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
	S0389	A. BUILDING: _____ B. WING _____	C 02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE CEDARS AL	6325 ROCKWELL DRIVE NE CEDAR RAPIDS, IA 52402

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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. Number of tenants without cognitive disorder: 44 Number of tenants with cognitive disorder: 7 TOTAL census of Assisted Living Program: 51 The Program met the definition of a dementia specific program at time of the recertification visit initiated on 2-3-22. The Program was made aware of the designation at the time of the visit. An onsite infection control visit was completed and no regulatory insufficiencies were identified. A comment was made to the program regarding at times observing staff not wearing their masks. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program and the investigation of Complaints of #94772-C and #102011-C.	A 000	POC ATTACHED OK 5-18-22	
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 its policies and procedures related the completion of incident reports. This pertained to 1 of 6 tenants reviewed (Tenant #2). Findings follow:	A 150		

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A 150	Continued From page 1 1. Record review of an Incident Report indicated on 1-27-22 at 7:15 p.m. staff went to get Tenant #2 to take her back to her apartment, as an activity had just ended. There was a commotion in the activity room with other tenants and staff got to Tenant #2 and noted she was convulsing. The staff who responded (no name provided in the incident report) called Staff D, a medication aide, for assistance and to take vitals. Tenant #2 convulsed for a few minutes, stopped and then slumped to her right side. Tenant #2 began to breathe very heavy, her eyes did not blink and began to water and her mouth was drooped to the right side. Staff D talked to her and "continually rubbed tenant's sternum to attempt getting back to alertness." Tenant #2 did not stop breathing; however, was "out for 5-10 minutes" before she starting blinking or would squeeze the staff's hand. Tenant #2 started to slowly squeeze staff's hand when prompted by staff and attempted to respond verbally. Tenant #2 returned to her baseline overnight; however, 10 minutes after the incident started she was not at her baseline. Tenant #2 was oriented to person but not to place or time. The report indicated Tenant #2 reaction to the incident, she was unresponsive for 5 to 10 minutes and then said she wanted to finish the activity. Staff got a bingo card with chips and pretended to finish the game as staff felt it was helping her form sentences again and kept her awake. Staff obtained vital signs and took her back to her apartment in a wheelchair. Staff walked back with the other staff to Tenant #2's apartment and called the on-call nurse for further instructions. The on-call nurse was notified on at 7:27 p.m. and instructed staff to obtain vital signs, take her	A 150		

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A 150	Continued From page 2	A 150		

back to her apartment and to put Tenant #2 into bed. One hour safety checks were also put into place throughout the night. She instructed staff to contact Tenant #2's family and to update the nurse with any changes from Tenant #2's baseline.

The incident report reflected Tenant #2 vital signs were as follows: temperature 96.9, pulse was 86, respiration rate 17 and blood pressure was 96/69.

Tenant #2's primary care physician (PCP) was notified on 1-31-22. The report indicated Tenant #2's family was notified on 1-28-22 at 7:59 p.m. The Director of Health and Wellness signed the incident report on 1-31-22. The report was signed and dated by Staff D on 1-28-22. The incident with Tenant #2 occurred on 1-27-22.

2. When interviewed on 2-9-22 at 4:19 p.m. Staff D said she was working second shift on the day of Tenant #2's incident and was the medication aide. She said Staff E called for vitals to the activity room. He had gone to the activity room, right as bingo was finished. He went to get Tenant #2 and she started convulsing when he got to her. When Staff D arrived Tenant #2 was in a wheelchair and was slumped to the left side. Tenant #2 did not look well, she convulsed; however, not rapid. She reported it did not look like a seizure. Staff E went to her apartment to get her hospice binder, Staff D called hospice and was told Tenant #2 was not a patient. She was not aware Tenant #2 had been discharged from hospice. Tenant #2's eyes were open, she remained in the wheelchair, she was "out of it" and sounded like she was struggling to breathe. She had a pulse present and did not stop breathing. Staff D rubbed her sternum for about five to six minutes, she said chest compressions

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were not completed and she did not attempt to perform cardiopulmonary resuscitation (CPR). It was approximately 5 to 10 minutes and Tenant #2 slowly started to squeeze her hand and talked to her. She said Tenant #2 started back to her baseline at 15 to 20 minutes. When she first woke up she wanted to play bingo. She called Nurse #1, the on-call nurse, and was told to take her back to her apartment and lay her down. She was told to call Tenant #2's family and see what they wanted to do. She called Tenant #2's family that night and Tenant #2 was not sent out for evaluation. One hour checks were also put in place for Tenant #2. Staff E got Tenant #2 ready for bed and he would have completed the safety checks. She said wrote down vital signs on scratch paper. She said she might have filled the incident report related to this incident the next day. Staff D said she called Tenant #2's family the same day of the incident.

