IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
58983-I

May 23, 2016

Ms. Cheri Schultz, Director
Prairie Hills at Cedar Rapids
2903 F Avenue NW
Cedar Rapids, IA 52405

RE: Final Recertification & Complaint/Incident Investigation Report, Prairie Hills at Cedar Rapids, Cedar Rapids, Iowa

Dear Ms. Schultz:

Enclosed is the **Final Recertification & Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **May 9 - 11, 2016.** A recertification visit and investigation of Incident #58983-I was completed. There were no regulatory insufficiencies identified related to the investigation of Incident #58983-I. The following allegation was investigated in regards to Incident #58983-I:

1. Allegation: Department of Inspections and Appeals (DIA) notification
   Findings: Unsubstantiated
   Comments: Review of a tenant file, staff interviews, a tenant interview and review of Program documents did not reveal a regulatory insufficiency related to DIA notification.

The Report notes a Regulatory Insufficiency related to the recertification visit in the area(s) of: Program policies and procedures.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0277	A. BUILDING: _____ B. WING _____	C 05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CEDAR RAPIDS	2903 F AVENUE NW CEDAR RAPIDS, IA 52405

(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	481-67 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. General Population Program Number of tenants without cognitive disorder: 45 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 46 TOTAL census of Assisted Living Program: 46 A recertification visit conducted to determine compliance with certification for an Assisted Living Program was completed. An investigation of Incident #58983-I was also completed. There was a regulatory insufficiency identified related to the recertification visit. No regulatory insufficiencies were given related to Incident #58983-I.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.	A 003		

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

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents the Program failed to follow their policies and procedures regarding medication administration. Staff administered as needed medications to Tenant #2 and Tenant #4; however, the effectiveness of the medication was not documented per the Program's medication administration policy. (Recertification) 1. Tenant #2, an 85 year old, was admitted on 8-1-12 and diagnoses included: dementia, asthma, chronic obstructive pulmonary disease, hypothyroidism, arthritis and left knee joint pain. Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. According to Tenant #2's service plan, staff administered Tenant #2's medications from a medication planner that was set up weekly. Tenant #2 used a handheld inhaler when needed independently. Staff assisted Tenant #2 with using the as needed nebulizer. According to Tenant #2's April 2016 medication administration record (MAR), Duoneb, one vial per nebulizer, four times daily as needed was ordered. On 4-3-16 and 4-13-16 the front of the MAR reflected Duoneb as needed was administered. The back of the MAR did not reflect the date, time, reason given or effectiveness of the medication. A follow up for the effectiveness of the as needed medication was not documented. 2. Tenant #4, a 62 year old, was admitted 3-13-15 and diagnoses included: osteoarthritis, dementia and fibromyalgia. Tenant #4 was	A 003		

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A 003	Continued From page 2 staged at a three on the GDS, which indicated mild cognitive decline. According to Tenant #4's service plan, staff administered Tenant #4's medications. According to Tenant #4's April 2016 MAR, Acetaminophen 325 milligram (mg), two tablets, every four to six hours as needed was ordered. On 4-8-16 the front of the MAR reflected Acetaminophen as needed was administered. The back of the MAR did not reflect the date, time, reason given or effectiveness of the medication. According to the April 2016 MAR, Docusate Sodium 100 mg, one tablet, twice daily as needed was ordered. On 4-19-16 the front of the MAR reflected Docusate Sodium as needed was administered. The back of the MAR did not reflect the date, time, reason given or effectiveness of the medication. According to the March 2016 MAR, Acetaminophen 325 mg, two tablets, every four to six hours as needed was ordered. On 3-15-16 the front of the MAR reflected two doses of Acetaminophen as needed were administered. The back of the MAR reflected one dose of Acetaminophen on 3-15-16 was charted with the date, time, staff initials, reason the medication was given and effectiveness of the medication with the time. The back of the MAR did not reflect the date, time, reason given or effectiveness of the medication for the second dose of the Acetaminophen administered on 3-15-16. A follow up for the effectiveness of the as needed medication was not documented. According to the DON, the expectation regarding as needed medications was the effectiveness of the as needed medications was documented and staff was trained regarding that expectation.	A 003		

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A 003	Continued From page 3 According to the Program's policy regarding medications, if a tenant received medication *management and received as needed* medications they were stored and labeled with the tenant's other medications or per the Nurse's direction. As needed medications were administered upon requested by the tenant. The as needed medications were charted in the MAR when administered with a follow-up check in 30 minutes, which was also charted in the MAR.	A 003		

Plan of correction for Prairie Hills at Cedar Rapids in response to DIA recertification on May 9th-11th, 2016.

The following RI, program policies and procedures not being met.

Tenant #2 and #4 had prn medications that were not documented on back of MAR for effectiveness.

1. The program will correct this RI by going over with each universal worker the medication policy and re-delegating them on medication management and administration.
2. The Wellness Coordinator will perform weekly MAR audits on all residents of the community and will address any issues immediately with universal workers.
3. The program will monitor performance and compliance by the Wellness Coordinator performing weekly MAR audits and holding staff accountable if there is any issue.
4. Wellness Coordinator has begun the weekly MAR audits. The re-delegating and the medication policy will all be completed by June 9, 2016.

Cheri Schuth RN BSN
Executive Director
June 6, 2016