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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE CEDARS AL	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 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: 60 Number of tenants with cognitive disorder: 8 Total census of Assisted Living Program: 68 The Program met the definition of a dementia specific program at time of the recertification visit on 7/24/24. The Program was made aware of the designation at the time of the visit. The following regulatory insufficiencies were cited during the investigation of Incident #117659-I, Complaint #122077-C and the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	As of October 7, 2024 the census of the assisted living program will be as follows: Number of tenants without cognitive disorder: 59 Number of tenants with cognitive disorder: 6 Total census of Assisted Living Program: 65	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policies and procedures including cell phones, social media and confidentiality. This pertained to 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Review of Tenant C1's file on 7/30/24 revealed an Incident Report dated 12/1/23 at 9:05 p.m. The location was Tenant C1's bathroom. Another	A 150		

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A 150	Continued From page 1 tenant heard Tenant C1 yelling for help from her apartment and staff found Tenant C1 on the bathroom floor on her stomach facing the wall in front of the toilet. Tenant C1 was unable to remember what happened and her pendant was not within her reach when she fell. Tenant C1 believed she was walking to the bathroom when she might have passed out and fallen. She was not able to verify what occurred. Emergency medical services came out to assist her to her feet and back to bed. She did not sustain any injuries related to the fall and did not require any outside medical care. An Investigation Summary indicated on 12/6/23 Staff E reported to the Executive Director that Staff A had sent a Snapchat to Staff B and Staff C with an electronic image of Tenant C1 laying face down on the floor post fall. An investigation was opened immediately. On 12/6/23 at 4:45 p.m. Staff A was interviewed by the Executive Director and Director of Health and Wellness. In the interview Staff A admitted she sent the Snapchat image to Staff B and Staff C on 12/1/23. It was determined Staff A would be terminated from her employment for personal degradation. - Staff B's written statement dated 12/7/23 indicated she received a picture of a tenant through Snapchat on 12/1/23. She did not save the picture or do anything with it on her phone. She did not show anyone the picture or ask questions about it. The picture was of the tenant was from the back and the tenant's face was not seen in the picture. Staff B noted she did not think to report it when she saw it. - Staff C's written statement dated 12/7/23 indicated at 8:00 p.m. she clocked out. The fall occurred later and she received the picture on Friday night. Staff C said Staff A was not aware that it was wrong and neither did she. The	A 150	1. The Community provided reeducation on established policies and procedures including cell phones, social media and confidentiality during the all-staff in-service on September 11, 2024. 2. The Community will provide additional training on its policies and procedures regarding cell phones, social media and confidentiality of resident information on a biannual basis. 3. The Executive Director and the Director of Operations will ensure that all staff are trained and retrained at least biannually on the Community's policies and procedures regarding cell phones, social media and confidentiality of resident information. 4. All staff have been retrained as of September 11, 2024.	

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A 150	Continued From page 2	A 150		

photograph was not added to her camera roll and there was no malicious intent. Staff C noted she did not think to report it as she did not realize how wrong it was.

- Staff E's written statement dated 12/6/23 indicated on 12/4/23 she was shown a picture of Tenant C1 on the floor in her bathroom. It was from a fall she had on 12/1/23. It was sent from Staff A's phone via Snapchat to Staff C. Staff C showed Staff E the picture on 12/4/23. Staff E reported it to the Executive Director and Director of Health and Wellness on 12/6/23.

2. When interviewed on 8/6/24 the Executive Director said Staff E said she needed to to talk to her and she reported a photograph of Tenant C1 was shared via social media. Staff E said the picture was taken by Staff A and it was shared with two other staff. Staff E said it had been shown to her. The Executive Director said none of the staff had the picture and it had been shared in a private format and not on a public platform. She and the Director of Health and Wellness met with Staff A and she confirmed she had taken the picture of Tenant C1 and had shared it with Staff B and Staff C via Snapchat. Staff A was terminated. The Executive Director said the picture was described to her as Tenant C1 being face down with some type of clothing on. She said Staff B and Staff C did not have the picture and had not shared the picture. Staff B and Staff C received disciplinary actions related to failure to report it. The Executive Director said Tenant C1 and her family were made aware. She stated staff were not to have their personal cell phones on their person at work and the employee handbook identified the expectations on social media.

