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 07/25/2024

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 impairment: 10 Number of tenants with cognitive impairment: 4 Total census: 14 The following regulatory insufficiencies were cited during the investigation of Complaint #117522-C, #118869-C, #120657-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	The POC is attached	
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 facility failed to administer medication as ordered to 1 of 5 discharged tenants reviewed (Tenant C1). Findings include: Record review on 7/22/24 revealed a summary of	A 285		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 285	Continued From page 1	A 285		

a hospitalization for Tenant C1 dated 12/6/23. Tenant C1 was admitted to the hospital on 12/1/23 with diagnoses of diabetic ketoacidosis, acute kidney injury and Type II diabetes with hyperglycemia.

The summary included information about changes to her previous medication, such as insulin, as well as medication she should continue taking. Tenant C1 was to decrease the amount of insulin glargine she took from 10 units twice daily to 6 units every morning.

A progress note from the program identified the corporate Clinical Specialist reconciled the medication list. She documented there were new orders for insulin glargine, 6 units twice daily (this was incorrect).

The December 2023 Medication Administration Record (MAR) directed staff to administer Tenant C1 6 units of insulin glargine (with a brand name of Lantus Solos) at 8:00 AM and 8:00 PM beginning on 12/6/23.

The hospital discharge list did not include the medication Metformin. The MAR directed staff to administer this medication twice daily which they did.

On 7/22/24 at 11:38 PM, the Regional Nurse Specialist reported the program transitioned from one electronic record system to a new one. Tenant C1 was to take a short acting insulin, Novolog, before consuming meals. When information about Tenant C1's Novolog was entered into the new MAR, there were duplicate orders placed in the system for Novolog.

Program staff documented for a short period of

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A 285	Continued From page 2 time on the MARs from the old electronic record system as well as the new system. On 12/9/23, two different staff both documented they administered Famotidine, Potassium Chloride and Thera-M at 8:00 AM. Tenant C1 was to begin taking Ferrous Sulfate following her hospital discharge on 12/6/23. It was not added to the MAR upon her discharge from the hospital as ordered. On 7/23/24 at 10:39 AM the Regional Nurse Specialist confirmed these findings.	A 285		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review, staff failed to provide supervision based on the training received to 1 of 3 current tenants (Tenant #3) and 1 of 5 discharged tenants (Tenant C3) reviewed. Findings include: 1) Record review on 7/21/24 revealed program staff completed an internal investigation following an incident involving Tenant #3. On 3/29/24 at 6:50 AM, Staff E noted Tenant #3 laying in bed with a laceration above her right eye, dried blood	A 361		

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A 361	Continued From page 3	A 361		

on her face and bruising to her eyes. The on-call nurse was contacted and Tenant #3 went to the emergency room for an evaluation. A hospital after visit summary noted Tenant #3 was hospitalized from 3/29/24 until 3/31/24.

Tenant #3 had a monthly task log which included the need for staff to check on her every hour daily. A review of the Monthly Task Log revealed the only entries made on 3/29/24 were at 5:34 AM (two entries made at this time noting Tenant #3 was fine and asleep) and at 9:26 AM (staff noted Tenant #3 was fine, although she was at the emergency room by this time). No entries were made on the Monthly Task Log from 12:00 AM - 5:33 AM on 3/29/24. Tenant #3 was found with visible injuries at 6:50 AM, more than one hour after her previously documented check at 5:34 AM.

On 7/24/24 at 10:28 AM, Staff E reported she came to work at 6:00 AM. She did rounds a short time after this and peeked into Tenant #3's apartment. The lights were off and she was unable to see Tenant #3. Staff E returned to Tenant #3's apartment to get her up for breakfast and saw bruising on Tenant #3's entire face. There was blood on the couch, in the bathroom and on her bedding. Staff E recalled Staff F told her the last time staff checked on Tenant #3 was at midnight. She was aware Tenant #3 was supposed to receive hourly visual checks, 24 hours a day. Staff were to document the checks on a tablet when they were done. If staff missed an hourly check, they received a notification to complete it.

