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 |
|---|---|---|---|
| | 570492 | A. BUILDING: _____ B. WING _____ | C 11/05/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EVERGREEN ESTATES I I I | 2204 JOHNSON AVENUE NW CEDAR RAPIDS, IA 52405 |

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| R 000 | Initial Comments<br><br>The following deficiencies were cited during the investigation of Incident #94099-I and Complaint #94062-C. | R 000 | | |
| R 834 | 481-57.22(3)c Orientation and Service Plan<br><br>57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III)<br><br>c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to amend the service plan as needed for 1 | R 834 | Please see attached document<br><br>1/12/21 | 1-14-21 |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Patricia A Georgea | President/CEO | |

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| R 834 | Continued From page 1<br>of 3 former residents reviewed (Resident C1). Findings include:<br><br>Resident C1 was admitted on 5/20/16 with diagnoses including anemia, psoriasis, atrial fib, angina, coronary artery disease, hypertension, post traumatic seizures, asthma, COPD (chronic obstructive pulmonary disease), osteoarthritis, subdural hematoma, history of falls, benign prostatic hyperplasia, trigeminal neuralgia, hyperlipidemia, and diabetes mellitus Type II. He had deceased balance, a history of falls, noncompliance using his walker and a history of alcohol abuse.<br><br>Resident C1's most recent service plan dated 9/16/20 revealed the following regarding his decreased balance and prevention of falls:<br><br>Current Need: Resident C1 has decreased balance, osteoarthrisis of pelvic, knee and thigh regions, and history of noncompliance of walker, history of subdural hematoma, alcohol abuse and history of falls.<br><br>Goal: Resident C1 will maintain current gait and ADL functions. He will not experience falls.<br><br>Objectives: Resident C1 will<br>1. Abstain from alcohol<br>2. Ask for assist as needed<br>3. PT/OT (physical therapy/occupational therapy) as ordered<br>4. Wheelchair only until PT releases to ambulate<br>5. Use call light<br>6. Stand by assist one on one<br><br>A review of nurse's notes revealed Resident C1 was hospitalized and received rehabilitation | R 834 | | |

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| R 834 | Continued From page 2<br>physical therapy from 8/9/20 through 8/31/20. Between 8/31/20 and 9/18/20, nurse's notes revealed facility nurses kept in close contact with Resident C1's physician on a regular basis which included daily assessment/vitals, physician appointments, and medication changes on 9/16/20.<br><br>On 9/18/20 at 9:40 am Resident C1 was found laying on the floor of the facility hallway outside of his room by a cook. The nurse was immediately called and the resident was assessed and taken to a chair in his room. The resident re-opened a small skin tear on his elbow. The nurse contacted the physician. The physician ordered the resident sent to the emergency room if he fell again or could not walk. At 11:50 am Resident C1 began leaning to the left and not following verbal commands. The resident was taken to the emergency room by ambulance. On 9/20/20 at 10:38 pm Resident C1 passed away at the hospital. The State of Iowa Certificate of Death listed the immediate cause of death as a subdural hemorrhage as a consequence of a fall (accident).<br><br>On 11/3/20 at 10:16 am, Staff B stated she worked the morning of 9/18/20. She last saw Resident C1 at approximately 8:00 am when she walked him back to his room after breakfast. Staff B stated she was on break at the time of Resident C1's fall outside of his room. He had been having a lot of falls and had recently returned from a hospital stay where he received physical therapy. Staff B stated after his return from the hospital, he was to ambulate with his walker with staff at his side. Resident C1 was supposed to pull his call light for assistance any time he wanted to get up from his chair or bed. Even though staff told him to use the call light, he | R 834 | | |

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| R 834 | Continued From page 3<br>did not do it. Staff increased their checks/supervision of Resident C1 because of his non-compliance with pulling his call light.<br><br>On 11/3/20 at 12:13 pm, Staff E stated she worked the morning of 9/18/20. She was just around the corner from Resident C1's room on 9/18/20 at 9:40 am, when a different resident went to get up out of a chair and began having a seizure. Staff E was assisting this resident when she heard Staff D yelling for help outside of Resident C1's room. The resident Staff E was assisting was okay so she ran to Resident C1 with Staff A. Resident C1 was on his side in the hallway outside of his room without his walker present. Staff E and Staff A assisted Resident C1 to his chair. According to Staff E, the resident was notorious for not using his walker and saying he did not need it. Resident C1 also did not pull his light for staff assistance as he was told to do. Staff E indicated staff increased supervision of Resident C1 because of his non-compliance. Prior to the fall on 9/18/20, Staff E stated she last saw Resident C1 between 7:00 am and 8:00 am when she gave him his medications at breakfast.<br><br>On 11/5/20 at 10:09 am Staff D stated he was in the kitchen several rooms down from Resident C1's room when he heard someone yell for help. Staff D came out of the kitchen and observed Resident C1 laying in the hall outside of his room at around 9:30 or 9:40 am. Staff D got the nurse for assistance.<br><br>On 11/3/20 at 8:15 am Staff C stated Resident C1's balance was bad after his return from the hospital in August so staff stood next to him at all times when he got up. Resident C1 was supposed to call for assistance when he needed to get up but since he did always pull his light, | R 834 | | |

