

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE CEDARS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6325 ROCKWELL DRIVE NE 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 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: 2 Number of tenants with cognitive impairment: 10 Total census: 12 The following regulatory insufficiencies were cited the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000	1. The program has updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure as of September 23, 2024 (a copy of which is attached as Exhibit A). The updated policy includes an exhibit which provides examples changes to a tenant's condition that would be considered a significant change and necessitate an evaluation and service plan change. 2. The Director of Health and Wellness will ensure that all Health and Wellness staff shall be retrained in the updated Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure by October 7, 2024. The Director of Health and Wellness will review resident service plans on a regular basis in conjunction with observation to ensure services plans are comprehensive. 3. The program updated the existing electronic charting system on September 24, 2024, to capture services, needs, observations, and tasks. 4. All service plans will be reviewed for adherence to the Community's policies not later than October 20, 2024.	
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 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	A 145		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2024
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KEYSTONE CEDARS MEMORY CARE

**6325 ROCKWELL DRIVE NE
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 145	Continued From page 1 Program failed to complete evaluations as needed with significant change. This pertained to 1 of 1 tenant reviewed who received wound care (Tenant #2). Findings follow: 1. Review of Tenant #2's file on 7/30/24 and 7/31/24 revealed a hospice Physician Orders document indicating the following: - On 7/26/24 an order was received to start a lateral foot treatment to remove the old dressing and cleanse with wound spray. Pat dry with gauze and apply Optifoam pad border dressing to cover the wound. Change the dressing every three days and as needed if it was soiled, saturated, or missing. - On 7/29/24 an order was received to change the current treatment for the open area on the right lateral foot and to discontinue Optifoam every three days. They were to change the Optifoam twice per week and keep the order to change as needed (PRN) if it was soiled, saturated, or missing. A Wound Details hospice document indicated on 7/29/24 the wound was assessed. It measured 2.3 centimeters (cm) x 3.3 cm x 0.02 cm. The surface area was 7.59 squared cm. It was noted as a suspected deep tissue injury. Further review revealed evaluations were last completed for Tenant #2 on 7/26/24 related to the increased use of her wheelchair; however, the evaluations did not reflect the open wound on Tenant #2's right lateral foot. Evaluations were not completed as needed with significant change when the open wound on the right lateral foot was noted and treatment was ordered. 2. When interviewed on 8/6/24 at 11:50 a.m. the Director of Health and Wellness said Tenant #2	A 145		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE CEDARS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6325 ROCKWELL DRIVE NE 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 145	Continued From page 2 had chronic weeping lower extremities. She said a new lateral right foot order was received to change three times per week and as needed. She confirmed all evaluations requested for the tenants reviewed were provided.	A 145		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans to reflect the service needs of the tenants. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file on 7/30/24 and 7/31/24 revealed a Physician Order Sheet reflecting medications could be crushed and placed in applesauce or pudding. The document also reflected an order for Boost (nutritional supplement) drink, one beverage everyday in the morning was ordered. Observation Notes in the file indicated the following:	A 350	1. The program has updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure as of September 23, 2024 (a copy of which is attached as Exhibit A). The updated policy includes an exhibit which provides examples changes to a tenant's condition that would be considered a significant change and necessitate an evaluation and service plan change. 2. The Director of Health and Wellness will ensure that all Health and Wellness staff shall be retrained in the updated Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure by October 7, 2024. The Director of Health and Wellness will review resident service plans on a regular basis in conjunction with observation to ensure services plans are comprehensive. 3. The program updated the existing electronic charting system on September 24, 2024, to capture services, needs, observations, and tasks. 4. All service plans will be reviewed for adherence to the Community's policies not later than October 20, 2024.	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2024
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KEYSTONE CEDARS MEMORY CARE

