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
	S0113	A. BUILDING: _____ B. WING _____	C 02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARNETT PLACE	202 35TH ST DR SE CEDAR RAPIDS, IA 52403

(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. General Population Number of tenants without cognitive disorder: 15 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 7 Number of tenants with cognitive disorder: 0 TOTAL Census of Assisted Living Program for People with Dementia: 22 The investigation of Complaint #87497-C resulted in regulatory insufficiencies.	A 000	See attached POC 6/19/20	
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 interview and record review the Program failed to develop service plans to reflect the identified needs of tenants. This pertained to 3 of 4 tenants reviewed (Tenants #2, #3 and #4). Findings follow:	A 089		

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A 089	Continued From page 1 1. Record review on 2-5-20 revealed Tenant #2 was discharged from the Program on 1-20-19. The January 2019 medication administration records (MARs) reflected staff administered medications from a planner twice daily. The medications included: Warfarin 4 milligrams (mg) on Monday, Wednesday and Friday and 2 mg on the remaining days, administered in the evening. Continued record review revealed Tenant #2's service plan dated 7-1-18 reflected Tenant #2's family ordered medications and provided the Program with a current medication list. The medication planner was set up by family with nurse supervision. Staff administered the medications from the medication planner. The service plan did not reflect Tenant #2 was administered an anticoagulant medication. 2. Record review on 2-5-20 revealed a 90 Day Review dated 2-4-20 indicated Tenant #3 ambulated with a wheeled walker when she was outside of her apartment. Continued record review revealed Progress Notes indicated the following: -On 1-15-20 it was noted staff found Tenant #3 on the floor when staff went to administer medications. No injuries were noted and Tenant #3 was assisted to a standing position. -On 1-21-20 it was noted that last evening Tenant #3 called for assistance and staff found Tenant #3 sitting on the floor. Tenant #3 reported she turned too fast with her walker, which caused her to fall. Tenant #3 hit her head and bleeding was noted. She also scraped her right hand and	A 089		

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A 089	Continued From page 2 forearm. Tenant #3's family transported her to the hospital for further evaluation. Tenant #3 returned from the hospital with no issues noted. Further record review revealed Tenant #3's service plan dated 4-1-19 did not reflect Tenant #3's use of an assistive device (wheeled walker) or the falls. 3. Review of Tenant #4's file revealed diagnoses included: frontotemporal dementia, obstructive sleep apnea (adult and pediatric), diabetes mellitus and chronic obstructive pulmonary disease. The Comprehensive Assessment dated 2-3-20 reflected Tenant #4 used a walker and wheelchair and was a one person assist with transfers. It also reflected bathing services were provided twice weekly. Continued record review revealed the January 2020 MARs reflected staff assistance with blood glucose monitoring three times daily on Mondays. When interviewed on 2-6-20 at 3:39 p.m. the Nurse revealed Tenant #4 had a continuous positive airway pressure (CPAP) machine; however, Tenant #4's spouse assisted and staff did not provide assistance with the CPAP. Further record review revealed Tenant #4's service plan dated 2-3-20 did not reflect the use of the assistive devices (wheeled walker and wheelchair), the frequency of Tenant #4's bathing services, the blood glucose checks or the use of a CPAP machine.	A 089		

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A 089	Continued From page 3 4. When interviewed on 2-6-20 at 3:39 p.m. the Nurse revealed the most recent service plan documents for the tenants listed were provided.	A 089		
A 118	481-69.29(4) Staffing 481-69.29(231C) Staffing 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to consistently check on tenants as indicated by the tenants' service plans. This pertained to 7 of 7 tenants with safety checks reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). Findings follow: 1. Observation on 2-6-20 at 5:31 a.m. revealed two staff on third shift for the Program, Staff C and Staff D. Staff C was assigned to the memory care unit on the third floor and Staff D was	A 118		