On 7/24/24 at 10:52 AM, Staff F reported she completed visual checks on Tenant #3 hourly, but did not document them. She was unsure why the

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A 361	Continued From page 4 visual checks were not completed timely. The program had skills delegations forms which documented the training staff received within the first 30-days of hire on how to complete visual checks on tenants. Staff were to enter the apartment and find out if the tenant was awake or sleeping. They were to document the visual check in on the tablet according to the scheduled check time. The tenant should be viewed throughout the entire shift to ensure safety. Following the incident, staff were re-educated on timely completion of visual checks and accurate documentation due to the injury noted related to Tenant #3's incident. Staff were to make visual contact with a tenant. If a tenant was sleeping they were to ensure the tenant was still breathing. Visual checks were to be completed as close to the scheduled time as possible. It was important for the tenant to be viewed throughout the entire shift to ensure tenant safety. 2) Record review on 7/22/24 revealed program staff completed an internal investigation after Tenant C3 suffered a fall. On 7/4/24 at 4:30 PM, Staff D entered Tenant C3's apartment and noted she was laying on her right side on the floor next to her bed. Tenant C3 reported right hip pain. Staff D contacted the on-call nurse and was instructed to send Tenant C3 to the emergency room for an evaluation. On 7/5/24 at 10:48 AM, the community nurse was notified by a nurse at the hospital Tenant C3 had a fractured right hip and brain bleed. The summary of the investigative findings revealed Tenant C3 was wandering around a lot during the shift she fell. Staff redirected her at times to use her walker or have a seat. Tenant C3	A 361		

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A 361	Continued From page 5 was assisted to bed at approximately 3:00 PM for a nap prior to supper. When staff went to assist her to the dining room for supper, she was laying on the floor. Tenant C3 had a history of getting up on her own without calling for staff assistance. The monthly task log for Tenant C3 identified staff were to provide visual/safety checks based on memory care protocol. The schedule for the checks was every 1 hour daily. Staff D filled out the task log form on 7/4/24 at 5:43 PM writing Tenant C3 was ok (although by this time she was at the emergency room), 8:42 PM and at 9:17 PM (Tenant C3 was out of the facility at these times). No staff documented they saw Tenant C3 from 3:00 PM to 4:30 PM in a timely manner when she was in her apartment alone. 3) On 7/24/24 at 2:21 PM the Health Care Coordinator reported the expectation was for staff to check on tenants with memory care protocol each hour and document the check when completed. On 7/24/24 at 11:12 PM the Regional Nurse Specialist reported the 3:00 PM, 4:00 PM and 5:00 PM visual checks for Tenant C3 were signed off by Staff D at 5:43 PM, which was why the re-education on visual check completion was done with staff. Tenant #3's last visual check prior to the incident was at 5:43 AM.	A 361		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued	A 145		

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A 145	Continued From page 6 eligibility for the program and to determine any changes to services needed. 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. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to evaluate the needs of 1 of 5 discharged tenants reviewed when needs changed (Tenant C2). Findings follow: Record review on 7/23/24 revealed Tenant C2 had a hospice order dated 5/4/24 for wound care to his coccyx for a stage II pressure ulcer. The hospice/facility nurse was to perform wound care once per week and/or as needed if the dressing was saturated or loose. A review of the Medication Administration Record showed a a new order dated 5/6/24. Staff were directed to change Tenant's C2 foam dressing on Fridays. Tenant C2 had a comprehensive assessment dated 4/18/24. It identified his overall skin condition as normal with no active wounds. Tenant C2 was not further assessed after developing a stage II pressure ulcer. On 7/23/24 at 11:30 am the Health Care Coordinator confirmed this finding.	A 145		

