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 _____	01/10/2024

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 impairment: 8 Number of tenants with cognitive impairment: 7 Total census: 15 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000	POC 4/25/24	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policy and procedure related to the completion of incident reports. This pertained to 2 of 4 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. Record review on 1/8/24 revealed a handwritten statement completed by the Nurse. The statement indicated on Tuesday, 10/3/23, Staff B noticed Tenant #2 walk to Tenant #1's apartment at approximately 2:45/3:00 p.m. At approximately 3:30/3:45 p.m. Staff B went to Tenant #2's apartment to administer medications and he was not there. Staff B remembered	A 150	Program Policies & Procedures: All staff will be retrained on policy and procedures for reporting incidents/completing incident reports by April 25th, 2024. Staff will receive yearly training on Policy and Procedures for reporting incidents.	

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A 150	Continued From page 1 Tenant #2 had gone to Tenant #1's apartment. Staff B went to Tenant #1's apartment, knocked on the door and no response was received. Staff B opened the door, which was unlocked, and found Tenant #1 and Tenant #2 unclothed and engaged in a sex act. They did not realize Staff B was there and he left. Tenant #2 went to his apartment about 20 minutes later. Continued record review on 1/8/24 and 1/9/24 of Tenant #1's file revealed she had a diagnosis of Alzheimer's disease and was staged at a 5.4 on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Further record review of Tenant #2's file revealed he had a diagnosis of dementia and scored a 26/30 (10/5/23) and 28/30 (11/14/23) on the Mini-Mental Status Examination. When interviewed on 1/10/24 at 10:52 a.m. the Nurse said Staff C reported to her that Staff B had found Tenant #1 and Tenant #2 engaged in a sex act. It had occurred the day prior and Staff B had reported it to Staff C and Staff C reported it to the Nurse. The Nurse spoke with Staff B about the incident after being informed by Staff C. Staff B said he had observed Tenant #1 and Tenant #2 in sex act in Tenant #1's apartment. The Nurse said there was language barrier with Staff B and he was very embarrassed (regarding the subject matter) when she talked to him about the incident. Leadership staff spoke with Tenant #1 and Tenant #2 and both tenants were comfortable with the relationship and voiced no concerns. The legal representatives and primary care providers for both tenants were also notified and voiced no concerns. The Nurse said no other statements or incident reports were completed related to the incident.	A 150		

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A 150	Continued From page 2 2. Record review of the Program's policy and procedure related to Incidents/Accidents indicated when an occurrence or event led to unintentional consequences and an unfortunate event for a tenant or others an incident/accident report would be completed by the person in charge at the time. It indicated to notify the nurse as soon as possible if there was an injury or suspected injury. It also indicated if in doubt to complete the form. The report would include statements from anyone who witnessed the incident. A copy of the report would be kept for three years. 3. Record review on 1/8/24 and 1/9/24 of Tenant #1 and Tenant #2's files revealed no incident reports were completed related to the incident. Staff B discovered the tenants engaged in a sex act on 10/3/23. Staff B reported it to a co-worker, Staff C. The Nurse was informed of the incident by Staff C the following day. She then spoke with Staff B about the incident. A handwritten statement was provided by the Nurse; however, she was not informed of the incident until the following day and she was not initially informed by the staff who discovered the incident. An incident report was not completed when the incident occurred, it was not completed by the person in charge at the time of the incident, and it was not documented on an incident report form. 4. When interviewed on 1/10/24 at 11:15 a.m. Director of Long-Term Support and Services confirmed all incident reports were provided for the tenants reviewed.	A 150		
A 395	481-69.26(4)a Service Plans	A 395		

