4/8/20

PRINTED: 03/16/2020
FORM APPROVED

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
	578962	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON HILL	202 12TH STREET SW CEDAR RAPIDS, IA 52405

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R 000	Initial Comments No deficiencies were cited during the investigation of Incident #89361-I. The following deficiencies were cited during the investigation of Complaint #88179-C.	R 000		
R 266	481-57.7(5)b General Requirements 481-57.7(135C) General requirements. 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comply with requirements related to notifications to the Department found in Iowa Administrative Code 481 - Chapter 50. Findings follow: A review of incident reports on 2/19/20 revealed the facility failed to notify the Department of an elopement as required by Iowa Administrative Code rule 50.7 (4). The Administrator confirmed this finding. See deficiency under 50.7 (4) for details.	R 266	Please see attached	
R 782	481-57.21(2)a Dietary 481-57.21(135C) Dietary.	R 782		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Aaron Parle	Administrator	3/25/2020

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R 782	Continued From page 1 57.21(2) Nutrition and menu planning. a. Menus shall be planned and followed to meet the nutritional needs of residents in accordance with the primary care provider's orders. Diet orders should be reviewed as necessary, but at least quarterly, by the primary care provider. (II, III) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow diet orders for 2 of 2 residents reviewed not on general diets (Residents #2 and #6). Findings follow: Resident #2 was admitted to the facility on 11/19/19. Record review on 2/18/20 revealed Resident #2 had a diet order dated 11/14/19 for a Constant Carbohydrate Diet which identified she should have no more than 75 grams of carbohydrates per meal. According to a hospital after visit summary dated 1/22/20, Resident #2 was diagnosed with diabetes mellitus type 2, schizophrenia, GERD with esophagitis, a history of gastric ulcer, bilateral lower extremity edema, shortness of breath, pressure injury stage 1 and hyperlipidemia, unspecified. Resident #6 was admitted to the facility on 7/1/19. He had a diet order dated 1/7/20 for a Constant carbohydrate, 75 gram diet. A hospital after visit summary dated 10/2/19 identified Resident #6 was diagnosed with diabetic nephropathy associated with type 2 diabetes mellitus, chronic kidney disease stage 3, essential hypertension,	R 782	Please see attached	

Aaron Panke Administrator 3/26/2020

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R 782	Continued From page 2 anemia in stage 3 chronic kidney disease and renal osteodystrophy. An observation of the noon meal was conducted on 2/18/20 from 11:45 AM - 12:10 PM. The menu consisted of ghoulash, green beans, Texas toast, apple pie, 2 glasses of milk and juice. Resident #1 had the pasta without sauce. She also had a glass of prune juice. Resident #1 and #6 had smaller pieces of pie served to them than the other residents. When interviewed on 2/18/20 at 9:30 AM the cook reported the only person on a special diet at the facility was Resident #2. She did not identify Resident #6 as being on a special diet. On 2/18/20 at 2:05 PM the Administrator and Dietary Services Coordinator reported Resident #1 had a lunch consisting of 117 grams of carbohydrates and Resident #6 had a lunch of 102 grams of carbohydrates. They stated the residents' constant carbohydrate diets were not being fully followed 100% of the time. The facility was in the process of switching over to a new food service provider which had easy to follow constant carbohydrate diets.	R 782	Please see attached	
R 834	481-57.22(3)c Orientation and Service Plan 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	R 834		

Aaron Parla Administrator 3/26/2020

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R 834	Continued From page 3 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) 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) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to update service plans as needs changes for 1 of 3 former residents reviewed (Resident C-2). Findings follow: Record review on 2/18/20 revealed Resident C-2 was admitted to the facility on 8/19/19 on a voluntary basis. The resident's service plan dated 8/19/19 included a goal to stay sober due to a long history of substance abuse which had negatively impacted his physical, emotional and mental health. It noted when Resident C-2 struggled with substance abuse in the past, his symptoms of paranoia and delusions increased. Resident C-2's service plan noted the treatment team had agreed he could have up to 7 hours per day of unsupervised alone time but that was subject to change if any safety concerns arose.	R 834	Please see attached	