When interviewed on 8/6/24 at 11:50 a.m. the

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A 150	Continued From page 3 Director of Health and Wellness said the Executive Director became aware of the picture from Staff E. The Executive Director told her Staff A sent a picture to Staff B and Staff C. She and the Executive Director met with Staff A who confirmed she took the picture of Tenant C1 in the bathroom and sent it to Staff B and Staff C. The Executive Director told Staff A she was no longer employed. The Director of Health and Wellness said she never saw the picture but typically Tenant C1 always wore long a night gown. Immediate re-training was provided for the staff involved. Staff were made aware of the cell phone policy as well as dependent adult abuse and tenant rights. When interviewed on 8/5/24 at 5:21 p.m. Staff B said she received a photo via Snapchat that showed the back of a tenant (Tenant C1). She was not working at that time. Staff B did not recall if she responded; however, said she not send it to anyone. She did not think to report it. Staff B said the Executive Director brought her into her office and she told her what had happened. Staff B confirmed she did not report at the time she received the picture. She was provided re-education related to it. 3. Review of the policy for cell phones indicated personal cell phones were not to be carried or used by staff at anytime except on break in the designated break area. A personal cell phone was not allowed at any time in a tenant apartment. There were no exceptions to the policy. The social media policy indicated staff were not allowed to reference or post any pictures of tenants. The policy regarding confidential information indicated staff should not share any confidential information with co-workers except as part of the job duties. Staff could not post any	A 150		

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A 150	Continued From page 4 information online that was confidential. The Program's Abuse Reporting and Investigation policy and procedure indicated anyone who witnessed or suspected abuse of a tenant was to report it to leadership staff immediately. 4. When interviewed on 8/6/24 the Executive Director confirmed Staff A had all required training related to the above expectations and polices for cell phone use, social media and confidentially.	A 150	1. Pursuant to the Staff Policy dated August 2, 2021, prior to employment of any person at Keystone Cedars, the Executive Director or the Director of Operations (or designee) shall request that the Iowa Department of Public Safety perform a criminal history check and that the Iowa Department of Human Services shall perform a dependent adult and child abuse check. The Director of Operations shall review the Iowa Record Check Request to verify that a prospective employee does not have a criminal history or abuse history and pursue authorization to employ if there is any matter which would prohibit employment. The Director of Operations shall acknowledge such review of records on the Personnel File Checklist maintained in the prospective employee's personnel file. If a prospective employee has a criminal history or an abuse history that prohibits employment, such person shall not be employed at Keystone Cedars. 2. The Executive Director and the Director of Operations have reviewed the policy and regulatory requirements and ensure that a criminal history check has been completed prior to staff working any hours. 3. The Director of Operations will conduct a quarterly review of all personnel files for new personnel for that calendar quarter to ensure that all criminal history check records are maintained in the staff member's personnel file. 4. All employees' criminal history checks have been determined to be completed as of September 30, 2024.	
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete background checks prior to staffs' employment. This pertained to 2 of 8 staff reviewed (Staff A and Staff D). Findings follow: 1. Review of Staff A's training documents on 8/5/24 revealed a hire date of 7/18/23. A State of Iowa Criminal History Record Check Request Form was started but not completed. The staff was under the age of 18 when she applied. 2. Review of Staff D's training documents on 7/29/24 revealed a hire date of 4/11/24. A State of Iowa Criminal History Record Check Request	A 400		

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A 400	Continued From page 5 Form was completed; however, was not sent in as no results were obtained. Continued record review revealed a Criminal Records Report indicated a nationwide check was completed for Staff D on 4/10/24 which did not reveal any records. 3. When interviewed on 8/6/24 the Executive Director confirmed there were no additional background checks for Staff D. She said she had been told background checks were not completed for applicants under the age of 18. She confirmed a criminal background check was not completed for Staff A.	A 400	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.	
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 ensure service plans were updated as needed to reflect the service needs of the tenants. This pertained to 7 of 7 current tenants reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). Findings follow:	A 350	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.	