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A 395	Continued From page 3 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 #1, #2 and #3). Findings follow: 1. Record review on 1/8/24 revealed a handwritten statement completed by the Nurse. The statement indicated on Tuesday, 10/3/23, Staff B noticed Tenant #2 walk to Tenant #1's apartment at approximately 2:45/3:00 p.m. At approximately 3:30/3:45 p.m. Staff B went to Tenant #2's apartment to administer medications and he was not there. Staff B remembered Tenant #2 had gone to Tenant #1's apartment. Staff B went to Tenant #1's apartment, knocked on the door and no response was received. Staff B opened the door, which was unlocked, and found Tenant #1 and Tenant #2 unclothed and engaged in a sex act. They did not realize Staff B was there and he left. Tenant #2 went to his apartment about 20 minutes later. When interviewed on 1/10/24 at 10:52 a.m. the Nurse said Staff C reported to her that Staff B had found Tenant #1 and Tenant #2 engaged in a sex act. It had occurred the day prior and Staff B had reported it to Staff C and Staff C reported it to the Nurse. The Nurse spoke with Staff B about the incident after being informed by Staff C. Staff B said he had observed Tenant #1 and Tenant #2	A 395	Service Plans: Tenant 1, Tenant 2, & Tenant 3's service plans were reviewed and updated with current needs/services on 3/25/2024. Service Plans will be audited with 90-day reviews to ensure the service plan is individualized and includes the residents' needs and preferences for assistance. Staff will be retrained on service plans and what should be included to ensure service plans are individualized and ensure residents' needs and preferences are met. This training will be completed with staff by April 25th, 2024.	

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A 395	Continued From page 4 in sex act in Tenant #1's apartment. Leadership staff spoke with Tenant #1 and Tenant #2 and both tenants were comfortable with the relationship and voiced no concerns. The legal representatives and primary care providers for both tenants were also notified and voiced no concerns. The Nurse said it was established that Tenant #1 and Tenant #2 did not go out of the building with each other's families. She said at times Tenant #1 slept in Tenant #2's apartment. She said Tenant #1 took clothing to Tenant #2's apartment and staff returned the items to her apartment. 2. Record review on 1/8/24 and 1/9/24 of Tenant #1's file revealed Interdisciplinary Notes indicated the following: a. On 10/5/23 (late entry for 10/4/23) it was noted staff told the nurse that the evening prior he had knocked on the door to Tenant #1's apartment and found Tenant #1 and a male tenant (Tenant #2) engaging in a sex act. Tenant #1's legal representative was made aware of the situation and was okay with the relationship. b. On 10/5/23 it was noted a significant change evaluation was completed related to the situation. Tenant #1's legal representative and physician were notified. c. On 11/14/23 it was noted Tenant #1 continued to enjoy the companionship of a a male tenant with family support. She did spend the night with him periodically. d. On 11/17/23 it was noted Tenant #1's legal representative was okay with her spending the night with the other tenant but was concerned with her taking clothes to his apartment.	A 395		

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A 395	Continued From page 5 e. On 1/4/24 it was noted Tenant #1 continued to enjoy the relationship with another tenant. The tenants spent much of every day and night together. If Tenant #1 slept in her room, she did not sleep in a bed. If she slept in the other tenant's apartment she slept in bed. Continued record review revealed Tenant #1's service plan was updated on 10/5/23 and reflected Tenant #1 had an intimate relationship with a male tenant. The service plan indicated to offer privacy as needed and if Tenant #1 wanted to end relationship to notify the nurse. The service plan was updated after the relationship was discovered; however, the service plan did not reflect at times Tenant #1 slept in the other tenant's apartment. It also did not reflect Tenant #1 took clothing to his apartment and the agreement regarding Tenant #1 not leaving the building with the other tenant's family. 3. Record review on 1/8/24 and 1/9/24 of Tenant #2's file revealed Interdisciplinary Notes indicated the following: ' a. On 10/5/23 (late entry for 10/4/23) it was noted staff told the nurse that the evening prior he had knocked on the door to Tenant #1's apartment and found Tenant #2 and the female tenant (Tenant #1) engaging in a sex act. Tenant #2's legal representative was made aware of the situation and was okay with the relationship. b. On 10/5/23 it was noted a significant change evaluation was completed related to the situation. Tenant #2's legal representative and physician were notified. c. On 11/14/23 it was noted Tenant #2 spent	A 395		

