

4/14/18 OK 4/14/18
 PRINTED: 03/28/2018
 FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0366	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2018
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NAME OF PROVIDER OR SUPPLIER GARDENS AT CEDAR RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 5710 DEAN ROAD SW CEDAR RAPIDS, IA 52404
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(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	<p>Initial Comments</p> <p>Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site.</p> <p>General Population Number of tenants without cognitive disorder: 23 Number of tenants with cognitive disorder: 0</p> <p>Memory Care Unit Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 4</p> <p>TOTAL Census of Assisted Living Program for People with Dementia: 30</p> <p>The following regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program.</p>	A 000	<p>See attached</p> <p>POC 4/12/18</p>	
A 064	<p>481-67.9(4)g Staffing</p> <p>481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences</p>	A 064		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A 064	<p>Continued From page 1</p> <p>that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to communicate in writing an occurrence that differed from a tenant's normal health, functional and cognitive status for 1 of 4 tenants reviewed (Tenant #4). Findings follow:</p> <p>1. Record review of Tenant #4's file revealed a diagnosis of dementia without behavioral disturbance. Tenant #4 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #4 resided in the dementia unit.</p> <p>Continued record review revealed the service plan indicated Tenant #4 received two hour safety checks and was encouraged to stay in the main lobby of the dementia unit during wake hours. The service plan indicated Tenant #4 would become agitated and yelled at times. Staff should offer a snack and to encourage him/her to stay in the apartment, as to not agitated other tenants. Staff should inform the nurse right away if Tenant #4 caused harm to other tenants.</p> <p>When interviewed on 2-28-18 at 9:03 a.m. Staff A revealed staff in the dementia unit called on the radio for assistance. Tenant #4 reported a person came into the Program and assaulted him/her. The person was not described by</p>	A 064		

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A 064	<p>Continued From page 2</p> <p>Tenant #4, except it was a person of the opposite gender. Tenant #4 said he/she was groped and he/she felt the police should be notified. There were no visitors of the opposite gender at that time. There was no injury noted to Tenant #4. Tenant #4 made statements about why other tenants were in the dementia unit and made threats to call the police. Staff A no concerns inappropriate touching occurred. It was reported to administrative staff.</p> <p>When interviewed on 2-28-18 at 9:36 a.m. Staff B revealed approximately a month ago Tenant #4 "flipped out" when he/she woke up and reported someone had touched him/her. There were no other people in his/her apartment at that time and no concerns were voiced from the overnight shift when Staff B arrived on first shift. Tenant #4 reported two people of the opposite gender attacked him/her and groped him/her. Staff B reported no concerns inappropriate touching occurred and assumed it was a bad dream. It was not reported to anyone.</p> <p>When interviewed on 2-28-18 at 4:25 p.m. the Nurse revealed she was made aware approximately a week ago when she arrived in the morning Tenant #4 reported there were two persons of the opposite gender in his/her apartment. It was reported to first shift staff from third shift staff. The Nurse was not made aware of any reports of inappropriate touching or harm involved with the incident with Tenant #4. A staff communication note was not completed.</p> <p>Further record review revealed Staff Communication Reports completed regarding Tenant #4 on 12-20-17 and 1-6-18 (two reports). The reports related to aggression, agitation and refusal of services. A Staff Communication</p>	A 064		

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A 064	Continued From page 3 Report was not completed related to the incident Tenant #4 reported to staff.	A 064		
A 089	<p>481-69.26(4)a Service Plans</p> <p>481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum:</p> <p>a. The tenant's identified needs and preferences for assistance</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to develop service plans to reflect tenants' identified needs and preferences for assistance. This affected 3 of 4 tenants reviewed. (Tenants #1, #2, and #4). Findings follow:</p> <p>1. Record review of Tenant #1's file revealed a diagnosis of Alzheimer's disease with late onset. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit.</p> <p>When interviewed on 2-28-18 at 9:36 a.m. Staff B revealed Tenant #1 went into other tenants' apartments and would lay on the bed or use the bathroom. There had been no harm to anyone regarding the behavior. Tenant #1 had made verbally inappropriate comments or jokes to staff and Staff B told him/her it was not appropriate.</p> <p>When interviewed on 2-28-18 at 4:25 p.m. the</p>	A 089		

