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
	S0405	A. BUILDING: _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY POINT MEADOWS	1900 STONEY POINT ROAD CEDAR RAPIDS, IA 52404

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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. General Population Number of tenants without cognitive disorder: 21 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 5 Total Census of Assisted Living Program for People with Dementia: 26 The following regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse 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.	A 118	Stoney Point Meadows will continue to submit backround checks; SING, Verified Credentials, OIG, SAM Report. If further research is needed: 1. Will submit State of Iowa Criminal History Record Check Request form 2. Will submit DHS Record Check Evaluation 3. Await response from DHS	

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A 118	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete background checks prior to employment for 1 of 8 staff reviewed (Staff A). Findings follow: Record review on 10-17-19 and 10-21-19 revealed Staff A's date of hire was 4-1-19. A criminal history background check and abuse registries background check was completed on 5-3-19. When interviewed on 10-22-19 at approximately 11:42 a.m. the Director of Housing revealed there was no additional background check information for Staff A.	A 118		
A 121	481-67.19(3)c Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program.	A 121	1. The policy regarding backround checks at Stoney Point Meadows is that before a position is offered, a SING, Verified Credentials, OIG and SAM Report must be completed. If a report returns then Stoney Point will contact DHS to determine if the individual is able to be employed by Stoney Point Meadows. 2. Measures taken: Potential hire checklist needs to be completed before hire 3. Compliance will be monitered often by Cassia Management HR. 4. Staff A corrected May 3rd 2019 Staff B submitted to DHS, DHS approved Staff B to be employed by Stoney Point Meadows Nov. 19th 2019	

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A 121	Continued From page 2 This REQUIREMENT Is not met as evidenced by: Based on interview and record review the Program failed to obtain an evaluation by the Department of Human Services (DHS) to determine if employment was prohibited prior to employment for 1 of 1 staff reviewed with a criminal history record (Staff B). Findings follow: Record review on 10-17-19 and 10-21-19 revealed Staff B's date of hire was 7-29-19. A criminal history background check and abuse registries background check was completed on 7-18-19. No results were indicated on the abuse registries background check but further research was required on the criminal history background check. Iowa Record Check Request Form S indicated a record was found as of 7-24-19. An evaluation by the DHS to determine if employment was prohibited could not be located. When interviewed on 10-22-19 at approximately 11:42 a.m. the Director of Housing revealed there was no additional background check information for Staff B.	A 121		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) 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:	A 089		

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A 089	Continued From page 3 Based on interview and record review the Program failed to develop service plans that reflected the identified needs for 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Review on 10-21-19 of Tenant #1's file revealed she resided in the memory care unit. Tenant Notes indicated the following: - On 9-30-19 it was noted nursing staff was informed Tenant #1 had cradle cap. When observed by nursing staff, Tenant #1's scalp had a waxy, scaly coating on it. - On 10-1-19 it was noted a new order was received for Nizoral A-d shampoo 1% to be used twice per week during bathing for dry scalp. The tenant's October 2019 Medication Admin Summary (MAR) reflected staff assisted with the application of the medicated shampoo to Tenant #1's scalp twice per week The tenant's service plan dated 7-26-19 reflected Tenant #1 needed assistance of one person for bathing and getting in and out of the shower. The service plan did not reflect the frequency of bathing assistance, the issue with Tenant #1's scalp and the use of the medicated shampoo twice per week. 2. Review on 10-21-19 of Tenant #2's file revealed diagnoses including congestive heart failure (CHF), acute chronic heart failure, chronic kidney disease (stage 3) and cellulitis of the right lower extremity. A Tenant Note dated 9-26-19 indicated Tenant #2 was hospitalized from 9-23-19 to 9-26-19 for a CHF exacerbation and cellulitis of the right lower	A 089	1) Rn has reviewed Tenant #1, #2, and #3 as noted in the summary and the deficiencies associated with each file. All of the deficiencies that were noted for each tenant have already been corrected, service plans updated, and service scheduled for the unlicensed staff updated as appropriate to match the service plans. Updated service plas have been sent out to all nurses and unlicensed staff for review. 2) The current electronic health record that we use, had default instructions for tasks that were generic. Those defaut instructions have been removed. This will ensure that the RN completing the assessments will need to add individual and specific instructions for each tenant based on needs and preferences. Also, re-education was completed with the Director of Health Services to explain the importance of the service plan is specific to each resident based on current assessments, needs, and preferences. 3) The Director of Assisted Living Clinical Services makes regular visits to Stoney Point Meadows. She will review new and updated service plans to ensure accuracy during her visits at the site, and/or from a distance as needed. All changes to service plans are automatically sent to her electronically. She will review any necessary changes with the staff nurses until the Director of Heal Services has a good understanding of the requirement and can complete this independently. 4) All corrections have already been made.	

