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 01/30/2024

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. Number of tenants without cognitive disorder: 11 Number of tenants with cognitive disorder: 9 TOTAL Census of Assisted Living Program for People with Dementia : 20 No regulatory insufficiencies were cited during the investigation into Complaint #113475-C and Incident #115248-I. The following regulatory insufficiencies were cited during the investigation into Complaint #116159-C and Complaint #116281-C:	A 000	See Attached POC 3/16/24	
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medication as prescribed to 1 of 1 discharged tenants reviewed (Tenant C1). Finding follows:	A 285		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Bob Bl TITLE Interim Director (X6) DATE 2/20/24

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A 285	Continued From page 1	A 285		

Record review on 10/18/23 revealed a progress note dated 10/4/23 at 7:22 AM documented a Resident Assistant called the LPN (Licensed Practical Nurse) because Tenant C1 was unresponsive. Tenant C1 received hospice services and her daughter was at bedside. The daughter asked the program LPN to contact the Hospice RN (Registered Nurse) instead of sending Tenant C1 to the hospital. On 10/4/23 at 8:30 AM, Tenant C1 was awake and moaned in her apartment. The program RN, Hospice RN and tenant's daughter were present. Tenant C1 tested positive for Covid-19. Tenant C1's PCP (Primary Care Provider) prescribed her an antiviral medication, Molnupiravir 800 mg. on 10/4/23. She was prescribed four tablets twice daily, for five days. The RN faxed the order to the pharmacy and updated the MAR (medication administration record) with the medication orders.

On 10/9/23, the RN documented she learned Tenant C1 did not complete her antiviral medication for Covid-19. The RN notified Tenant C1's PCP doses remained of the antiviral medication. The RN received a phone order to continue the medication until all doses of the medication were administered. The RN called and spoke with the Hospice RN on 10/10/23 about the need to discontinue all oral medication as Tenant C1 was unable to swallow. The PCP approved discontinuing oral medication on 10/10/23 at 5:15 PM. Tenant C1 died on 10/10/23 at 11:30 PM.

A review of the October Medication Administration Record (MAR) for Tenant C1 revealed staff members documented they administered Molnupiravir twice daily from the evening of 10/4/23 through the evening of 10/8/23. The RN added Lagevrio (brand name for Molnupiravir) to

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A 285	Continued From page 2 the MAR for the evening of 10/9/23 and the morning of 10/10/23. Staff noted they administered the medication, four pills, both of these days. Staff at the program completed a Record of the Inventory and Destruction of Controlled and Uncontrolled Substances form on 10/13/23. The RN and LPN documented they destroyed 36 pills of Molnupiravir, indicating Tenant C1 received one dose of the medication. The Community Nurse and Community Director completed an internal investigation on 10/25/25 regarding Tenant C1 not receiving the prescribed doses of Molnupiravir and confirmed Tenant C1 did not receive the ordered doses of antiviral medication. The investigation noted staff documented medication was provided to Tenant C1 although it was not administered. On 10/24/23 at 2:05 PM the Director reported Tenant C1's antiviral medication was delivered in a bottle from the pharmacy while all of her other medication was in cards. If the staff followed the MAR, they would have realized they weren't administering the antiviral medication as prescribed. Tenant C1's certificate of death listed the immediate cause of death as systolic heart failure. Tenant C1's revised certificate of death listed Covid-19 infection under other significant conditions. When interviewed on 1/30/24 at 2:57 p.m. the Nurse Practitioner (NP) confirmed the missed doses of the antiviral medication did not impact Tenant C1's dying process.	A 285		

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A 635	Continued From page 3	A 635		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the program failed to have an operating alarm system connected to each exit door. This potentially effected all tenants at the Program (Tenant #1 - Tenant #20). Finding follows: On 10/18/23 at 2:50 p.m. the monitor set up a work space in the area described as the "messy" activity area. There was a door propped open so an electrical cord could pass through it. Workmen were observed in the building passing through the door. The area outside of the door was unsecured. Staff did not monitor the door. The door was shut by 3:15 p.m. On 10/24/23 at 12:05 p.m., the Director stated the front doors were not locked or alarmed from approximately 8:00 a.m. to 8:00 p.m. daily. Staff were generally seated within visual distance of the front door until approximately 5:00 p.m.. She could not guarantee staff monitored the front door at all times after 5:00 p.m., especially on the weekends. The three exit doors to the exterior courtyards were not alarmed. Two of the doors exited onto unsecured courtyards on each side of the building. One door went to the semi-secured courtyard which had a snow fence over a section of the fence.	A 635		

