood on the comforter and asked Tenant #2 if she was ok and she replied she was fine. Staff B notified the MCS who arrived later with the Registered Nurse (RN) and they completed an assessment of Tenant #2. Staff B stated the MCS and the RN informed her the act was consensual between the two and no other</p>	A 013		

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A 013	<p>Continued From page 2</p> <p>instructions were given. On 6-27-20 Staff B observed Tenant #1 with his arm around another female tenant (Tenant #4) and one hand on her walker trying to move her into his apartment. Staff B told Tenant #1 to stop pulling on the other tenant and he said "F ... off." Staff B asked again and he complied. Another tenant (Tenant #5) had told Staff B she did not like to be in her room alone when Tenant #1 was walking around. She expressed fear of Tenant #1 and refused to sit in the dining room with him.</p> <p>On 7-7-20 at 10:00 a.m. Staff C stated she observed Tenant #1 attempt to take at least 2 women into his apartment claiming to be their husband. Tenant #5 had told her she did not feel safe with that "creepy man" when she saw him. Staff C stated she reported this behavior to the RN and was instructed to ensure Tenant #1's door remained open. She believed staff found Tenant #2 in Tenant #1's bed multiple times. Tenant #2 called Tenant #1 her husband and when reminded he wasn't she became upset because he had lied to her, but then seemed to forget and continued to engage in sexual activity with him. She found out about the incident between Tenants #1 and #3 from other staff the day after it happened. She talked to Tenant #3 who recalled the incident and said she did not like what had happened. She stated she observed a small amount of bloody discharge in Tenant #3's undergarment later that day. Staff C proceeded to call Tenant #3's daughter to inform her of the incident and the daughter stated the Executive Director (ED) called her and stated the act was consensual. The daughter said she would stop by later in the day to visit her mother through the window, but when Staff C told her what she knew, the daughter decided she was going to take her home for a few days to decide what to do. When</p>	A 013		

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A 013	<p>Continued From page 3</p> <p>the daughter arrived Staff C let her go to her mother's apartment and pack a few things. Staff C called the ED and told her Tenant #3's daughter was not happy about her mother being around Tenant #1. The ED told her to keep it quiet while she figured out what to do. Staff C believed the relationship between Tenants #1 and #2 began approximately a week prior to the incident with Tenant #3. Staff B stated her concern regarding Tenant #1's behavior due to several women's inability to communicate any inappropriate encounters with him.</p> <p>On 7-1-20 at 10:26 a.m. Staff D stated she observed Tenant #1 and Tenant #2 engaged in sexual activity several times. The MCS instructed staff the act was consensual but to separate them when found together. On Saturday 6-27-20 she noticed Tenant #1's door was closed. She knocked and when she walked in she observed Tenant #1 pulling his pants on and Tenant #3 on the bed naked from the waist down. Staff D stated Tenant #3 had her fists clenched near her face and appeared to be very stiff. She proceeded to walk Tenant #3 to her apartment and notified Staff B and Staff F. All three noted blood in the tenant's her undergarments. Another staff reported the incident to the RN. Later in the dining room, Staff D stated she asked Tenant #3 if she was ok and she cried and said "no, no, no."</p> <p>On 7-1-20 at 9:47 a.m. Staff E stated in mid-June she reported concerns to the MCS about Tenant #1 being "touchy, feely" with staff including her, but nothing changed.</p> <p>On 7-1-20 at 10:10 a.m. Staff F stated Tenant #1 engaged in sexual behavior with other tenants. Staff F observed blood in Tenant #3's undergarment after the incident with Tenant #1,</p>	A 013		