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A 395	481-69.26(4)a 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 revise the service plan when needs changed for 1 of 5 discharged tenants (Tenant C2) and 1 of 3 current tenants (Tenant #1)reviewed. Findings follow: 1) Record review on 7/23/24 revealed Tenant C2 had a hospice order dated 5/4/24 for wound care to coccyx for a stage II pressure ulcer. The hospice/facility nurse was to perform wound care once per week and/or as needed if the dressing was saturated or loose. A review of the Medication Administration Record showed a a new order dated 5/6/24. Staff were directed to change Tenant's C2 foam dressing on Fridays. Tenant C2 had a service plan dated 4/18/24. The service plan was not updated to address Tenant C2's wound care needs. On 7/23/24 at 11:30 am the Health Care Coordinator confirmed this finding. 2) Tenant #1 had a comprehensive assessment dated 7/12/24. Tenant #1 required total staff assistance for bathing with preferences noted for	A 395		

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A 395	Continued From page 8 showers. Staff were to ensure she used a shower chair or bench with showering. On 7/23/24 at 12 pm Staff B stated when assisting Tenant #1 with bathing she did not give Tenant #1 showers but instead utilized wipes and bed baths. Tenant #1 screamed or yelled for help when given a shower. When interviewed on 7/23/24 at 10:30 am Staff E stated when assisting Tenant #1 with bathing the tenant yelled and was agitated so she sometimes gave her bed baths. On 7/24/24 at 10:45 am Staff C stated when assisting Tenant #1 with bathing she provided the tenant with showers and bed baths. Tenant #1 screamed or yelled for help when given a shower, but seemed less agitated when given a bed bath. Tenant #1 had a service plan dated 7/12/24. The service plan did not reflect Tenant #1's preference for bed baths rather than showers. On 7/24/24 at 11:12 pm the Regional Nurse Specialist confirmed this finding.	A 395		
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, interview and record review, the program failed to ensure an operating	A 635		

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A 635	Continued From page 9	A 635		

alarm system was connected and in use at all times at each exit door potentially affecting 4 of 10 tenants with cognitive impairment. Findings follow:

The building had two double doors at the main entrance to the building. The interior double door, to which the alarm was connected, was propped open on 7/22/24 and the majority of 7/23/24 when monitors were present. Observations on 7/22/24 and 7/23/24 revealed the following examples of times the exit door at front of the building was not able to function properly due to being propped open:

- 7/22/24 at 10:10 AM, the interior double door was propped open with no staff present for approximately two minutes.
- 7/22/24 at 10:34 AM, the interior double door was open without a staff member present to monitor the exit.
- 7/22/24 at 5:00 PM, the interior double door was propped open. No staff were in the vicinity until 5:08 PM.
- 7/23/24 at 8:00 AM, the interior double door was propped open without any staff in the area.

During a previous visit from the department the program was cited for not having an operating alarm system connected to each exit door. The program submitted an immediate plan of correction on 10/25/23 identifying they would check each door weekly to ensure the door alarms were functioning. All exit doors would have a functioning Arial Wide Gap alarm by 11/9/23.

On 7/22/24 at 4:20 PM, Staff A reported staff received alarms on their walkie talkies when people went in and out of the doors. They generally kept the front interior door propped

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A 635	Continued From page 10 opened so it would not constantly alarm. The front interior door was shut at 10:00 PM. On 7/23/24 at 3:20 PM, the Regional Nurse Specialist confirmed all doors needed to have functioning alarms but the front door would not alarm if it was propped open. When she entered the building on 7/23/24, the door was open and no staff were in the area. The Regional Nurse Specialist said she would ensure the front door remained closed.	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 properly maintain the fencing surrounding an enclosed courtyard. Findings follow: On 7/23/24 at 3:20 PM an observation of the courtyard area with the Regional Nurse Specialist revealed a portion of the fencing was missing. The gap in the fence was enclosed with orange safety fencing. During a prior visit to the program by the department on 10/18/23, the same fence panel was missing. The program noted on a plan of correction a bid for a fence panel replacement was obtained on 11/15/23. The program would have the work completed by 3/16/24.	A 710		