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A 395	Continued From page 6 much of his day and night with another tenant and was comfortable with the situation. d. On 11/17/23 it was noted Tenant #2's legal representative was okay with Tenant #2 spending night with a female tenant. e. On 1/4/24 it was noted Tenant #2 continued to have a relationship with a female tenant and was comfortable with the companionship. Continued record review revealed Tenant #2's service was updated on 10/5/23 and reflected Tenant #2 was in an intimate relationship with a female tenant. The service plan indicated to offer privacy and if Tenant #2 wanted to end the relationship to notify the nurse. The service plan was updated after the relationship was discovered; however, the service plan did not reflect at times the other tenant slept in Tenant #2's apartment. It also did not reflect the agreement regarding Tenant #2 not leaving the building with the other tenant's family. 4. Record review on 1/8/24 and 1/9/24 of Tenant #3's file revealed a diagnosis included major depressive disorder. Interdisciplinary Notes indicated the following: a. On 11/6/23 it was noted Tenant #3 removed her briefs and defecated in inappropriate places. It was noted there was bowel movement on the carpet and on a chair in her respite room. b. On 11/21/23 it was noted staff reported Tenant #3 was incontinent of urine and stool. She removed her brief at night and was incontinent. Her nightclothes were soaked and at times the bed linens. Tenant #3 had been incontinent of bowel and used clothing to clean herself up. The	A 395	Service Plans: Tenant 1, Tenant 2, & Tenant 3's service plans were reviewed and updated with current needs/services on 3/25/2024. Service Plans will be audited with 90-day reviews to ensure the service plan is individualized and includes the residents' needs and preferences for assistance. Staff will be retrained on service plans and what should be included to ensure service plans are individualized and ensure residents' needs and preferences are met. This training will be completed with staff by April 25th, 2024.	

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A 395	Continued From page 7 soiled items were often put back in her dresser. To keep to her from using her clean clothes for incontinence clean up, a majority of her clean clothes would be locked in a closet and a few items would be left unlocked in the closet. c. On 11/21/23 it was noted Tenant #3 had loose stools every morning. A new order was received Imodium 2 milligram (mg) every day and Imodium 2 mg up to twice daily for loose stools. d. On 11/30/23 it was noted Tenant #3 had occasional tearfulness but it had improved. Tenant #3 went to bed later and slept in later in the morning. e. On 12/19/23 it was noted Tenant #3 was tearful about having her clothes taken from her that she wanted to wear. Staff reported Tenant #3 had been incontinent of stool and attempted to wash the clothing in her bathroom sink. The clothes were found with stool smeared and clothes (not clean from stool) were on heating vents. f. On 12/27/23 it was noted a new order was received to increase Imodium to 2 mg, twice daily. g. On 1/8/24 it was noted Tenant #3 still had loose stools after the Imodium was increased. When interviewed on 1/8/24 Staff A said Tenant #3 was difficult to get up and she thought maybe she was depressed. She said Tenant #3 cried and was tearful. Once she was up for the day she was okay, just getting her up was the issue. Tenant #3 missed her family, was tearful and she did it more often than before.	A 395		

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A 395	Continued From page 8 When interviewed on 1/10/24 at 10:52 a.m. the Nurse said said Tenant #3 had a loss of a family member years prior and thought it occurred recently. She also had a family member who visited and it was upsetting to her. She said at times Tenant #3 had tearfulness and it was redirected with activities. Tenant #3 had loose stools prior to her admission and they were working on the issue. Continued record review revealed Tenant #3's service plan was most recently signed on 11/30/23. It reflected Tenant #3 might have moments of tearfulness but it had improved. The service plan indicated to redirect her to activities. The service plan also reflected Tenant #3 was incontinent of bladder and bowel and wore a protective undergarment. It indicated Tenant #3 tried to clean up incontinence with clothing and she removed her brief at night. The service plan did not reflect Tenant #3's family visits that were upsetting to her and the loss of her family member related to her tearfulness. The service plan also did not reflect Tenant #3's frequent loose stools and the occurrence noted above regarding defecating in a place other than the toilet. 5. When interviewed on 1/10/24 at 11:15 a.m. the Director of Long-Term Support and Services confirmed all current service plans were provided for the tenants reviewed.	A 395		