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A 013	<p>Continued From page 4</p> <p>and as she cleaned the area Tenant #3 said "ow, ow, ow." Later Tenant #3 shook so bad she could not hold a glass of water. She stated staff were instructed to maintain one to one staffing with Tenant #1, keep other tenants away from him, and report any further behavior.</p> <p>On 7-1-20 at 11:37 a.m. the MCS stated when she completed the admission process with Tenant #1 there was no history of inappropriate sexual behavior. She stated Tenant #1's behavior started a few weeks ago with the sexual encounter between him and Tenant #2. She interviewed both and determined they had the ability to give consent. She stated she examined Tenant #2's genital area and noticed blood on her undergarment. She asked Tenant #2 if she was ok and Tenant #2 stated yes and seemed to understand what happened. Tenant #2 told the MCS, "If I did not want it I would have done this," and proceeded to slap one hand with the other. She contacted Tenant #1's nephew and he stated nothing like that had happened before. She stated Tenant #2's husband responded by asking if there was anything he could do about it and the MCS told him not at this time. The MCS stated she received a call from the RN that Tenant #1 had engaged in sexual activity with Tenant #3. She contacted Tenant #3's daughter who expressed no concerns about the incident and stated her mother had engaged in hugging and kissing male tenants previously. The MCS stated a representative of the Department of Human Services arrived at the building later that evening and instructed them to provide a one on one staff to Tenant #1 which they implemented that evening. She said staff never informed her of their concerns timely which could have possibly prevented the incident with Tenant #3.</p>	A 013		

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A 013	<p>Continued From page 5</p> <p>On 7-1-20 at 2:25 p.m. the Executive Director stated she interviewed Tenant #1 and Tenant #2 and believed both tenants had the ability to give consent to sexual activity despite having a GDS score of 5.</p> <p>On 7-2-20 at 12:36 p.m. the Wellness Coordinator Registered Nurse (RN) stated the MCS notified her of an incident between Tenant #1 and Tenant #2 on June 24th. She met the MCS at Tenant #1's room and asked if he had sex with a lady in his room. He stated it did not get that far. There was visible blood on his bed but he continued to deny anything happened and seemed to be on edge. The RN proceeded to Tenant #2's room and physically examined her. The RN stated she found blood in the undergarment and asked to examine her genital area. She noticed some abrasion and pulled skin in the vaginal/urethra area along with some bloody fluid. The RN stated Tenant #2 denied any pain. At first she denied having an encounter with a man, but then admitted she had sex with a man that was not her husband. The RN stated after her interview she determined the encounter to be consensual even though both tenants maintained a GDS of 5 that indicated moderately severe cognitive decline which could affect ability to give informed consent. She confirmed she completed a Community Note on 6-24-20 to notify staff the relationship was consensual, but to try to deter if possible, and if found engaged in sexual activity be mindful of their dignity but ask them to stop and get dressed. The RN stated staff informed her they had removed Tenant #2 from Tenant #1's room several times after the initial encounter. Neither family of Tenant #1 or #2 expressed any concerns about the relationship so she allowed it to continue. The RN stated on June 27th staff informed her they found Tenant #1 in Tenant #3's</p>	A 013		

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A 013	<p>Continued From page 6</p> <p>room engaged in a sexual encounter. Tenant #3 had been crying but was now ok. The RN stated she instructed staff to monitor Tenant #1 and to examine Tenant #3 for any trauma or bleeding. Staff later reported to the RN they found bloody discharge in Tenant #3's undergarment. She followed up with staff on June 29th and they informed her of Tenant #1's behaviors toward them and other tenants. She stated staff failed to provide this information timely.</p> <p>Record review on 7-1-20 revealed Tenant #1 was admitted to the program on 5-7-20 with diagnoses including late onset Alzheimer's disease, major depressive disorder, dementia without behavioral disturbances, and polyneuropathy. Resident Assessment Forms dated 5-7-20 and 6-5-20 revealed a Global Deterioration Score (GDS) of 5 indicating moderately severe cognitive decline. Tenant #2 was admitted on 2-27-20 with diagnoses including of anxiety, dementia, and memory loss. Resident Assessment Forms dated 3-27-20 and 6-26-20 revealed a GDS score of 5 that indicated moderaltely severe cognitive decline.</p>	A 013		
A 024	<p>481-67.4(3) Program Notification to Department</p> <p>481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:</p> <p>67.4(3) When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a</p>	A 024		