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| R 834 | Continued From page 4<br>staff increased supervision of him. Staff C stated there were no specific checks they were to do. They were to keep an increased eye on him.<br><br>On 11/3/20 at 8:56 am Staff A described Resident C1 as independent and stubborn. Staff A stated Resident C1 had been falling since he returned from his physical therapy inpatient stay. Staff A stated they were in contact with his physician regularly to monitor him. Resident C1 was supposed to pull his call light if he wanted to get up but he didn't always do that. Staff increased supervision of him but there were no specific checks they had to do.<br><br>The service plan for Resident C1 mentioned a wheelchair and physical therapy which was no longer active. Staff indicated they performed increased supervision for Resident C1 but the service plan did not provide guidance on what "increased supervision" entailed or meant. On 11/5/20 at 1:00 pm the administrator stated she had no idea why the service plan addressed a wheelchair. The administrator confirmed the service plan failed to dictate what increased supervision was for Resident C1. | R 834 | | |
| R1042 | 481-57.35(5) Housekeeping<br><br>481-57.35(135C) Housekeeping.<br><br>57.35(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to ensure odors were kept | R1042 | Please see attached document | 1-4-21 |

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| R1042 | Continued From page 5<br>under control for 1 of 8 residents reviewed (Resident # 7). Findings include:<br><br>On 10/26/20 at 12:01 pm during a tour of the facility, Resident #7's room had a strong urine odor. Resident #7 was present laying on her bed at the time of the tour.<br><br>Record review reveled Resident #7 was admitted on 7/24/17 with a diagnosis of urinary incontinence. Resident # 7's service plan dated 9/16/20 revealed the resident had urinary incontinence and failed to change incontinence pads as needed. The resident was to be reminded every 2 hours to use the restroom.<br><br>On 10/26/20 at 12:14 PM, Staff F stated Resident #7 was incontinent several times a day.<br><br>On 11/3/20 at 8:15 AM, Staff C stated Resident #7 occasionally urinated on her bed due to urine soaking through her incontinence pad. She stated Resident #7 also left wet incontinence pads in her garbage that staff needed to empty. Resident #7 sometimes refused showers and became upset when the subject of her incontinency was brought up to her.<br><br>On 11/3/20 at 8:56 AM, Staff A stated Resident #7 was very stubborn but was doing better than she used to. Resident #7 had the ability to change her wet incontinence pad herself but needed staff prompting to do so. Staff A stated Resident #7 was not on a toileting schedule. She required assistance for bathing but did not like to do it.<br><br>On 11/3/20 at 10:16 AM, Staff B stated Resident # 7 did not let staff assist her. Resident #7 often refused 2 hour toileting checks. When staff saw signs she was incontinent, they prompted her to | R1042 | | |

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| R1042 | Continued From page 6<br>change until she did. Staff had also caught Resident #7 hanging up urine soaked clothing to dry. Staff took the clothing to the laundry if discovered.<br><br>Resident #7's room contained a strong urine odor. Staff interviewed described Resident #7 as someone who had frequent incontinence that could sometimes lead to wet furniture or clothing in her room. Staff also described Resident #7 as having no formal toileting schedule but staff prompted her to change if suspected she was incontinent. Resident #7 refused showers with staff assistance on occasion. Resident #7's service plan indicated she was on a 2 hour toileting schedule. Staff did not follow a specific regimen to help keep Resident #7 dry and were not able to keep urine odors under control in her room.<br><br>On 11/5/20 at 1:00 PM, the Administrator confirmed the above findings. | R1042 | | |

1/12/21

Evergreen Estates III

Incident #94099-I

R 834

Since this resident had been discharged before this survey, there is no correction to the resident's Service Plan which can be done.

Administration, Social Services, and Nursing Departments met on 11/16/2020 and were re-educated on 57.22(3) which requires that any resident's change in condition be documented in the Service Plan within five working days of the change. In addition, the two departments were re-educated on the importance of being sure the change in condition shall be conveyed to all individuals inside and outside the residential care facility who work with the resident.

The Social Worker is now responsible for reviewing all nurse's communication records and the daily communication report of the nurse aides to ensure that any change of condition is recognized and that the Service Plan is updated within five business days. This instruction was acknowledged on 11/16/2020.

Correction done on 11/16/2020.

Complaint #94062-C

R 1042

Housekeeping and Nursing Department met with the Administrator on 11/16/2020 to review the concern of the surveyor regarding 1 of 8 reviewed residents. This resident is extremely challenging regarding incontinence and personal hygiene non-compliance.

A new toileting form was devised and both Housekeeping and Nursing Department staff were re-educated on 11/16/2020 on the importance of documentation on this form. The service plan is correct, but staff needed to be re-educated on the importance of documenting every refusal and incident of non-compliance. Both Housekeeping and Nursing Department were re-educated that all members of the staff can document on this form, not just Nursing Staff members. They were reminded that without proper documentation, it is difficult to prove the work was done.

In addition, Housekeeping and Nursing Department members were re-educated on the importance of including Social Services whenever a difficult resident or situation occurs. Staff were advised that all departments need to communicate more frequently with Social Services when a resident is not cooperative so that all departments can work as a team to help the resident maintain better hygiene.

Resident #7 is capable of better hygiene but consistently refuses to cooperate with staff. On 1-4-2021, the Administrator advised Resident #7 that further lack of cooperation will result in the facility recommending a higher level of care.

Correction done on 11-16-2020.

1/12/21