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A 350	Continued From page 6 1. Review of Tenant #1's file on 7/31/24 revealed Observations (nurse's notes) dated 4/17/24 indicated a communication report was received from staff that a bug was found on Tenant #1's bed the previous night. Staff threw it in the toilet but she looked it up online and she thought it was a bed bug. Maintenance staff and the front desk was informed and pest company was called. Continued record review of an email dated 8/2/24 from the Executive Director indicated on 4/18/24 Pest Company #1 was out to examine the apartment and did not find any bed bugs. On 5/6/24 Pest Company #1 was back out to look at the apartment and did not find any bed bugs. There were no bed bugs found by staff from 5/6/24 to about 6/18/24. On 6/19/24 a contract was set up to treat Tenant #1's apartment for bed bugs with Pest Company #1. On 6/20/24, 7/1/24 and 7/11/24 the apartment was treated for bed bugs by Pest Company #1. On 7/26/24 Pest Company #2 completed a treatment in Tenant #1's apartment and completed an inspection of the entire building using a trained canine. Tenant #1's service plan did not address the on-going treatment of the apartment for bed bugs or to monitor for any bites or skin irritations related to the on-going pest issue in the apartment. It also did not reflect if any precautions were needed for staff or visitors entering the apartment. 2. Review of Tenant #2's file on 7/31/24 revealed the 90 day assessment (nurse review) dated 6/7/24 reflected her apartment was extremely messy and unkempt as was her person. It was noted she was very odorous. Tenant #2 had a history of refusing cares and did not like to take care of her personal hygiene needs.	A 350		

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A 350	Continued From page 7 Tenant #2's service plan did not reflect the condition of her apartment and if additional housekeeping services were needed. It also did not reflect her care refusals and hygiene concerns and interventions. 3. Review of Tenant #3's file on 8/5/24 revealed an Order Sheet indicating on 6/11/24 Tenant #3 was admitted to hospice. The Hospice Plan of Care dated 6/11/24 reflected she would receive chaplain visits one to two visits every month for three months, hospice aide visits one to two visits weekly for 12 weeks, medical social worker visits one to two visits every month for three months and skilled nursing visits one to two visits weekly and as needed for 12 weeks. It indicated the hospice aide would assist with toileting, bathing, dressing and undressing and to report pain to the nurse at each visit. The tenant's task administration record for May, June and July 2024 reflected refusals for dressing independently, assistance with dirty laundry and a bathing reminder. An After Visit Summary (AVS) indicated Tenant #3 was hospitalized from 5/28/24 to 6/3/24. Her diet instructions indicated to limit sodium to 2000 milligrams (mg) per day and a fluid restriction of 2000 total milliters (ml)/1200 ml with meals. Tenant #3's service plan reflected she was on hospice; however, did not indicate the services provided, including hospice assistance with activities of daily living. The service plan also did not include the diet instructions from the hospitalization in June. The service plan reflected Tenant #3 frequently refused bathing reminders; however, did not include the frequent	A 350		

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A 350	Continued From page 8 refusals related to the removal of her dirty laundry. 4. Review of Tenant #4's file on 8/5/24 revealed a 90 day assessment (nurse review) dated 5/16/24 indicating Tenant #4 received assistance with medications, showers, and ambulation/escorts to meals and activities as needed due to vision loss from macular degeneration. Tenant #4 used a cane to ambulate inside and outside of her apartment. When interviewed on 7/30/24 at 10:57 a.m. Staff F said Tenant #4 could not see well and took long walks but returned. She had a a vision impairment and used a cane. She said she walked daily. She had seen her walk past some of the buildings and was off property. She had not had any falls. When interviewed on 8/6/24 the Executive Director said Tenant #4 was a frequent walker. One time this summer she received a phone call from either a family member or staff member regarding a concern for Tenant #4 when she was out walking. She went to help her back to the building. She did not have to guide the tenant on their return walk. The Executive Director said Tenant #4 knew how to get back to the building and was dressed appropriately for weather conditions when she is out walking. Tenant #4's service plan reflected the macular degeneration and severe loss of eye sight but the ability to still get around. It indicated she received assistance with ambulation due to vision loss. It indicated Tenant #4 needed assistance to meals and activities related to her impaired vision. The service plan did not reflect Tenant #4 frequent walks, including outside of the building.	A 350		