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A 089	<p>Continued From page 4</p> <p>Nurse revealed Tenant #1 went into other tenants' apartments and would use the bathroom. Tenant #1 had also laid on another tenant's bed.</p> <p>Further record review revealed Tenant #1's service plan dated 1-23-18 did not reflect Tenant #1 at times went into other tenant apartments and interventions related to the behavior. The service plan also did not identify the comments Tenant #1 made to staff and interventions related to the behavior.</p> <p>2. Record review of Tenant #2's file revealed a diagnosis of major depressive disorder (MDD). Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #2 resided in the dementia unit and was admitted on 11-28-17.</p> <p>Incident Report documentation indicated the following:</p> <p>a. On 12-9-17 staff heard the alarm and ran out to see what was going on. Staff saw Tenant #2's pajama shirt as the door closed. Tenant #2 was looking for his/her spouse and family. Staff was unaware of how he/she got out.</p> <p>b. On 12-13-17 staff was assisting another tenant and heard the alarm. Staff ran out and Tenant #2 was out of the door. The first key pad had been unlocked.</p> <p>c. On 2-7-18 Tenant #2 exited the dementia unit door looking for his/her spouse.</p> <p>When interviewed on 2-28-18 at 4:25 p.m. the Nurse revealed Tenant #2 never left the building but left the dementia unit into the general</p>	A 089		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**GARDENS AT CEDAR RAPIDS 5710 DEAN ROAD SW
CEDAR RAPIDS, IA 52404**

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A 089	<p>Continued From page 5</p> <p>population. The alarms sounded and staff responded when Tenant #2 left the dementia unit.</p> <p>Further record review revealed Tenant #2's service plan updated on 2-27-18 and reflected when Tenant #2 went to the exit looking for his/her spouse staff redirected to his/her room and reminded Tenant #2 his/her spouse slept in a different apartment. Staff should offer a whirlpool or to look at photos if Tenant #2 was exit seeking. Despite incidents when Tenant #2 left the dementia unit on 12-9-17, 12-13-17 and 2-7-18, the service plan was not updated to reflect the behavior and interventions until 2-27-18.</p> <p>3. Record review of Tenant #4's file revealed a diagnosis of dementia without behavioral disturbance. Tenant #4 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #4 resided in the dementia unit.</p> <p>Continued record review revealed a physician's progress note dated 1-9-18 reflected Tenant #4 had ongoing persistent loose stools over the last few months. Tenant #4 was initially on a stool softener, which was discontinued. Tenant #4 took Immodium as needed and continued to have daily loose stools and Questran was started. The service plan dated 1-30-18 did not reflect Tenant #4 had loose stools and interventions.</p> <p>A Progress Note dated 2-27-18 reflected Tenant #4 had a red perineal area and Nystatin cream was to be applied twice daily. Tenant #4 ran out of the cream earlier in the month and an order was faxed but they were not aware the order did not go through. Tenant #4's redness did not</p>	A 089		

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A 089	<p>Continued From page 6</p> <p>worsen in that time without the cream. There were no open areas to the perineal area. The service plan was updated to reflect the Nystatin cream.</p> <p>Review of the February 2018 medication administration records indicated Nystatin cream applied twice daily topically was ordered on 10-26-17.</p> <p>When interviewed on 2-28-18 at 4:25 p.m. the Nurse revealed Tenant #4 had an order for the Nystatin cream since admission. She said there were no open areas and staff applied the cream twice daily.</p> <p>Further record review revealed the service plan dated 1-30-18 was updated on 2-27-18 and reflected staff should apply Nystatin cream to the perineal area twice a day and to notify the Nurse if the area opened or appeared worse. Despite an treatment order date of 10-26-17, the service plan did not reflect the reddened perineal area and staff application of Nystatin cream until 2-27-18.</p>	A 089		



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OK
41418

5710 Dean Road SW
Cedar Rapids, IA 52404
Phone: (319) 632-1350
TheGardensCR.com

April 2, 2018

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

Dear Ms. Campbell:

On behalf of The Gardens of Cedar Rapids, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report dated March 28, 2018. 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.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency.
 - Staff will complete a communication report for Tenant #4 as necessary.
 - Staff will re-educated on use of the Communication Report tool.
2. What measures will be taken to ensure the problem does not recur.
 - The RN will be re-educated on use of the Communication Report tool.
 - Blank Communication Report tool forms will be accessible to staff.
3. How the Program plans to monitor performance to ensure compliance.
 - The RN and/or Designee will review Communication Report forms and follow-up on any concerns. The RN and/or Designee will document in the tenant's clinical record as necessary.
 - Use of the Communication Report tool will be audited at least two times per year.
4. The date by which the regulatory Insufficiency will be corrected.


- This regulatory insufficiency will be corrected by April 28, 2018.

Service Plan

1. Elements detailing how the Program will correct each regulatory insufficiency.
 - Tenant #1, #2, and #4 will have service plans developed by the RN that meet the tenant's identified needs and requests for assistance.
2. What measures will be taken to ensure the problem does not recur.
 - The RN will be re-educated on regulatory requirements related to service plan.
3. How the Program plans to monitor performance to ensure compliance.
 - The RN and/or Designee will monitor for compliance every 90 days as part of the nurse review process. The RN will review services being provided and make updates to the service plan if applicable.
4. The date by which the regulatory insufficiency will be corrected.
 - This regulatory insufficiency will be corrected by April 28, 2018.

If you have any questions regarding this plan of correction, please feel free to contact me at 319-632-1350. Thank you.

Sincerely,



Lisa Elwick
Administrator