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
	S0108	A. BUILDING: _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTOM CARE	1224 13TH ST 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: 22 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 22 TOTAL census of Assisted Living Program: 22 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	It should be noted that the residents cited here were not harmed. Documentation on service plans for Residents #1,2,3, and 4 was added by April 7th, 2017 by the program nurse and social worker. All resident service plans will be audited and corrected as needed by April 21, 2017. Resident #1 on anticoagulant medication will have proper documentation added to their service plan with instructions for staff. Any resident on antibiotics will be documented in the service plan by the program nurse along with instructions for staff. Resident #2 will have proper documentation added to their service plan, reflecting that they are a fall risk and interventions related to the falls. Resident # 3 will have proper documentation added to their service plan, reflecting they use an anticoagulant medication and instructions for staff. Resident #4 will have proper documentation added to their service plan, reflecting that they use a bed rail per his/her request. Custom Care Nurse will review all service plans and changes in care for every resident with the program Social Worker on a weekly basis. The Custom Care Manager documenting reviews and changes in the service plans will keep notes. Custom Care Nurse and Social Worker will meet weekly to review each individual's condition.	
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the Program failed to develop service plans indicitive of tenants' identified needs. This affected 4 of 4 tenant files reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. a. Record review of Tenant #1's file revealed Interdisciplinary Notes dated 12-13-16 indicated,	A 089		

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

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A 089	Continued From page 1 while an assessment was being completed, Tenant #1 exposed his/her genitals and initiated masturbating. Interdisciplinary Notes dated 2-17-17 reflected Tenant #1 continued to have incidents where he/she was observed by staff and tenants "fondling" his/her genitals in public places such as the dining room and small lounge area. Simple redirection to go to Tenant #1's apartment if he/she wanted to continue the behavior was usually effective. An interview with the Nurse Manager on 3-9-17 at approximately 11:46 a.m. revealed Tenant #1's behavior occurred approximately one time per week and when Tenant #1 first got there it was approximately twice per week. Further record review revealed Tenant #1's service plan dated 12-14-16 reflected staff was to monitor for sexually inappropriate behaviors and advise the nurse of any changes. The service plan dated 12-14-16 did not address Tenant #1's specific behavior and interventions related to the behavior. b. Record review of Tenant #1's file revealed Tenant #1 was prescribed Eliquis 5 milligram (mg), take one tablet twice daily. The March 2017 medication administration records (MARs) reflected the order for Eliquis. The Director of Long Term Support and Services provided a typed statement which indicated all tenants on an anticoagulant medication had a chart flag on the front page of the profile page in the Electronic Health Record. All staff had access to the Electronic Health Record system. It was verified the tenant in question had their chart flagged for the medication.	A 089		

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A 089	Continued From page 2 Observation of a profile page on 3-9-17 at 1:48 p.m. indicated "ANTICO" for anticoagulant therapy. The profile page did not provide staff instructions for monitoring. Further record review revealed Tenant #1's service plan dated 12-14-16 reflected staff administered Tenant #1's medication. The service plan did not reflect Tenant #1 took an anticoagulant medication and monitoring instructions for staff. c. Interdisciplinary Notes dated 1-22-17 reflected Tenant #1 had blood in his/her urine when voiding. A urinalysis and culture if positive was ordered and Tenant #1 was started on an antibiotic 250 mg twice daily for three days. The service plan dated 12-14-16 did not reflect the order for the antibiotic. 2. Record review of Tenant #2's file and incident reports revealed Tenant #2 had falls on 11-10-16, 11-23-16, 12-6-16, 1-13-17 and 2-12-17. The service plan dated 9-23-16 indicated Tenant #2 ambulated independently with a walker and used a wheelchair for longer distances. Tenant #2 was able to self propel himself/herself in the wheelchair. An interview with the Nurse Manager on 3-9-17 at approximately 11:46 a.m. revealed an intervention of physical therapy/occupational therapy offered and declined by Tenant #2. Further record review revealed Tenant #2's service plan dated 9-23-16 did not reflect the a history of falls and interventions related to the falls. 3. Record review of Tenant #3's file revealed	A 089		

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A 089	Continued From page 3 Tenant #3 prescribed Warfarin 4 mg tablet, one tablet by mouth daily. The February 2017 MARs reflected the order for Warfarin. The service plan dated 2-14-17 reflected staff administered Tenant #3's medication. The service plan failed to reflect Tenant #3's took an anticoagulant medication and monitoring instructions for staff. 4. Record review of Tenant #4's file revealed the service plan dated 3-1-17 reflected Tenant #4 assisted with ambulation and transfers at times. The ALP Monitoring Entrance Form reflected Tenant #4 had a half bed rail. The previous service plan, dated 8-26-16, reflected Tenant #4 had a half bed rail per his/her request. An interview the Nurse Manager on 3-9-17 at approximately 11:46 a.m. revealed Tenant #4 had a bed rail. Further record review revealed Tenant #4's current service plan dated 3-1-17 did not reflect the bed rail.	A 089		