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A 635	Continued From page 4 The program ensured all exit doors were alarmed by the end of the day on 10/24/23. They trained staff on the use of the door alarms on 10/25/23.	A 635		
A 710	481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to maintain the building and grounds in a safe manner. This potentially effected all tenants at the Program (Tenant #1 - Tenant #20). Findings follow: A tour of the building on 10/18/23 at 4:05 p.m. with the Director revealed the following: 1. A fire door at the top of a stairway was not locked or alarmed. The Director reported it should be locked and alarmed. A new handle for a door sat on the inside of the stairwell. The drywall was gouged out at the top of the door frame for an unknown reason. The Director stated the locking plate on the hallway side of the door appeared loose. The Program no longer employed maintenance personal and the Director stated the issues with the door were not reported to her. 2. The courtyard at the back of the building had a wooden fence around it. An approximately six foot area of the fence was missing. A piece of sagging orange storm fencing was placed in the	A 710		

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A 710	Continued From page 5 six foot gap. The Director said the fence piece was missing when she started in May 2023. The Administrative Assistant believed the fence piece came down in March, 2023. The Director confirmed the findings during the tour.	A 710		

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Tag #1	**481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following:** **f. When medications are administered traditionally by the program:** **(4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.** This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medication as prescribed to 1 of 1 discharged tenants reviewed (Tenant C1).	**A 285**	Staff 1, 2, 3, 4, 5 were reeducated on Medication Administration and Six Rights of Medication on 10/11/2023. These staff were counseled for the medication issues on 10/18/2023. HCC and AHCC were both counseled and re-educated regarding medication policy and expectations on 11/1/2023. AHCC no longer employed last day 12/6/23 HCC no longer employed last day 2/15/24. Medication Error/ Incident Report was completed for tenant C1 on 10/24/2023. All Med Managed employees will be reeducated regarding the Medication Administration process and the Six Rights of Medication administration by 03/16/2024.	Director, Nurse or Designee will complete weekly, monthly, as needed, as determined by the Director or designee, audits of medication cards/EMARs to ensure scheduled medications have been administered as ordered. Upon completion of a medication manger course, employees will be educated regarding the Medication Administration process and the Six Rights of Medication administration.	**Implementation Date:** 10/18/2023 **Completion Date: Ongoing** **Responsible Party: Director and/or designee**

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.

Tag #2	**481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program**. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the program failed to have an operating alarm system connected to each exit door. This potentially effected all tenants at the Program (Tenant #1 - Tenant #20)	**A 635**	New Arial Wide Gap Alarm placed on IL Activity Door Fire Exit on 10/24/2023 Battery was replaced in Arial Wide Gap alarm for the IL Courtyard on 10/24/2023. All exit doors were checked for proper alarm functioning on 10/24/2023 and non-functioning alarms were replaced immediately. An Immediate POC was implemented on 10/25/2023 and sent to Catie Campbell on 10/25/2023 as well. a. Audit tool implemented for checking of each exit door for appropriate functioning. This will occur weekly as needed until a sufficient process and compliance is sustained. b. Instant In-service Provided to all staff 10/25/2023. c. Labeling of the Doors Implemented to Assist in Identifying Locations of Alarms on 10/25/2023.	All exit doors for AL and MC, will have functioning Arial Wide Gap Alarms by 11/9/23. Director or Designee will complete door alarm checks daily, weekly, monthly and as needed to ensure appropriate functioning.	**Implementation Date:** 10/24/2023 **Completion Date: Ongoing** **Responsible Party: Director and/or designee**
Tag #3	**481-69.35(1)b Structural Requirements 69.35(1) General requirements.**	**A 710**	Bids for Fence/Panel Replacement obtained on 11/15/23.	Director or Designee will complete weekly, monthly, as needed, as	**Implementation**

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	b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to maintain the building and grounds in a safe manner. This potentially affected all tenants at the Program (Tenant #1 - Tenant #20).		The door lock of stairwell door fixed as of 11/9/23. Previous Director is no longer employed as of, 11/29/23.	determined by the Director or designee, fence audit to ensure it is well maintained and safe. Maintenance Coordinator or Designee will complete weekly, monthly, as needed, as determined by the Director or designee rounds of the community and grounds to ensure compliance.	**Date:** 10/24/2023 **Completion Date: Ongoing** **Responsible Party: director and/or designee**

Compliance Date: 03/16/2024

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