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A 118	Continued From page 4 assigned to the first and second floors. At 5:40 a.m. it was observed Staff C was completing safety checks (5:00 a.m. rounds). Staff C had the Program's ipad with her as she completed the checks. 2. Record review on 2-24-20 revealed the safety checks completed on third shift on 2-5-20/2-6-20 indicated: checks were documented for Tenant #5 on 2-5-20 at 10:41 p.m. (scheduled for 10:00 p.m.) and at 10:44 p.m. (scheduled for 11:00 p.m.). On 2-6-20 at 12:43 a.m. (scheduled for 12:00 a.m.), at 12:44 a.m. (scheduled for 1:00 a.m.), at 1:56 a.m. (scheduled for 2:00 a.m.), at 3:55 a.m. (scheduled for 3:00 a.m.), at 3:56 a.m. (scheduled for 4:00 a.m.) and at 5:38 a.m. (scheduled for 5:00 a.m.). Checks were documented for Tenant #6 on 2-5-20 at 10:44 p.m. (scheduled for 10:00 p.m.) and at 10:45 p.m. (scheduled for 11:00 p.m.). On 2-6-20 at 12:44 a.m. (scheduled for 12:00 a.m.), at 12:44 a.m. (scheduled for 1:00 a.m.), at 1:57 a.m. (scheduled for 2:00 a.m.), at 3:55 a.m. (scheduled for 3:00 a.m.), at 3:58 a.m. (scheduled for 4:00 a.m.) and at 5:39 a.m. (scheduled for 5:00 a.m.). Checks were documented for Tenant #7 on 2-5-20 at 10:41 p.m. (scheduled for 10:00 p.m.) and at 10:45 p.m. (scheduled for 11:00 p.m.). On 2-6-20 at 12:43 a.m. (scheduled for 12:00 a.m.), at 12:44 a.m. (scheduled for 1:00 a.m.), at 1:56 a.m. (scheduled for 2:00 a.m.), at 3:55 a.m. (scheduled for 3:00 a.m.), at 3:57 a.m. (scheduled for 4:00 a.m.) and at 5:39 a.m. (scheduled for 5:00 a.m.). Tenants #5, #6 and #7 were all scheduled for visual checks eight times per shift. 3. Record review on 2-6-20 of Tenant #1's file revealed diagnoses included: anxiety disorder	A 118		

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A 118	Continued From page 5 and major depressive disorder. Tenant #1 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. Tenant #1 resided in the memory care unit and was discharged on 5-16-19. Continued record review of a Documentation Survey Report May of 2019 reflected safety and wellness checks were to be completed eight times per shift. On 5-7-19 at 12:00 a.m. the check was not documented as completed. Safety checks were documented in groupings including on: 5-1-19 the 2:00 a.m. and 3:00 a.m. check were both documented at 3:01 a.m. On 2-7-19 the 2:00 a.m. check was documented at 5:07 a.m. The 3:00 a.m., 4:00 a.m. and 5:00 a.m. safety checks were documented at 5:14 a.m. Further record review revealed Tenant #1's service plan dated 5-2-19 reflected Tenant #1 had 24 hour supervision and visual checks in the memory care unit. 4. Record review on 2-5-20 of Tenant #2's file revealed diagnosis included: dementia without behavioral disturbance and conversion disorder with seizures or convulsions. Tenant #2 was staged at a three on the GDS, which indicated mild cognitive decline. Tenant #3 resided in the memory care unit and was discharged on 1-20-19. An Incident Report (handwritten) dated 1-17-19 at 7:30 a.m. indicated Staff A entered Tenant #2's apartment to get him for breakfast and observed him laying on the floor in the bedroom. Staff A called for assistance to get him up. When staff assisted him up to his walker he kept leaning forward. The Nurse was called and he said to call the non-emergency ambulance. Staff noticed	A 118		