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A 024	<p>Continued From page 7</p> <p>30-day period.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify the department of a pattern of behaviors resulting in injury committed by 1 of 3 tenants reviewed (Tenant #1). Findings follow:</p> <p>On 7-2-20 at 10:40 a.m. Staff B stated she noticed Tenant #1's door closed on 6-24-20 which was unusual so she checked on him. She discovered Tenant # in his bed on top of Tenant #2. Neither had on pants, socks, or shoes so she asked them to get up and get dressed. Tenant #1 yelled "Get out of here" and Staff B stated she told him it was not acceptable behavior and asked him again to get up and he complied. Staff B noticed some blood on the comforter and asked Tenant #2 if she was ok and she replied she was fine. Staff B notified the MCS who arrived later with the Registered Nurse (RN) and they completed an assessment of Tenant #2.</p> <p>On 7-2-20 at 12:36 p.m. the Wellness Coordinator Registered Nurse (RN) stated the Memory Care Specialist (MCS) notified her of an incident between Tenant #1 and Tenant #2 on June 24th. She met the MCS at Tenant #1's room and asked if he had sex with a lady in his room. He stated it did not get that far. There was visible blood on his bed but he continued to deny anything happened and seemed to be on edge. The RN proceeded to Tenant #2's room and physically examined her. The RN stated she found blood in the undergarment and asked to</p>	A 024		

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A 024	<p>Continued From page 8</p> <p>examine her genital area. She noticed some abrasion and pulled skin in the vaginal/urethra area along with some bloody fluid. The RN stated Tenant #2 denied any pain.</p> <p>On 7-1-20 at 10:26 a.m. Staff D stated Saturday 6-27-20, she noticed Tenant #1's door was closed. She knocked and when she walked in she observed Tenant #1 pulling his pants on and Tenant #3 on the bed naked from the waist down. Staff D stated Tenant #3 had her fists clenched near her face and appeared to be very stiff. She proceeded to walk Tenant #3 to her apartment, notified Staff B and Staff F, and found blood in the tenant's undergarments when she checked her. Another staff reported the incident to the RN.</p> <p>On 7-2-20 at 12:36 p.m. the RN stated on June 27th staff informed her they found Tenant #1 in Tenant #3's room engaged in a sexual encounter. Staff informed her Tenant #3 had been crying but was now ok. The RN stated she instructed staff to monitor Tenant #1 and to examine Tenant #3 for any trauma or bleeding. Staff later reported to the RN they found bloody discharge in Tenant #3's undergarment.</p> <p>On 7-16-20 the RN confirmed the Department had not been notified of this pattern of injuries.</p>	A 024		

✓ 10/29/20



September 15, 2020

Department of Inspections and Appeals
Attn: Deb Dixon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of Primrose Path at the Kensington, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report dated August 27, 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 insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Tenant Rights

1. Elements detailing how the Program will correct each regulatory insufficiency.
 - Tenants #2 will receive adequate and appropriate care, treatment and services.
 - Tenant #1 and #3 no longer resides at Primrose Path at the Kensington.

2. What measures will be taken to ensure the problem does not recur.
 - The RN, Director, and Primrose Path Manager will be educated on regulatory requirements for tenant rights and sexual relationships between tenants in memory care.
 - Direct care staff will be re-educated on Staff Communication to the RN including sexual relationships policy.
 - Staff will be educated to communicate observations of relationship development among memory care tenants to the RN.
 - Staff will be educated on sexual relationships within 30 days of hire and annually.

✓ 10/22/20

3. How the Program plans to monitor performance to ensure compliance.
 - The RN, Director, or Designee will monitor for compliance at least every 90 days. The monitoring process will involve review trending of staff communication as well as visual observations of tenants specific to relationships.
4. The date by which the regulatory insufficiency will be corrected.
 - This regulatory insufficiency will be completed by September 27, 2020.

Program Notification to the Department

1. Elements detailing how the Program will correct each regulatory insufficiency.
 - Tenant #1 no longer resides at The Kensington.
2. What measures will be taken to ensure the problem does not recur.
 - The RN, Director, and Primrose Path Manager will be educated on regulatory requirements for Program Notification to the Department.
3. How the Program plans to monitor performance to ensure compliance.
 - The Director and Designee will review staff communication and incident reports at least two times a year to ensure compliance with Program notification to the Department.
4. The date by which the regulatory insufficiency will be corrected.
 - This regulatory insufficiency will be completed by September 27, 2020.

If you have any questions regarding this plan of correction, please feel free to contact me at 319-372-4233. Thank you.

Sincerely,



Leia Morrison
Director