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3/12/21

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FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/15/2020
NAME OF PROVIDER OR SUPPLIER COTTAGE GROVE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2115 1ST AVENUE SE CEDAR RAPIDS, IA 52402		
(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 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: 11 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 13 The investigation of Complaint #93973-C was completed and resulted in the following regulatory insufficiencies:	A.000	See attached POC 3/15/21	
A.037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 2 current tenants reviewed (Tenants #1 and	A.037		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 037	Continued From page 1 #3). Findings follow: 1. When interviewed on 10-13-20 at 1:41 p.m. Staff A reported Tenant #1 experienced visual hallucinations. Tenant #1 lashed out and had behaviors on second and third shifts. When interviewed on 10-14-20 Staff B said Tenant #1 experienced visual hallucinations. When interviewed on 10-14-20 at approximately 4:29 p.m. Staff C said Tenant #1 experienced visual hallucinations. Record review of Report Sheets for September and October 2020 reflected visual hallucinations for Tenant #1, including seeing people and animals out of her window (apartment not on the ground floor). On 9-24-20 it was documented that Tenant #1 barricaded herself in the apartment, verbalized that someone was outside of her window all night watching her, covered the windows with towels and refused to come out of her apartment. On 10-7-20 it was documented she was verbally and physically abusive with second and third shift staff per the third shift nurse. Tenant #1 used foul language and was "getting in their face." When staff changed her bed on first shift she used foul language once and said there were monkeys all over the apartment. Continued record review of Tenant #1's file revealed diagnoses included major depressive disorder (single episode) and generalized anxiety disorder. Evaluations were completed on 9-11-20 and 10-11-20; however, evaluations were not completed as needed with significant change related to Tenant #1's behaviors.	A 037		

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A 037	Continued From page 2 2. When interviewed on 10-13-20 at 1:41 p.m. Staff A said staff did everything for Tenant #3 and she had bladder incontinence. When interviewed on 10-14-20 Staff B said Tenant #3 had bladder incontinence. For bathing, dressing and grooming staff did everything. Staff B could assist with cares; Tenant #3 liked the attention. When interviewed on 10-14-20 at approximately 4:29 p.m. Staff C said at times Tenant #3 felt low and wanted more attention. Sometimes Tenant #3 could be helpful and could be cued or prompted (regarding cares). When interviewed on 10-15-20 at 10:06 a.m. the Navigator and Resident Services Director said Tenant #3 could do things regarding her cares. Tenant #3 might not like a staff member or would get upset when staff took their breaks. Tenant #3 wanted more attention. Record review revealed evaluations were completed on 7-10-20 and 10-11-20 (90 day reviews); however, evaluations were not updated as needed with significant change and did not reflect the staff identified attention seeking behaviors and increased cares. 3. When interviewed on 10-15-20 at 10:06 a.m. the Navigator and Resident Services Director confirmed the above the finding for Tenant #1.	A 037		
A 071	481-69.25(1) Tenant Documents 481-69.25(231C) Tenant documents.	A 071		

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A 071	Continued From page 3 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurses' notes by exception. This pertained to 2 of 3 tenants reviewed (Tenants #1 and #2). Findings follow: 1. When interviewed on 10-13-20 at 1:41 p.m. Staff A said Tenant #1 experienced visual hallucinations. Tenant #1 lashed out and had behaviors on second and third shifts. When interviewed on 10-14-20 Staff B said Tenant #1 experienced visual hallucinations. When interviewed on 10-14-20 at approximately 4:29 p.m. Staff C said Tenant #1 experienced visual hallucinations. Record review of Report Sheets for September and October 2020 reflected visual hallucinations for Tenant #1, including seeing people and animals out of her window (apartment not on the ground floor). On 9-24-20 it was documented that Tenant #1 barricaded herself in the apartment, verbalized that someone was outside	A 071			

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A 071	Continued From page 4 of her window all night watching her, covered the windows with towels and refused to come out of her apartment. On 10-7-20 it was documented she was verbally and physically abusive with second and third shift staff per the third shift nurse. Tenant #1 used foul language and was "getting in their face." When staff changed her bed on first shift she used foul language once and said there were monkeys all over the apartment. Continued record review of Tenant #1's file revealed diagnoses included major depressive disorder (single episode) and generalized anxiety disorder. There was one entry in Clinical Notes dated 10-11-20 that reflected Tenant #1's behaviors including confusion, aggression and hallucinations continued. There were no other notes documented by exception regarding Tenant #1's behaviors and hallucinations. 2. Record review on 10-14-20 of Tenant #2's file revealed Tenant #2 was discharged from the Program on 10-9-20. Review of Clinical Notes indicated the notes lacked an entry regarding Tenant #2's discharge, including date and reason for discharge. 3. When interviewed on 10-15-20 at 10:06 a.m. the Navigator and Resident Services Director confirmed the above finding.	A 071		
A 224	481-69.26(3)d Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care	A 224		

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A 224	Continued From page 5 or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days (signed and dated by all parties) and failed to updated service plans as needed with significant change. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review on 10-14-20 of Tenant #1's file revealed Tenant #1 was admitted on 9-10-20. An initial service plan was developed, signed and dated on 9-11-20. A service plan was not developed, signed and dated by all parties within 30 days of taking occupancy. When interviewed on 10-13-20 at 1:41 p.m. Staff A said Tenant #1 experienced visual hallucinations. Tenant #1 lashed out and had behaviors on second and third shifts. When interviewed on 10-14-20 Staff B said Tenant #1 expereinced visual hallucinations. When interviewed on 10-14-20 at approximately 4:29 p.m. Staff C said Tenant #1 experienced visual hallucinations. Continued record review of Report Sheets for	A 224			