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A 118	Continued From page 6 he had a rug burn on the left cheek and his left eye was red and swollen. Tenant #2 did not complain of any pain. Tenant #2's family was called. An un-witnessed incident report dated 1-17-19 at 7:30 a.m. (revision date of 1-18-19) reflected staff entered the apartment to get Tenant #2 for breakfast. Tenant #2 was on his left side on the floor next to his bed with the walker nearby. Staff called for additional staff. Staff "observed resident for pain and injuries." None were noted at that time. Staff assisted Tenant #2 to a seated position and it was noted Tenant #2 had rug burn on the left cheek and his left eye was red and swollen. Tenant #2 was not able to hold his upper body up and leaned forward. Tenant #2 did not complain of pain. The Nurse and family were notified and the non-emergency ambulance was called to transport to a hospital. When interviewed on 2-24-20 at 10:10 a.m. Staff A said (regarding the above incident with Tenant #2) it was between 7:00 a.m. and 8:00 a.m. when she found Tenant #2 on the floor against/by his bed. Tenant #2 had medications and cares at that time. She called other staff to assistance. Range of motion (ROM) was completed and Tenant #2 talked to staff and was not hurt. Staff lifted him onto the bed and there was no complaints of pain when moved to the bed. Tenant #2 had a walker; however, the walker was not beside him. The Nurse was called when Tenant #2 was on the bed and he instructed staff to call the non-emergency ambulance. The ambulance arrived and Tenant #2 was sent out. Staff A said she would assume a safety check for Tenant #2 was completed prior to the 7:00 a.m. to 8:00 a.m. check but she was not certain. She also did not know when the last check would	A 118		

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A 118	Continued From page 7	A 118		

have been completed on third shift. Staff A said Tenant #2 had not been feeling well the day prior.

When interviewed on 2-24-20 at 11:07 a.m. Staff B said (regarding the above incident with Tenant #2) she last checked on Tenant #2 4:00 a.m. into 5:00 a.m. and he was asleep in bed. She had assisted him to the bathroom earlier and everything was fine. Tenant #2 had hourly checks and she completed the checks for Tenant #2 every hour. She received a disciplinary action related to not documenting the check (4:00 a.m. into 5:00 a.m. check) Staff B said she completed the check; however, did not document it. Staff B said she was busy in the last hour with another tenant and did not document the check.

When interviewed on 2-6-20 at 3:39 p.m. the Nurse revealed he would like the checks to be documented as soon as they see the person. Regarding Tenant #2's fall, the Nurse was in the building and went to Tenant #2's apartment. Staff had started ROM and there had been no grimacing or complaints of pain. Tenant #2 was moved to the bed and was more lethargic. Tenant #2 was sent to the hospital and family was notified. The Nurse said Tenant #2 was due for a check and he did not remember asking when the last check was completed. Tenant #2 did not have any missed services. The Nurse called the hospital and he was informed Tenant #2 had transferred to Hospice. The Nurse said Tenant #2's cause of death was renal failure.

Continued record review revealed Tenant #2's service plan dated 7-1-18 reflected staff was to provide hourly safety checks for comfort, safety and ostomy bag closure. The service plan also reflected Tenant #2 had a history of falls, which put Tenant #2 at risk if he ambulated without

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A 118	Continued From page 8	A 118		

assistance. Staff provided stand by assistance with walking to and from meals and as needed. Staff provided reminders to use the assistive device he was seen without it. The service plan also reflected Tenant #2 demonstrated deficits in judgement regarding safety.

Further record review revealed hospital documentation indicated Tenant #2 was admitted to the hospital on 1-17-19 and discharged on 1-19-19 to a hospice house. Tenant #2 was found on the ground at the Program (unknown how long on the floor) and had abrasions on the left upper extremity, left chest, left side of the face and bilateral knees. There was "mild cortical irregularity of the lateral left 5th and 6th ribs which could represent nondisplaced fractures." Tenant #2's creatine kinase level was 9507, blood urea nitrogen was 41 and creatinine was 2.4. Discharge diagnoses included: encephalopathy, acute kidney failure, traumatic rhabdomyolysis, aspiration pneumonia, fall, and chronic kidney disease (stage III).

Continued record review of a Documentation Survey Report January 2019 revealed Tenant #2 had safety checks hourly for comfort, safety and ostomy closure. The document indicated the following:

-On 1-16-19 from 1:00 a.m. to 5:00 a.m. there were no checks recorded as completed.