Attempts to contact Staff E for an interview were unsuccessful.

When interviewed on 2-7-22 at 4:43 p.m. Nurse #1 said Staff D notified her that Tenant #2 had a transient ischemic attack (TIA) episode but it lasted longer than usual. She was told it happened in the activity room. She told Staff D to take Tenant #2 to her apartment, lay her in bed and take her vitals. She called with her vitals and the electronic system was updated to reflected one hour safety checks. She told Staff D to call her family and let them know about the incident and to give family the option of sending her out. Nurse #1 was not contacted again related to Tenant #2. Staff D did not tell her what Tenant #2's family said. She did not follow up the next day to see what happened. The Director of Health and Wellness came in and saw her the

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next morning. Nurse #1 said she was not aware of the right side facial drooping or sternum rub at the time of the incident. The next day Nurse #1 was told by Staff F that she heard Staff D started CPR on Tenant #2. Staff D worked the next day and she denied starting chest compressions. The incident report was filled out in the afternoon the next day. Staff E was helping Staff D and he did not complete a witness statement.

When interviewed on 2-9-22 at 2:31 p.m. the Director of Health and Wellness said on 1-28-22 staff reported Tenant #2 did not feel well, did not eat breakfast and was in bed. She went to see Tenant #2, she was on the couch, dressed and was watching television. She watched her walk, checked her hand grips, she felt good and went to breakfast. She went on with her day and did not know about the incident from night prior until later Friday afternoon. Nurse #1 asked her if she followed up on the incident report from Thursday night for Tenant #2. The Director of Health and Wellness said she had not seen an incident report related to the incident. Nurse #1 told there Tenant #2 had an unresponsive episode in the activity room and Staff D had called her. Nurse #1 had told Staff D to take Tenant #2 to her apartment and take vitals. The Director of Health and Wellness told Nurse #1 to have Staff D fill out an incident report and to make sure Tenant #2's family had been contacted. On Monday 1-31-22, she saw the incident report related to Tenant #2 and went to see her. A fax was sent to Tenant #2's PCP on Monday. She said Staff E was also there when the incident occurred. She said incident reports should be completed on the same shift of the incident.

When interviewed on 2-8-22 at 2:35 p.m. Staff F said she was the medication aide in the memory

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care unit. Staff D asked her to check Tenant #2's code status. She went to the laptop and saw that indicated do no resuscitate and she reported it to Staff D. Staff D said that Tenant #2 "back with us." Tenant #2 was back in bed. She never talked to Staff D about the incident but did talk to Staff E. Staff E told her that he went to the activity room and another tenant was holding Tenant #2's hands and she was slumped over in her wheelchair. Staff E called Staff D to the activity room and to bring vitals. Staff E was sent to her apartment to get her hospice binder and when he came back Staff D was completing chest compression on Tenant #2 in the wheelchair. Staff D said they had her back and Tenant #2 was taken to her apartment and she had lost her bowels. Staff F said Staff E reported that Staff D called Nurse #1 after the fact and Nurse #1 said not to call the family and she would get a hold of family. The next day Staff F told nursing staff about it and Staff D was called in to write an incident report as she did not write an incident that day.

When interviewed on 2-9-22 at 10:03 a.m. the Executive Director said she heard gossip that a staff did chest compressions or a sternal rub. The incident report should have been filled out that shift. She had heard it was completed after. She confirmed Staff E did not complete a witness statement.

An incident report was completed by Staff D related to the incident; however, it was not completed until the following day, on 1-28-22. A witness statement was not completed by Staff E related to the incident with Tenant #2.

