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
	S0065	A. BUILDING: _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PLACE	1140 K 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	Initial Comments 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. Number of tenants without cognitive disorder: 14 Number of tenants with cognitive disorder: 11 TOTAL Census of Assisted Living Program for People with Dementia: 25 The investigation of Complaint #83929-C resulted in a regulatory insufficiency.	A 000	POC 9/9/19 10-2-19	
A 012	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure healthcare documents regarding tenants' care and services were signed by the tenant and/or a designated legal representative for healthcare. This pertained to 1 of 2 discharged tenants reviewed (Tenant #2). Findings follow: 1. Record review on 8-7-19 and 8-8-19 revealed Tenant #2 was admitted to respite services on 6-11-18. Tenant #2 was admitted as a permanent tenant on 7-6-18 and was discharged on 10-3-18. Tenant #2's diagnoses included dementia, hypertension, and depression. At the time of the	A 012	Plan of Correction: Meth-Wick Community admissions staff received training and appropriate legal use of Advanced Directives on 8/22/19. Training given by legal counsel. Advanced Directives will continue to be requested at admission. We will continue to document the DMPOA and General POA in the resident's chart. We will continue to update the resident's chart with changes to Advanced Directives that we receive. All Arbor Place resident charts will be audited by 9/9/19. Random audits will be preformed annually on a sample of resident charts.	

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A 012	Continued From page 1 initial cognitive evaluation, dated 7-6-18, Tenant #2 scored a 21/30 on the Mini Mental Status Examination (MMSE). The Global Deterioration Scale (GDS), dated 9-27-18, indicated Tenant #2 was staged at a 5.6, which indicated moderately severe cognitive decline. Continued record review revealed Tenant #2's file included a General Power of Attorney (POA) (non-healthcare), which was effective immediately upon execution. The record also included a Durable Power of Attorney (DPOA) for Health Care Decisions, though no document located in the file to activate the document by the physician could be located. The following documents included in the tenant's record lacked Tenant #2's signature and were signed either by a General POA or a DPOA for healthcare (non-activated): a. Respite Care/Assisted Living Agreement contract dated 6-11-18 was signed by a General POA b. Pharmacy Billing Information document dated 6-11-18 was signed by a General POA c. Primary Health Provider Designation Form dated 6-11-18 was signed by a General POA d. Emergency Information form dated 5-24-18 was signed by a General POA. This documented listed emergency notifications. e. Respite Service Plan dated 6-11-18 was signed by a General POA f. Assisted Living Unit Agreement dated 7-6-18 was signed by a DPOA for healthcare/General	A 012		

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A 012	Continued From page 2 POA g. Assisted Living Service Plan dated 7-6-18 was signed by a DPOA for healthcare/General POA h. Assisted Living Service Plan dated 7-27-18 was signed by a General POA. The service plan update was completed for a significant change of condition post hospitalization and increase in cares and services. Changes included a one person assist with bathing, total assistance at meal time, two person transfer with a gait belt and wheelchair for ambulation and a two person assist with a check and change for toileting. i. Assisted Living Service Plan dated 7-31-18 was signed by a General POA. The service plan update was completed for a significant change of condition and addition of Hospice services. Changes included Hospice providing bed baths daily, assistance with eating with as tolerated, the head of the bed to be elevated when eating or drinking, a hospital bed with two half rails, admission to Hospice and crushed medications. j. Assisted Living Service Plan dated 9-27-18 was signed by a General POA. The service plan updated was completed for a significant change and changes included bed baths provided three times per week by Hospice and other days by Program staff, toileting one to two person assist (two hour toileting program), one to two person for transfers and ambulation, refusals of medications, attempts to get out of bed often independently and to monitor every two hours and report to supervisor attempts to ambulate. k. Assisted Living Service Plan dated 10-2-18 dated was signed by a General POA. The service plan was completed for significant change	A 012		

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A 012	Continued From page 3 of condition and changes included repositioning every two hours, Vaseline Moisturizer to lips every two hours and as needed and to make the nurse was aware of any skin issues. 2. Continued record review revealed Tenant #2 had three incident reports including on 6-13-18 (respite stay) and 7-24-18 and 9-21-18. The reports indicated the following: a. On 6-13-18 it was noted Tenant #2 was found on the bathroom floor. The report indicated the health contact was notified; however, it was a General POA. b. On 7-24-18 it was noted Tenant #2 was on the floor between the bed and chars. Tenant #2 had tried to stand from the bed to sit on the chair. The report indicated the health contact was notified; however, it was a General POA c. On 9-21-18 it was noted Tenant #2 fell to the floor and did not hit her head. Tenant #2 became nauseated and vomited undigested food post fall. The report indicated the health contact was notified; however, it was a General POA. 3. Further record review revealed Interdisciplinary Notes revealed the following: a. On 10-2-18 it was noted a care conference was held with some of Tenant #2's family in attendance by phone and in person, as well as Program staff and Hospice staff. Concerns were voiced by a family member regarding Tenant #2 not drinking enough fluids, not getting enough calories and not getting enough exercise. A family member said if Tenant #2 received	A 012		

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A 012	Continued From page 4 intravenous (IV) fluids she might "perk" up. One of the family members said the goal was to keep Tenant #2 alive. It was explained if Tenant #2 received IV fluids Hospice care would be revoked and Tenant #2 would not be re-admitted to the Program as Tenant #2 exceeded level of care and was on a waiver from the Department. b. On 10-2-18 it was noted Hospice provided the Program documentation regarding Tenant #2's medical POA. c. On 10-3-18 it was noted Tenant #2 was going to transfer to a Hospice house that morning per a family member's request. Tenant #2 was sent via ambulance. d. On 10-4-18 it was noted staff from the Hospice house called and said Tenant #2 was doing well taking in fluids. If Tenant #2 continued to be stable discharged would be planned. 4. When interviewed on 8-8-19 at 10:30 a.m. the Nurse revealed one of the family members that was a General POA was the one primarily involved. That family member always took Tenant #2 to appointments and was always there. Tenant #2 fell during the night and did not appear to have injuries. The next morning she had difficulty and was sent out to be seen. Tenant #2 was transferred to another hospital and testing indicated a brain bleed. It could not be determined if the bleed was new or old. Tenant #2 returned to the Program and it took two people to assist Tenant #2 out of the car. She progressively declined and family was given several options and an election was made for Hospice services. A care conference was held with Program staff, Hospice and family. A	A 012		

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A 012	Continued From page 5 concern was voiced regarding Tenant #2 getting fluids and nutrition at the hospital and one of the family members said the goal was to keep Tenant #2 alive. After the care conference it was determined Tenant #2 would be discharged. The document for the DPOA for healthcare was not provided until shortly before Tenant #2 discharged. They had gone on the General POA. The family member who was a General POA was contacted for falls, new orders and Hospice called that family member. When interviewed on 8-8-19 at 11:30 a.m. the Director of Long Term Support and Services revealed Tenant #2 was respite and then became a permanent tenant. Tenant #2 was hospitalized, upon return from the hospital she had declined and an order was received for Hospice services. Towards the end of Tenant #2's stay there was a care conference. At the care conference a concern was voiced regarding Tenant #2's fluid and nutritional intake and wanting her to receive IV fluids. One of the family members wanted to do anything to keep Tenant #2 alive. The DPOA for healthcare was not received until right before Tenant #2 was discharged. The General POA took her to appointments and brought supplies. There were no objections from the other family members until the end of Tenant #2's stay.	A 012		