-On 16-19 checks were documented at 6:32 a.m. (6:00 a.m. check), 7:42 a.m. (7:00 a.m. check), 8:05 a.m. (8:00 a.m. check), 9:32 a.m. (9:00 a.m. check), 9:56 a.m. (10:00 a.m. check), 11:10 a.m. (11:00 a.m. check), 12:02 p.m. (12:00 p.m. check), 1:00 p.m. (1:00 p.m. check), 2:27 p.m. (2:00 p.m. check), 2:27 p.m. (3:00 p.m. check),

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A 118	Continued From page 9 3:12 p.m. (4:00 p.m. check) 4:50 p.m. (5:00 p.m. check), 5:46 p.m. (6:00 p.m. check), 6:50 p.m. (7:00 p.m. check), 8:07 p.m. (8:00 p.m.), 8:07 p.m. (9:00 p.m. check), 10:05 p.m. (10:00 p.m. check) and 10:05 p.m. (11:00 p.m. check. -On 1-17-19 checks were documented at 10:17 p.m. (12:00 a.m. check), 1:04 a.m. (1:00 a.m. check) 1:04 a.m. (2:00 a.m. check) 4:32 a.m. (3:00 a.m. check), 4:32 a.m. (4:00 a.m. check), 4:32 a.m. (5:00 a.m. check), 6:31 a.m. (6:00 a.m. check) and 7:59 a.m. (7:00 a.m. check). As the checks indicated above on the date of Tenant #2's fall (1-17-19) the check due at 12:00 a.m. on 1-17-19 was documented as completed at 10:17 p.m., prior to the time of the check. It was also documented 12 minutes after the time of the 10:00 p.m. check. The 2:00 a.m. check was documented at 1:04 a.m., prior to the time of the check and at same time the 1:00 a.m. check was documented. The 3:00 a.m. check was documented at 4:32 a.m., after the time of the check and documented at the same time of the 4:00 a.m. and 5:00 a.m. checks. The 4:00 a.m. check was documented at 4:32 a.m. and was documented at the same time of the 3:00 a.m. and 5:00 a.m. checks. The 5:00 a.m. check was documented at 4:32 a.m., prior to the time of the check and documented at the same time of the 3:00 a.m. and 4:00 a.m. checks. Tenant #2 went to the hospital on 1-17-19 and did not return to the Program. Staff documented safety checks as completed over 30 times from 1-18-19 to 1-21-19, when Tenant #2 was not in the building. Review of the above documentation revealed checks were not documented as completed every	A 118		

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A 118	Continued From page 10 hour for Tenant #2, including checks that were documented prior to and after the the time of the check, checks that were completed greater than one hour from the time of the last check, checks that were not documented with any documentation, multiple checks documented with the same time in groupings and checks documented as completed when Tenant #2 was not present in the building. Further record review of Counseling Documentation Forms indicated Staff A and Staff B received written warnings dated 1-17-19 related to the failure to record safety checks appropriately and accurately regarding Tenant #2. The documents indicated safety checks could not be marked off in groups. The safety checks should be marked off when they were completed to ensure the time was accurate. The safety checks that were hourly were to be done in accordance with that policy. It indicated not to take another person's word that a safety check had been done and sign off the check for them. 5. Record review on 2-5-20 of Tenant #3's file revealed a diagnosis included: major depressive disorder. Continued record review revealed Documentation Survey Reports for January and February 2020 revealed safety and comfort checks twice per shift. The documents reflected greater than 10 entries that lacked staffs' initials and the time of the completion of the check. On 2-22-20 the 12:00 a.m. check was documented at 5:02 a.m. and the 4:00 a.m. check was documented at 5:03 a.m. Further record review revealed Tenant #3's	A 118		