3. Continued record review of Tenant #2's file revealed a diagnosis of history of TIAs. Tenant

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#2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The service plan dated 2-7-22 reflected Tenant #2 had a history of transient alteration of awareness. Tenant #2 had been to the emergency department (ED) previously for evaluation and a cause could not be determined. The service plan indicated to fill out an incident report and to notify nursing.

Observation notes indicated the following:

-On 3-18-21 at 10:00 a.m. it was noted Tenant #2 was unresponsive in the salon chair and a nurse responded. Tenant #2 responded to pain but not verbal or physical stimuli. Tenant #2's eyes were rolled back and her mouth was open. The nurse began to obtain vital signs and Tenant #2 became more responsive. Tenant #2 "came around" in approximately five minutes. At approximatley 10:15 a.m. staff were called to Tenant #2's apartment as Tenant #2 was "fumbling" her words and had word salad. Tenant #2's family said Tenant #2 had a TIA that summer and her symptoms "mirror" a TIA. Tenant #2's family was visiting and agreed to have Tenant #2 sent out for an evaluation at the ED.

-On 3-18-21 at 4:15 p.m. it was noted Tenant #2 was brought back from the ED by her family. Tenant #2's diagnosis included: syncopal episode and acute cystitis.

-On 8-4-21 it was noted Tenant #2 was observed outside by a visitor's car and needed help. Staff did not report seeing Tenant #5 go out the front door but staff had observed her walking towards the front door at approximatley 4:30 p.m. Staff went out to walk her back inside. A nurse went to see Tenant #2 due to "confusion and getting lost

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A 150	Continued From page 7 outside." Tenant #2 knew she was in the front lobby but could not name the building. The service plan was updated to reflect one hour safety checks until the following morning, when the PCP could be contacted regarding her confusion. Tenant #2 had been prescribed an antibiotic for a urinary tract infection and it was scheduled to be completed on 8-6-21. Further record review revealed incident reports were not completed related the unresponsive episode on 3-18-21 or the incident on 8-4-21 when Tenant #2 was confused and outside of the building. 4. Continued record review revealed the Program's Incident Report policy and procedure indicated all incidents that were "unusual, improper or harmful" to a tenant would be reported. The person in charge at the time of the incident would complete the report. The incident report "must be completed on the shift that the incident occurred or was discovered." The report would include the following: name of staff who first discovered the incident, staff and witnesses present and the level of consciousness and ambulatory status prior to the incident. The Director of Health Services or the Executive Director would notify the tenant's family and documented the notification and discussion. An investigation of the incident would occur when the incident report was received. 5. When interviewed on 2-21-22 at 12:38 p.m. the Executive Director confirmed all incident reports and witness statements were provided.	A 150		
A 160	481-67.3(2) Tenant Rights	A 160		

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A 160	Continued From page 8 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate services to a tenant. This pertained to 1 of 1 tenant reviewed with an unresponsive incident (Tenant #2). Findings follow: 1. Record review of an Incident Report indicated on 1-27-22 at 7:15 p.m. staff went to get Tenant #2 to take her back to her apartment, as an activity had just ended. There was a commotion in the activity room with other tenants and staff got to Tenant #2 and noted she was convulsing. The staff who responded (no name provided in the incident report) called Staff D, a medication aide, for assistance and to take vitals. Tenant #2 convulsed for a few minutes, stopped and then slumped to her right side. Tenant #2 began to breathe very heavy, her eyes did not blink and began to water and her mouth was drooped to the right side. Staff D talked to her and "continually rubbed tenant's sternum to attempt getting back to alertness." Tenant #2 did not stop breathing; however, was "out for 5-10 minutes"before she starting blinking or would squeeze the staff's hand. Tenant #2 started to slowly squeeze staff's hand when prompted by staff and attempted to respond verbally. Tenant #2 returned to her baseline overnight; however, 10 minutes after the incident started she was not at her baseline. Tenant #2 was oriented to	A 160		

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person but not to place or time.

The report indicated Tenant #2 reaction to the incident, she was unresponsive for 5 to 10 minutes and then said she wanted to finish the activity. Staff got a bingo card with chips and pretended to finish the game as staff felt it was helping her form sentences again and kept her awake. Staff obtained vital signs and took her back to her apartment in a wheelchair. Staff walked back with the other staff to Tenant #2's apartment and called the on-call nurse for further instructions.