**6325 ROCKWELL DRIVE NE
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 350	Continued From page 3 - On 6/4/24 an order was requested for physical therapy (PT) and occupational therapy (OT) to improve strength and balance to decrease and/or prevent future falls. - On 6/11/24 therapy reported she refused to work with them. - On 6/19/24 Tenant #1 was discharged from therapies on 6/11/24 due to consistently not participating. - On 7/9/24 it was noted Tenant #1 was being seen twice weekly by PT for history of falls. - On 7/23/24 it was noted Tenant #1 was being seen twice per week by PT. She was unable to remember safety questions but participated for the full session. Review of the June and July 2024 task administration records reflected Tenant #1 refused bathing six times when it was scheduled. Tenant #1's service plan did not reflect the crushed medications in applesauce or pudding, the nutritional supplement, PT services that were currently being provided or the bathing refusals. 2. Review of Tenant #2's file on 7/30/24 and 7/31/24 revealed hospice Physician Orders indicated the following: - On 7/26/24 an order was received to start a lateral foot treatment to remove the old dressing and cleanse with wound spray. Pat dry with gauze and apply Optifoam pad border dressing to cover the wound. Change the dressing every three days and as needed if it was soiled, saturated, or missing. - On 7/29/24 an order was received to change the current treatment for the open area on the right lateral foot and to discontinue Optifoam every three days. They were to change the Optifoam twice per week and keep the order to	A 350		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE CEDARS MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6325 ROCKWELL DRIVE NE 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 350	Continued From page 4 change as needed (PRN) if it was soiled, saturated, or missing. A Wound Details hospice document indicated on 7/29/24 the wound was assessed. It measured 2.3 centimeters (cm) x 3.3 cm x 0.02 cm. The surface area was 7.59 squared cm. It was noted as a suspected deep tissue injury. Tenant #2's service plan was updated on 7/26/24; however, did not reflect the open wound on the right lateral foot or the treatment ordered. 3. Review of Tenant #3's file on 7/31/24 revealed Observations (nurse's notes) indicated the following: - On 5/3/24 Tenant #3 pushed himself backward when seated in his chair and hit his head on the floor. He had an abrasion and swelling. - On 6/6/24 a staff communication document was received regarding a skin irritation to his toes. The primary care provider (PCP) was notified and would assess him on Monday. - On 6/10/24 a staff communication document was received regarding itching feet. The PCP was going to see his feet today. - On 6/10/24 a new order was received for doxycycline 100 milligram (mg), twice daily for 10 days for itching to the lower legs. - On 6/28/24 it was noted on 6/27/24 that staff found Tenant #3 on the floor next to his bed. - On 7/22/24 a staff communication document was received (dated 7/18/24) regarding a sore on Tenant #1's great toe. A bunion pad was requested on 7/25/24. - On 7/27/24 a new order was received for bunion pads. A Long Term Care Facility Acute Visit completed by the PCP on 6/10/24 indicated nursing staff had	A 350			

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE CEDARS MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6325 ROCKWELL DRIVE NE 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 350	Continued From page 5 concerns related to itching. The worst affected area was on his scrotum. On exam there some areas to the sides of his trunk that had been scratched as well. Staff kept fingernails trimmed. Tenant #3 had a history of methicillin-resistant staphylococcus aureus (MRSA) skin infection with a good response to doxycycline. New orders were received for doxycycline 100 mg twice daily for 10 days and Hibiclens to be used with showers. Tenant #3's service plan indicated he was a risk for falls and to complete an incident report if a fall occurred. The service plan did not reflect fall interventions for Tenant #3. The service plan identified Tenant #3 had a history of scattered rash; however, did not reflect Tenant #3's history of MRSA and interventions or precautions needed. 4. Review of Tenant #4's file on 7/31/24 revealed Observations (nurse's notes) indicated the following: - On 5/14/24 Tenant #4 was discharged from PT and OT. - On 5/20/24 Tenant #4 was found on the floor and had hit his head on the floor. - On 7/8/24 Tenant #4 was heard yelling for help in his apartment. He was found on the floor. - On 7/16/24 orders were received to evaluate for PT and OT - On 7/23/24 a weekly therapy note indicated Tenant #4 received PT/OT three times per week. Tenant #4's service plan indicated he was a risk for falls and to complete an incident report if a fall occurred. The service plan did not reflect fall interventions for Tenant #4. The service plan reflected PT and OT started on 2/13/24. The service plan was not updated when therapies	A 350			

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE CEDARS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6325 ROCKWELL DRIVE NE 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 350	Continued From page 6 were discontinued in May or when therapies were initiated again in July. 5. When interviewed on 8/6/24 at 11:50 a.m. the Director of Health and Wellness confirmed all service plans requested were provided for the tenants reviewed.	A 350		