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A 224	Continued From page 6 September and October 2020 reflected visual hallucinations for Tenant #1, including seeing people and animals out of her window (apartment not on the ground floor). On 9-24-20 it was documented that Tenant #1 barricaded herself in the apartment, verbalized that someone was outside of her window all night watching her, covered the windows with towels and refused to come out of her apartment. On 10-7-20 it was documented she was verbally and physically abusive with second and third shift staff per the third shift nurse. Tenant #1 used foul language and was "getting in their face." When staff changed her bed on first shift she used foul language once and said there were monkeys all over the apartment. Further record review of Tenant #1's file revealed diagnoses included major depressive disorder (single episode) and generalized anxiety disorder. The signed service plan was not updated as needed and did not reflect the visual hallucinations and behaviors with interventions for Tenant #1. 2. Record review on 10-14-20 of Tenant #2's file revealed Tenant #2 was admitted on 8-27-20. An initial service plan was developed, signed and dated on 8-27-20. A service plan was not developed, signed and dated by all parties within 30 days of taking occupancy. 3. When interviewed on 10-13-20 at 1:41 p.m. Staff A said staff did everything for Tenant #3 and she had bladder incontinence. When interviewed on 10-14-20 Staff B said	A 224			

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A 224	Continued From page 7 Tenant #3 had bladder incontinence. For bathing, dressing and grooming staff did everything. Staff B could assist with cares; Tenant #3 liked the attention. When interviewed on 10-14-20 at approximately 4:29 p.m. Staff C said at times Tenant #3 felt low and wanted more attention. Sometimes Tenant #3 could be helpful and could be cued or prompted (regarding cares). When interviewed on 10-15-20 at 10:06 a.m. the Navigator and Resident Services Director said Tenant #3 could do things regarding her cares. Tenant #3 might not like a staff member or would get upset when staff took their breaks. Tenant #3 wanted more attention. Record review revealed Report sheets of 9-10-20 and 9-11-20 reflected Tenant #3 sold her scooter. The service plan most recently signed by Tenant #3 on 2-20-19 still reflected the use of scooter. The signed service plan was not updated as needed and did not reflect the staff identified attention seeking behaviors and increased cares. It also did not reflect the scooter was no longer used. 4. When interviewed on 10-15-20 at 10:06 a.m. the Navigator and Resident Services Director confirmed the above finding for Tenant #1 and Tenant #2.	A 224		

Investigation #93973-C

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 the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or State Law.

A037

Assisted Living designee will review all service plans by 03/15/2021 to ensure accuracy and residents will be evaluated per guidelines unless a significant change has occurred. Behaviors are considered significant changes and will be added to the service plan and be signed by responsible parties. Tenant #1 service plan has been updated and reviewed with responsible party. Staff will continue to monitor behaviors and these changes will be noted as significant changes. Update occurred on 3/02/21.

Tenant #3 A review of the tenant's service plan was performed on 3/01/21 to include identified behaviors and signed by responsible party. Behaviors of this nature will be reviewed and added to service plan as they develop.

Resident Services Director and Navigator provided education to Program nurse on documentation and regular reviews of all resident behaviors on 11/04/20. Nurse will monitor this through visiting floors, reading the communication logs and at monthly staff meetings. Staff will monitor changes in resident's behavior, document in daily logs and report it to the Nurse or Resident Services Director if needed. This request was also discussed with staff on 11/04/20. Documentation of changes will be reflected on service plans, will be signed and dated by all parties going forward.

The program has developed a spreadsheet to track all assessment and the due dates. This tracking device will be monitored by the Resident Services Director, Assisted Living nurse, and navigator to ensure timely completion of assessments.

Resident review of all Service Plans and overall wellbeing will be reviewed for changes weekly by Assisted Living Nurse, Resident Services Director and Navigator. These meetings are designed to discuss all communication reports from each floor, review service plans and changes in residents to ensure updates of changes occur timely.

A071

Tenant #1 behavior changes were noted in the nurses' notes for a single occasion. Program reviewed and updated service plan for tenant and had responsible party sign. Resident Services Director and Navigator provided education on 10/28/20 to program nurse regarding follow up documentation of all behaviors outside of what is considered normal for the individual.

Tenant #2 lacked discharge information for tenant in the clinical notes. Program has recently added myUnity electronic charting and will discuss with the program nurse proper charting for all discharges from the program.

Resident review of all Service Plans, overall wellbeing will be reviewed for changes weekly by Assisted Living Nurse, Resident Services Director and Navigator. These meetings are designed to discuss all communication reports from each floor, review service plans, update nurses notes and changes in residents to ensure updates of changes occur timely.

A224

Program will review all 30-day service plans along with significant changes and have responsible parties sign and date the changes on 3/1/21. Resident Services Director and Navigator provided education with program nurse on this requirement on 10/28/20.

Tenant #1 and #3 service plans have been updated and signed by responsible parties. Tenant # 2 has been discharged from the community, note of discharge is documented in the physical chart.

Resident review of all Service Plans, overall wellbeing will be reviewed for changes weekly by Assisted Living Nurse, Resident Services Director and Navigator. These meetings are designed to discuss all communication reports from each floor, review service plans and changes in residents to ensure updates of changes occur timely.