The on-call nurse was notified on at 7:27 p.m. and instructed staff to obtain vital signs, take her back to her apartment and to put Tenant #2 into bed. One hour safety checks were also put into place throughout the night. She instructed staff to contact Tenant #2's family and to update the nurse with any changes from Tenant #2's baseline.

The incident report reflected Tenant #2 vital signs were as follows: temperature 96.9, pulse was 86, respiration rate 17 and blood pressure was 96/69.

Tenant #2's primary care physician (PCP) was notified on 1-31-22. The report indicated Tenant #2's family was notified on 1-28-22 at 7:59 p.m. The Director of Health and Wellness signed the incident report on 1-31-22. The report was signed and dated by Staff D on 1-28-22. The incident with Tenant #2 occurred on 1-27-22.

2. When interviewed on 2-9-22 at 4:19 p.m. Staff D said she was working second shift on the day of Tenant #2's incident and was the medication aide. She said Staff E called for vitals to the activity room. He had gone to the activity room,

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right as bingo was finished. He went to get Tenant #2 and she started convulsing when he got to her. When Staff D arrived Tenant #2 was in a wheelchair and was slumped to the left side. Tenant #2 did not look well, she convulsed; however, not rapid. She said it did not look like a seizure. Staff E went to her apartment to get her hospice binder, Staff D called hospice and was told Tenant #2 was not a patient. She was not aware Tenant #2 had been discharged from hospice. Tenant #2's eyes were open, she remained in the wheelchair, she was "out of it" and sounded like she was struggling to breathe. She had a pulse present and did not stop breathing. Staff D rubbed her sternum for about five to six minutes, she said chest compressions were not completed and she did not attempt to perform cardiopulmonary resuscitation (CPR). It was approximately 5 to 10 minutes and Tenant #2 slowly started to squeeze her hand and talked to her. She said Tenant #2 started back to her baseline at 15 to 20 minutes. When she first woke up she wanted to play bingo. She called Nurse #1, the on-call nurse, and was told to take her back to her apartment and lay her down. She was told to call Tenant #2's family and see what they wanted to do. She called Tenant #2's family that night and Tenant #2 was not sent out for evaluation. One hour checks were also put in place for Tenant #2. Staff E got Tenant #2 ready for bed and he would have completed the safety checks. She said wrote down vital signs on scratch paper. She said she might have filled the incident report related to this incident the next day. Staff D said she called Tenant #2's family the same day of the incident.

Attempts to contact Staff E for an interview were unsuccessful.

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When interviewed on 2-7-22 at 4:43 p.m. Nurse #1 said Staff D notified her that Tenant #2 had a transient ischemic attack (TIA) episode but it lasted longer than usual. She was told it happened in the activity room. She told Staff D to take Tenant #2 to her apartment, lay her in bed and take her vitals. She called with her vitals and the electronic system was updated to reflected one hour safety checks. She told Staff D to call her family and let them know about the incident and to give family the option of sending her out. Nurse #1 was not contacted again related to Tenant #2. Staff D did not tell her what Tenant #2's family said. She did not follow up the next day to see what happened. The Director of Health and Wellness came in and saw her the next morning. Nurse #1 said she was not aware of the right side facial drooping or sternum rub at the time of the incident. The next day Nurse #1 was told by Staff F that she heard Staff D started CPR on Tenant #2. Staff D worked the next day and she denied starting chest compressions. The incident report was filled out in the afternoon the next day. Staff E was helping Staff D and he did not complete a witness statement.