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A 350	Continued From page 9 5. Review of Tenant #5's file on 8/5/24 revealed Observations (nurse's notes) indicated the following: - On 5/28/24 it was noted Tenant #5 fell three times today. - On 6/6/24 Tenant #5 fell on 6/6/24 and re-opened a prior skin tear and sustained a large bruise. It was also noted Tenant #5 had significant redness and yeast in the right armpit. A fax was sent to the primary care provider (PCP) regarding encouraging family to get Nystatin powder and Mepilex bandages for the skin tear. - On 6/10/24 Tenant #5 and his family requested to see the PCP for possible concerns with cellulitis in his toe. - On 6/24/24 the PCP saw Tenant #5 today and she was going to send in a prescription for Prednisone for possible gout. - On 6/25/24 a note was received that Prednisone was ordered for the left great toe and it had been painful and red. - On 7/8/24 Tenant #5 slid out of bed. - On 7/22/24 Tenant #5 had multiple falls without major injuries. Tenant #5's spouse was in the hospital and was going to a skilled nursing facility so additional services were added for showering and toileting. It also indicated received therapies and was undergoing iontopheresis for chronic right shoulder pain. A Long Term Care Facility Visit note dated 7/15/24 indicated Tenant #5 was feeling down as his spouse was currently in the hospital. (Tenant #5 lived with his spouse in the apartment and she was out of the program from 7/7/24 to the time of the review). The tenant's service plan dated 7/22/24 reflected dressing and medication assistance would be	A 350		

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provided by Tenant #5's spouse. The service plan reflected a risk of falling and to notify the nurse if unstable. The service plan was not updated to include Tenant #5's spouse was not providing the cares listed as she was not in the building. It also did not provide fall interventions, the reddened area in his armpit and redness and painful great toe.

6. Review of Tenant #6's file on 8/5/24 revealed Observations (nurse's notes) indicated the following:
- On 4/3/24 Tenant #6 came down to the nurse's station and had three areas on her right arm that were red and swollen. Tenant #6 was assisted to make an appointment with her PCP.
- On 4/18/24 Pest Company #1 came out and did not find any bed bugs at that time. The PCP was called to inform her since the red spots on Tenant #6 were being assessed today.

Review of an email dated 8/2/24 from the Executive Director indicated on 4/18/24 Pest Company #1 was out to examine the apartment and did not find any bed bugs. On 5/6/24 Pest Company #1 was back out to look at the apartment and did not find any bed bugs. There were no bed bugs found by staff from 5/6/24 to about 6/18/24. On 6/19/24 a contract was set up to treat Tenant #1's apartment for bed bugs with Pest Company #1. On 6/20/24, 7/1/24 and 7/11/24 the apartment was treated for bed bugs by Pest Company #1. On 7/26/24 Pest Company #2 completed a treatment in Tenant #1's apartment and completed an inspection of the entire building using a trained canine.

When interviewed on 8/6/24 at approximatley 12:15 p.m. Tenant #6 said there had been spray treatment three times and a canine had been out

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A 350	Continued From page 11 to her apartment. She said there had still been one each day but today she had not seen a bed bug. She said it had been going on for awhile, since at least April. She had bites and they were in groups of three but were all healed now. She said it was a frustrating process but she felt like it was being treated and she noted they were hard to get rid of. Tenant #6 said she had a lot of stress on her. Tenant #6's service plan did not address the on-going treatment of the apartment for bed bugs or to monitor for any bites or skin irritations related to the on-going pest issue in the apartment. It also did not reflect if any precautions were needed for staff or visitors entering the apartment. 7. Review of Tenant #7's file on 8/5/24 and 8/6/24 revealed diagnoses including major depressive disorder, single and recurrent episodes, and anxiety disorder. A Long Term Care Facility Acute Visit Note dated 6/17/24 indicated Tenant #7 reported he was a little lonely and that his spouses had died. He said he enjoyed activities at the Program and had friends he could visit with. Tenant #7 denied a need for a medication adjustment. A PCP visit document dated 7/1/24 indicated Tenant #7 said he was feeling down and that his age and people he had lost were getting to him. He said he was not finding enjoyment in daily activities and conversations. An order was received to increase in venlafaxine ER to 150 mg daily. Tenant #7's service plan did not reflect his history of major depressive disorder and comments	A 350		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 350	Continued From page 12 shared with the PCP regarding increased loneliness and not finding enjoyment in activities and interventions. 8. 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		