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A 118	Continued From page 11 service plan dated 4-1-19 reflected safety and comfort checks twice per shift. 6. Record review on 2-5-20 and 2-6-20 of Tenant #4's file revealed diagnoses included frontotemporal dementia. Tenant #4 was staged at at three on the GDS, which indicated mild cognitive decline. Tenant #4 resided in the memory care unit. Continued record review of the Documentation Survey Report February 2020 revealed visual checks were to be completed eight times per shift. From 2-1-20 at 11:00 a.m. to 2-24-20 at 4:00 p.m. there were greater than 15 entries that lacked staffs' initials and the time of the completion of the check. Additionally, safety checks were documented in groupings including on: 2-5-20 the 1:00 a.m. safety check was documented at 4:28 a.m., the 2:00 a.m., 3:00 a.m. and 4:00 a.m. safety checks were all documented at 4:29 a.m. The 5:00 a.m. safety check was documented at 4:30 a.m. On 2-7-20 the 2:00 a.m. and 3:00 a.m. safety checks were documented at 3:38 a.m. The 4:00 a.m. safety check was documented at 3:39 a.m. On 2-18-20 the 12:00 a.m., 1:00 a.m. and 2:00 a.m. safety checks were all documented at 2:09 a.m. The 3:00 a.m., 4:00 a.m. and 5:00 a.m. safety checks were all documented at 4:54 a.m. On 2-22-20 the checks at 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m. and 5:00 a.m. were all documented between 5:03-5:05 a.m. On 2-24-20 the 2:00 a.m. and 3:00 a.m. checks were documented at 5:26 a.m. and the 4:00 a.m. and 5:00 a.m. checks were documented at 5:27 a.m. Further record review of Tenant #4's service plan dated 2-3-20 reflected visual checks were	A 118		

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
	S0113	A. BUILDING: _____ B. WING _____	C 02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARNETT PLACE	202 35TH ST DR SE CEDAR RAPIDS, IA 52403

(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 118	Continued From page 12 completed eight times per shift. 7. The Program's Staffing policy and procedure indicated staff provided personal care according to the service plan. 8. When interviewed on 2-24-20 at 4:14 p.m. the Clinical Quality Manager confirmed all of the tasks with visual checks requested for the tenants listed above were provided.	A 118		

ok
5/28/20

202 35TH ST DR SE
CEDAR RAPIDS, IA 52403

Garnett Place

319-362-3630
GARNETTPLACE.NET

May 22, 2020

✓ 6/1/20

Complaint Visit:
Garnett Place visit 2/5/20, 2/6/20 and 2/24/20

Iowa Department of Inspection & Appeals
Catie Campbell
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

To Whom It May Concern,

Please consider this our plan of correction for the regulatory insufficiency cited during 2/24/20 visit, with the **Final Results, Garnett Place, Cedar Rapids, IA** completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapter 481-69, pertaining to regulatory insufficiencies in the areas of service plans.

Service Plans
A089
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

1. **Elements detailing how the program will correct the regulatory insufficiency.**
   a. Residents' ISPs are being reviewed and updated as appropriate.

2. **What measures will be taken to ensure the problem does not recur?**

   a. HCC, Manager or designee will ensure the residents service plan is current and specific to the individual upon admission, with any change of condition assessment, 90-day assessments, and/or annually by completing an ISP review with each assessment.

3. **How the program plans to monitor performance to ensure compliance.**

a. HCC, Manager or designee will review a random sample of ISPs for accuracy and specified for individualized needs monthly for four months and then as scheduled by the Program Manager or designee.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 6/19/20.

Staffing
A118
69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans.

A non-dementia-specific assisted living program shall have one or more staff persons sho monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans.

1. **Elements detailing how the program will correct the regulatory insufficiency.**
   a. Appropriate number of staff are scheduled each day to meet residents' needs.

2. **What measures will be taken to ensure the problem does not recur?**
   a. HCC, Manager or designee will ensure appropriate number of staff are scheduled each day to meet residents' needs.

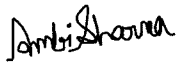
3. **How the program plans to monitor performance to ensure compliance.**
   a. HCC, Manager or designee will review documentation daily for timeliness for two weeks, three times a week for two weeks and then as scheduled by the Program Manager or designee.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 6/19/20.

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 regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Thank you for your time and consideration in correcting these important matters.

Sincerely,



Ambika Sharma
Manager