When interviewed on 2-9-22 at 2:31 p.m. the Director of Health and Wellness said on 1-28-22 staff reported Tenant #2 did not feel well, did not eat breakfast and was in bed. She went to see Tenant #2, she was on the couch, dressed and was watching television. She watched her walk, checked her hand grips, she felt good and went to breakfast. She went on with her day and did not know about the incident from night prior until later Friday afternoon. Nurse #1 asked her if she followed up on the incident report from Thursday night for Tenant #2. The Director of Health and Wellness said she had not seen an incident report related to the incident. Nurse #1 told there

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A 160	Continued From page 12 Tenant #2 had an unresponsive episode in the activity room and Staff D had called her. Nurse #1 had told Staff D to take Tenant #2 to her apartment and take vitals. The Director of Health and Wellness told Nurse #1 to have Staff D fill out an incident report and to make sure Tenant #2's family had been contacted. On Monday 1-31-22, she saw the incident report related to Tenant #2 and went to see her. A fax was sent to Tenant #2's PCP on Monday. She said Staff E was also there when the incident occurred. She said incident reports should be completed on the same shift of the incident. When interviewed on 2-8-22 at 2:35 p.m. Staff F said she was the medication aide in the memory care unit. Staff D asked her to check Tenant #2's code status. She went to the laptop and saw that indicated do no resuscitate and she reported it to Staff D. Staff D said that Tenant #2 "back with us." Tenant #2 was back in bed. She never talked to Staff D about the incident but did talk to Staff E. Staff E told her that he went to the activity room and another tenant was holding Tenant #2's hands and she was slumped over in her wheelchair. Staff E called Staff D to the activity room and to bring vitals. Staff E was sent to her apartment to get her hospice binder and when he came back Staff D was completing chest compression on Tenant #2 in the wheelchair. Staff D said they had her back and Tenant #2 was taken to her apartment and she had lost her bowels. Staff F said Staff E reported that Staff D called Nurse #1 after the fact and Nurse #1 said not to call the family and she would get a hold of family. The next day Staff F told nursing staff about it and Staff D was called in to write an incident report as she did not write an incident that day.	A 160		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 160	Continued From page 13	A 160		

When interviewed on 2-9-22 at 10:03 a.m. the Executive Director said she heard gossip that a staff did chest compressions or a sternal rub. The incident report should have been filled out that shift. She had heard it was completed after. She confirmed Staff E did not complete a witness statement.

3. Continued record review of Tenant #2's file revealed a diagnosis of history of TIAs. Tenant #2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The service plan dated 2-7-22 reflected Tenant #2 had a history of transient alteration of awareness. Tenant #2 had been to the emergency department (ED) previously for evaluation and a cause could not be determined. With the episodes, Tenant #2 might not respond to touch or voices and would not make eye contact. Tenant #2 might also be limp for awhile. The service plan indicated to stay with her, rub her arm and talk to her until she was alert. Staff was to obtain vitals and notify the nurse on-call and family. Staff was to give at least 15 minutes for Tenant #2 to become alert. Tenant #2 was to be sent to the ED per Tenant #2 or her family. The service plan indicated to fill out an incident report and notify nursing. The service plan also reflected Tenant #2 was seen by palliative care and was discharged from hospice several weeks ago.

Observation notes indicated the following:

-On 12-30-21 it was noted Tenant #2 was discharged from hospice.

-On 1-28-22 it was noted the Director of Health and Wellness went to see Tenant #2 that morning as staff reported Tenant #2 was laying bed in bed,

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A 160	Continued From page 14	A 160		

was not feeling well and did not want to go to breakfast. When she went to her apartment Tenant #2 was dressed, sitting on the couch and watching television. Tenant #2 said she felt fine and she wanted to go to breakfast. She assisted her to a standing position and watched her ambulate across the room to her wheelchair. Her gait was steady, grip strength was bilateral and she was able to feed herself in the dining room.

-On 1-31-22 it was noted the Director of Health and Wellness followed up with Tenant #2 regarding an incident report from 1-27-22. The report indicated Tenant #2 had been playing bingo and had a 5 to 10 minute unresponsive episode. The episodes were not abnormal for Tenant #2. Staff assisted to her to her apartment and slowly she returned to her baseline. When the nurse spoke with her on 1-31-22, she denied pain, said she felt okay and her vitals were stable. Tenant #2's family was notified and she would notify the PCP.

-On 1-31-22 it was noted the PCP acknowledged the unresponsive episode and said to monitor.

Further record review revealed the task administration record reflected under scheduled care notations on 1-28-22 at 6:46 a.m. that Tenant #2 asked for a nurse, she was not feeling well and she thought she had another stroke. The note indicated Tenant #2 seemed scared.