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A 710	Continued From page 11 On 7/24/24 at 10:22 AM, the Regional Director of Sales and Operations reported when she became the Regional Director in April of 2024, the new program Director said he had a cheaper, better option to repair the fence and she encouraged him to follow up with this. When another Regional Director was in the building at a later date, that person noted the fence was not repaired. The Regional Director of Sales and Operations talked with the Director and he assured her it would be taken care of. When she got to the program on 7/23/24, she saw the fence was not fixed and made a plan with the maintenance director to have the fence company install the panel as soon as possible.	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 facility failed to administer medication as ordered to 1 of 5 discharged tenants reviewed (Tenant C1).	**Tag # A 285**	HCC and AHCC will be re-educated on timely order processing by 10/31/24. Tenant C1 discharged from the community.	Director or Designee will complete routine audits of order implementation, medication administration, and documentation to ensure compliance.	**Implementation Date: 7/31/2024** **Completion Date:** Ongoing **Responsible Party: Director 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	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review, staff failed to provide supervision based on the training received to 1 of 3 current tenants (Tenant #3) and 1 of 5 discharged tenants (Tenant C3) reviewed.	**Tag # A 361**	HCC and AHCC will be retrained on service plan expectations by 10/31/24. All staff were reeducated on visual checks on 8/30/24.	Director or Designee will complete routine audits to ensure compliance.	**Implementation Date:** 07/23/2024 **Completion Date:** Ongoing **Responsible Party: Director or Designee**
Tag#3	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. 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. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	**Tag # A 145**	An audit of all current tenants who receive wound care was done on 08/15/24 to ensure all wound care ordered and provided is on the service plans. HCC and AHCC were re-educated on change of condition timepoints and expectations on 10/31/24. Tenant CS was discharged on 6/8/24.	HCC and AHCC will be retrained on service plan expectations by 10/31/24. Director or Designee will complete routine audits to ensure compliance.	**Implementation Date:** 07/23/24 **Completion Date:** Ongoing **Responsible Party: Director or Designee**

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Tag#4	481-69.26(4)a 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 revise the service plan when needs changed for 1 of 5 discharged tenants (Tenant C2) and 1 of 3 current tenants (Tenant #1) reviewed.	**Tag# A 395**	Tenant #1: service plan was updated to reflect behaviors and bathing preference on 7/25/24. An audit of all current tenant service plans was done on 8/15/202 to ensure that any behavior and bathing preferences are identified on the service plans.	HCC and AHCC will be retrained on service plan expectations by 10/31/24. Director or Designee will complete routine audits to ensure compliance.	**Implementation Date**: 7/23/24 **Completion Date:** Ongoing **Responsible Party:** Director or Designee
Tag #5	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, interview and record review, the program failed to ensure an operating alarm system is connected and in use at all times at each exit door potentially affecting 4 of 10 tenants with cognitive impairment.	**Tag # A 635**	The front door was immediately secured on 7/23/24 and the alarm was checked to ensure proper functioning. All coordinators were educated on 10/31/24 regarding not propping any exit doors open and that all exit doors need to be locked and alarmed. All staff will be educated on not propping open exit doors and reporting any issues with doors to their supervisor immediately on 8/30/24.	Director or Designee will complete routine door alarm checks to ensure appropriate functioning.	**Implementation Date: 7/23/24** **Completion Date:** Ongoing **Responsible Party: Director or Designee**
Tag #6	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	**Tag # A 710**	Bids for Fence/Panel Replacement obtained on 11/15/23. Signed approval to replace the fence on 3/1/2024. Parts were ordered on 7/31/2024, Huber Fencing received the parts and completed the Fence/gate installation on 9/6/24.	Director or Designee will complete routine audits as determined by the Director or designee, to ensure the fence is well maintained and safe.	**Implementation Date: 7/23/24** **Completion Date:** 9/6/24

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	properly maintain the fencing surrounding an enclosed courtyard.				**Responsible Party: Director or Designee**

Compliance Date:_____10/17/2024_____

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