Aaron Paulo Administrator 3/26/2020

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R 834	Continued From page 4 A Resident Incident Report Form dated 10/27/19 noted Resident C-2 presented with increased agitation and paranoia. He refused to take his morning medication and stated the cook was trying to poison him. Resident C-2 gave staff permission to check his room. An empty 750 ML bottle of Black Velvet was found which he admitted to ingesting within the previous 24 hours. Staff also found a list of employee names on the wall with descriptions of how he wanted to hurt those individuals. Resident C-2 was immediately placed on enhanced observations. On 11/6/19 a Resident Incident Report Form indicated Resident C-2 was lethargic when he was checked on at bed time. A nurse was called in to assess and he was easily rousible but slurring his words. Vital signs were normal. He had been in good spirits earlier that evening, participated in a group and eaten supper. Resident C-2's room was checked and staff found 2 empty bottles of lorazepam, 1 partial bottle of pantoprazole, and 4 xanax tablets in a cellophane wrapper. The bottles all had his name on them and were from prior to his admission to the facility. The items were removed from his room. Resident C-2's physician was made aware of his condition and he was scheduled to see his doctor the following day. Resident C-2 saw his doctor on 11/7/19 and according to a Med Review Progress note admitted he had been self-medicating with alcohol and xanax. The staff person in attendance indicated Resident C-2 had been going on unauthorized passes and using drugs. According to a Resident Incident Report Form dated 11/8/19, 17 trazodone pills were found on	R 834	Please see attached	

Aaron Parle Administrator 3/26/2020

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R 834	Continued From page 5 the floor of Resident C-2's room. Resident C-2 denied having any other medication in his room. Resident C-2 was hospitalized for suicidal ideation on 11/14/19. An emergency provider's note indicated Resident C-2 had been running away from the facility the last few days and had used methamphetamine the previous night. He was discharged back to the facility on 11/18/19. According to Resident Incident Report Form dated 12/7/19 Resident C-2 could not be found when staff went to do rounds at 8:00 PM. Staff looked around the facility and could not find him. Resident C-2 did call the facility and informed staff he had left because he could not trust anyone there and did not feel safe. During the phone call, staff noted they could hear music in the background. A Resident Incident Report Form dated 12/8/19 noted Resident C-2 returned to the facility at 2:45 PM very confused and smelling strongly of alcohol. The police were called but they were unable to do anything at the time. The LPN took Resident C-2 to the hospital but he refused to enter the building. The resident got out of the facility van and walked away. Resident C-2 never returned to the facility. On 2/19/20 at 11:40 AM the Administrator and Social Services Director confirmed Resident C-2's service plan had not been updated to address need areas of elopement, or bringing alcohol and drugs to the facility. There was also no indication his seven hours of unsupervised alone time was discontinued even though several safety issues had occurred.	R 834	Please see attached	

Aaron Parks Administrator 3/26/2020

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C 147	Continued From page 6	C 147		
C 147	50.7(4) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the department of an elopement for 1 of 3 forme residents reviewed (Resident C-2). Findings follow: Review of Resident Incident Reports on 2/19/20 revealed Resident C-2 could not be found when staff went to do rounds at 8:00 PM on 12/7/19. Staff looked around the facility and could not find him. Resident C-2 did call the facility and informed staff he left because he could not trust anyone there and did not feel safe. An Incident Report Form dated 12/8/19 noted Resident C-2 returned to the facility at 2:45 PM smelling strongly of alcohol. On 2/19/20 at 11:00 AM the Administrator confirmed Resident C-2 left the facility without staff knowledge however the elopement was not reported to the department as the resident then called to report his whereabouts to the facility. The Administrator had considered Resident C-2's actions an unauthorized pass rather than an elopement.	C 147	Please see attached	

Aaron Park Administrator 3/26/2020

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Aaron Park Administrator 3/26/2020

V.4 3/30

DIA Investigation completed 2/20/2020 Plan of Correction

Nutrition and menu planning 57.21(2)
The immediate corrective action was the Dietary Services Coordinator providing training with the Dietary staff regarding our current menu and serving requirements per the resident diets. The long-term corrective action is the facility is changing food service providers including a menu system that easily identifies different dietary serving requirements per the diet order, including a 75 gram constant carbohydrate diet. The Dietary Services Coordinator will train dietary staff on the new menus and serving procedures by 4/24/2020. The Dietary Services Coordinator will update Dietary staff ongoing of diet order changes.

Orientation and Service Plan 481-57.22

Staff will be trained on the Service plan section of Chapter 57 as well as on the policy and procedure *Individual Service Plan* with emphasis on modifying the plan as the resident's needs change. This training will be completed by 4/24/2020.

Incident Reporting 481-50.7, 481-57.17

Staff will be trained on the policy *Investigation and Reporting of Accidents or Incidents* as well as the applicable Iowa Administrative Code sections. The Director of Nursing and Director of Social Services are responsible to ensure incidents are reported to the Director within reporting requirements. This training will be completed by 4/24/2020.

All staff will be trained on the policy *Investigation and Reporting of Accidents or Incidents* by 4/24/2020.

Aaron Pauls

Aaron Pauls, Administrator

3/26/2020

3/31/20