4. When interviewed on 2-10-22 the Executive Director said if an incident report was received the nurses should follow up within the following day, if the incident occurred on a weekend, then they would follow up on Monday. If an incident report was not received and an incident occurred they would follow up within 24 hours of knowing

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A 160	Continued From page 15 about it. In summary, Tenant #2, who had moderately severe cognitive decline had a unresponsive episode on 1-27-22 that lasted approximatley 5 to 10 minutes. Tenant #2 had a history of unresponsive episodes; however, this episode lasted longer. Staff D was not aware Tenant #2 was no longer receiving hospice services, called hospice and was informed she was no longer a hospice patient. She called Nurse #1, the on-call nurse, and was told to take Tenant #2 to her apartment, take vitals, notify the family and call with changes. The Director of Health and Wellness received a report from staff the following morning that Tenant #2 was not feeling well. She was not aware of the incident the night prior with Tenant #2 when she went to check on her. An incident report had not been completed at that time. She later found out from Nurse #1 about the incident the night prior and directed her to have Staff D complete an incident report. Nurse #1 said she did not follow up the next day to see what happened and she was not made aware of the right side facial drooping or sternal rub at the time of the incident. Staff D did not complete the incident report related to the incident with Tenant #2 until the afternoon of the following day, on 1-28-22. A documented nurse follow up related to the incident that occurred on 1-27-22 with Tenant #2 was not completed until 1-31-22. The PCP was also not notified until 1-31-22. Tenant #2 did not receive services that were adequate and appropriate related to the incident on 1-27-22.	A 160		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The	A 361		

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A 361	Continued From page 16	A 361		

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 observation, interview and record review the Program failed to have staff provide services in accordance with training provided. This pertained to 1 of 1 tenant observed that had insulin administered (Tenant #7) and 1 of 1 tenant observed that received a medication reminder (Tenant #8). Findings follow:

1. When observed on 2-7-22 at approximately 11:10 a.m. Staff C administered medications to Tenant #8. Staff C asked Tenant #8 to rate his pain and he responded it was at an eight. Staff C reminded Tenant #8 to take his cannabidiol (CBD) medication. Tenant #8 dropped the medication on his bedroom floor. Tenant #8 said it was a "30 second rule" regarding the medication on the floor. Staff C picked up the medication with a bare hand for Tenant #8, gave it to him and he consumed the medication.

Record review revealed Tenant #8's service plan reflected Tenant #8 would independently administer his CBD medication with medication reminders from the staff. Staff administered the rest of Tenant #8's medications.

Continued record review revealed Tenant #8's February 2022 medication administration records (MARs) reflected Staff C signed off the medication reminder for the CBD medication on

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A 361	Continued From page 17 2-7-22 at 11:00 a.m. and entered a rating for Tenant #8's pain. 2. Continued observation revealed Staff C also administered medications to Tenant #7 during the medication pass observed. He assisted Tenant #7 with blood glucose monitoring and insulin administration. He wiped Tenant #7 finger with alcohol prior to the blood glucose monitoring. Staff C administered insulin subcantaneously (SQ) to Tenant #7's abdomen. Staff C did not cleanse Tenant #7's abdomen with alcohol prior to the insulin administration. Further record review of Tenant #7's MAR reflected an order for Novolog 10 units, inject SQ, to abdomen 15 minutes before lunch. It also reflected a blood glucose check, three times per day before meals and before bed. Staff C initialed for the completion of these tasks on 2-7-22 at 11:30 a.m. 3. Continued record review revealed Staff C had a Med Aide Delegation Checklist completed dated 12-9-21, which indicated training was completed for insulin administration and oral medication administration. 4. Further record review revealed the training for insulin pen injection indicated to choose the injection site, open an alcohol pad, wipe the area, air dry, hand the insulin pen to the tenant and have them insert the needle and press the button to release the insulin, remind the tenant to leave the needle in for at least five seconds, the tenant would remove the needle and hand it to staff. The training for administering oral medications indicated if the capsule or tablet fell on the floor, to discard it in the drug buster and administer a	A 361		

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A 361	Continued From page 18 new capsule or tablet. 5. When interviewed on 2-10-22 and 2-21-22 at 12:38 p.m. the Executive Director said she would expect staff to cleanse the skin prior to insulin administration if it was visibly soiled. She said if a medication dropped, the medication should be discarded and if staff touched a medication it should be with a gloved hand.	A 361		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received dependent adult abuse training within six months of employment. This pertained to 2 of 4 staff reviewed that had been employed six months or greater (Staff A and Staff B). Findings follow: 1. Record review on 2-7-22 of Staff A's training documents revealed a hire date of 4-13-21. No dependent adult abuse training completed within six months of employment could be located. 2. Record review on 2-7-22 of Staff B's training documents revealed a hire date of 7-21-21. No dependent adult abuse training completed within six months of employment could be located. 3. When interviewed on 2-10-22 at 10:03 a.m. and 2-21-22 at 12:38 p.m. the Executive Director	A 380		

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A 380	Continued From page 19 confirmed dependent adult abuse training was not found for the staff listed above.	A 380		
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 develop service plans that reflected the identified needs of the tenants. This pertained to 3 of 6 tenants reviewed (Tenants #3, #4 and #5). Findings follow: 1. Record review on 2-8-22 and 2-9-22 of Tenant #3's file revealed Observation notes indicated the following: -On 1-31-22 it was noted the service plan was updated to reflect staff would provide medication reminders for "a few days" when Tenant #3's spouse would be gone. Tenant #3's spouse filled the medication planners one with prescription medications and one with over the counter medications. -On 2-4-22 it was noted Tenant #3's spouse had returned and medication reminders provided by staff were no longer needed. Continued record review revealed the most current service plan reflected Tenant #3's spouse administered her medications. The service plan	A 395		

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A 395	Continued From page 20	A 395		

also reflected Tenant #3's spouse was gone for a short time period and staff assisted with medication reminders. The service plan was not updated to reflect the staff medication reminders were not longer needed.

2. When interviewed on 2-8-22 at 10:03 a.m. Staff C said Tenant #4 had sexually inappropriate behavior at times towards staff and it was typically verbal comments towards to staff.

Record review on 2-8-22 and 2-9-22 of Tenant #4's file revealed Observation notes indicated the following:

-On 8-24-21 it was noted nursing followed up with Tenant #4 regarding inappropriate behavior towards a staff the night prior when staff was assisting him with a shower. Tenant #4 had a history of making inappropriate comments to staff and it was reflected on his service plan.

-On 11-8-21 it was noted Tenant #4 fell yesterday afternoon at 1:30 p.m. when walking with staff to his apartment.

-On 1-17-22 it was noted at approximately 4:32 p.m. when pivoting into a dining room chair, Tenant #4 tripped over his other foot and fell. Tenant #4 hit his head on the floor.

-On 2-7-22 it was noted Tenant #4 had dark bruising around his left eye and was unsure what happened.

Continued record review revealed Tenant #4's service plan dated 12-7-21 did not reflect Tenant #4's inappropriate behavior or interventions. The service plan reflected Tenant #4 needed to call for assistance over night to get out of bed (family's

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A 395	Continued From page 21	A 395		

request) due to a fall history. Tenant #4 had signs in his apartment to remind him to call for assistance. The service plan did not mention Tenant #4's history of falls, with the exception of the above information.

3. Record review on 2-9-22 of Tenant #5's file revealed a Physician Order Sheet noted on 11-18-21 reflected blood glucose checks daily in the morning.

Continued record review revealed Observation notes indicated the following:

-On 1-31-22 it was noted Tenant #5 had "multiple falls" in the past 60 days. The falls were noted on 12-26-21, 1-6-22, 1-7-22 and 1-31-22.

Further record review revealed the January 2022 MAR reflected staff initialed for the completion of checking Tenant #5's blood glucose once daily in the morning.

Continued record review revealed the current service plan did not reflect Tenant #5's history of falls or staff assistance with blood glucose checks.

4. When interviewed on 2-21-22 at 12:38 p.m. the Executive Director confirmed all current service plans for the tenants requested were provided.

Keystone Cedars Assisted Living
Plan of Correction
May 2, 2022

OK 5-9-22

A150 – Program Policies and Procedures 481-67.2(3)

Findings:

1. Program failed to follow its policy and procedure related to the completion of incident reports.

Plan of Correction:

1. The program has updated its Incident Report Form to faciliate prompt completion by staff members (a copy of which is attached as Exhibit 1). All staff will be retrained on completion of Incident Reports and where within the establishment blank Incident Report Forms are available. Retraining will be completed by May 15, 2022.

2. The program has amended it policy Incident Reporting Policy and Procedure (a copy of which is attached as Exhibit 2. The policy has been updated to specify additional situations in which staff are to complete an Incident Report Form to facilitate completion of Incident Reports for situations which may be ordinary events concerning a particular resident. The policy has also been updated to clarify that an Incident Report should be completed anytime a resident is exit seeking or a memory care resident is found outside memory care unaccompanied, but is still within the building and not in health or safety jeopardy.

3. The Executive Director will conduct further review and testing of the memory care door alarm system and any needed repairs or replacements will ordered no later than May 5, 2022.

4. All Health and Wellness staff will be retrained with respect to the new Incident Report Form, the updated Incident Reporting Policy dated April 29, 2022. Retraining will be completed by May 18, 2022.

A 160 – Tenant Rights 481-67.3(2)

Findings:

1. The program failed to meet tenant rights by failure to provided care, treatment and services which are adequate and appropriate.

Plan of Correction:

1. The program has updated its Incident Report Form (a copy of which is attached as Exhibit 1) to add emphasis on documentation of notification of family members/representatives and emphasis on documentation of attempts to contact a family member. All staff will be retrained on completion of Incident Reports and where within the establishment blank Incident Report Forms are available. Retraining will be completed by May 18, 2022.

2. As part of its revision to the Incident Reporting Policy and Procedure dated April 29, 2022 (a copy of which is attached as Exhibit 2), the program included the requirement for completion of an Incident Report Form in the event of a resident has a physical reaction to a medication or any time a resident has an event – even if ordinary for that specific resident – such as a seizure or fainting.

3. All Health and Wellness staff will be retrained with respect to the new Incident Report Form, the updated Incident Reporting Policy dated April 29, 2022. Retraining will be completed by May 18, 2022.

4. All staff will be retrained on Tenant Rights with examples of situations that could constitute actions to be taken by the program in the absence of availability of family or other legally responsible parties relating to care, treatment and services. Retraining will be completed by May 18, 2022.

A361- Staffing 481-67.9(4)

Findings:

1. Regarding nurse delegation procedure the program failed to ensure staff provided services in accordance with training provided.

Plan of Correction:

1. The program has revised its Medication Needs of Tenants/Medication Management Policy and Procedure effective as of April 29, 2022 (a copy of which is attached as Exhibit 3).

2. All staff will be trained on the Medication Needs of Tenants/Medication Management Policy and Procedure no later than May 18, 2022.

A380 – Staffing 481-67.9(6)

Findings:

1. Program failed to properly complete and document training completed for newly hired staff within 30 days of employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include a checklist for Orientation Training. The Orientation Training includes dependent adult abuse training.

2. The Program has amended its' Staff Training Policy and Procedure as of April 29, 2022 (a copy of which is attached as Exhibit 4).

3. The Director of Operations shall conduct audits of the personnel files including verification of training and documentation of training at the intervals set forth on the Staff Training Policy and Procedure and ensure that any training is completely on a timely basis in accordance with regulatory requirements and the policy and procedure.

A 395 – Service Plans 481-69.26(4)

Findings:

1. Program failed to complete service plans as needed and failed to develop service plans to reflect the identified needs of tenants and preferences for assistance. Program failed to modify service plans to include all service changes even temporary and failed to modify service plans to show frequency of condition or incidents.

Plan of Correction:

1. The Program has updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure as of April 29, 2022 (a copy of which is attached as Exhibit 5). The updated policy includes a list (which is not comprehensive) of 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 May 18, 2022.

3. All Health and Wellness staff will be retrained by the program on the importance of documenting services, needs, observations, tasks and utilizing automated alerts as promptly as possible on the Community's electronic charting system. The Chief Experience Officer will work directly with the Executive Director and the Director of Health and Wellness to identify and further develop to the extent possible additional within ECP that will provide for efficiency by staff. The Chief Experience Officer will train the Executive Director and Director of Health and Wellness on tools within ECP that allow for temporary changes in a service plan with automated alerts to revise.