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A 089	Continued From page 4 extremity. Approximately three weeks prior Tenant #2 fell on a curb and skinned her knees when out with family. Approximately one week later she developed significant swelling in both legs and voiced her legs hurt when she ambulated. Tenant #2 was started on Kelfex for suspected cellulitis and her Lasix was increased to reduce the swelling. There was not much improvement in the swelling and she began to have difficulty sleeping due to pain. On 9-23-19 she went to her primary care provider and was told she needed to see her cardiologist that afternoon. She was was admitted directly to the hospital by her cardiologist and was told that she had a CHF exacerbation along with cellulitis of the lower right leg. Tenant #2's service plan dated 9-26-19 reflected bathing assistance one to three times per week. The type of assistance required was not specified. The service plan reflected the recent CHF exacerbation; however, did not reflect the history of cellulitis. 3. Review on 10-21-19 of Tenant #3's file revealed diagnoses including a history of hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting the right dominant side, and cellulitis of the right lower leg. Tenant Notes indicated the following: - On 10-8-19 It was noted nursing staff was informed Tenant #3's shin was red, warm to touch and had an area that was raised. Tenant #3 had one more dose of antibiotic and then was done. The area had a red scab on it and looked like it should be drained. Tenant #3 was instructed to apply ice and use an ointment (Bacitracin) to see if it would help. Tenant #3's temperature was 99.3 and staff were instructed	A 089		

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A 089	Continued From page 6 to re-check her temperature at shift change. - On 10-18-19 it was noted an order was received for Tenant #3 to have a safety extension bar/rail on her bed. It was recommended by Tenant #3's therapy team and an order was obtained from her physician. - On 10-18-19 it was noted nursing staff was called to the dining room for tenant choking. Other tenants in the dining room said at first Tenant #3 was unable to talk but coughed. She was still coughing but able to talk when nursing staff arrived. After Tenant #3's coughing stopped she was helped to another area and vitals were taken. Tenant #3 reported she ate cottage cheese and it went down the wrong way. She said at first she was unable to talk but after she coughed she was able to catch her breath. Extra checks were added to the service plan (especially after meal times to monitor Tenant #3 over the weekend). Tenant #3's service plan dated 10-17-19 did not reflect the use of a bed rail, the choking episode or the history of cellulitis. The service plan reflected assistance of one person with a shower once per week and a whirlpool once per week. The service plan was not specific to the type of assistance provided for bathing. 4. When interviewed on 10-22-19 at 11:02 a.m. the Director of Health Services indicated the service plans provided were the most current service plans for the tenants noted above.	A 089		
A 138	481-69.32(2) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements.	A 138		

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A 138	Continued From page 6 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 have an operating alarm system connected to each exit door in a dementia-specific program. This potentially affected all tenants of the Program (census of 26 tenants). Findings follow: Observations on 10-17-19, 10-21-19 and 10-22-19 revealed the front door was not alarmed at all times. On 10-21-19 it was observed the community room exit door had an electronic wandering monitoring device; however, no other alarms were observed on the door. A layout of the building provided by the Program with mechanisms at each exterior door identified indicated the following: the front exit door had an electronic wandering monitoring system and a maglock (it was not locked from 9:05 a.m. to 4:05 p.m.), the stairwell doors on all floors had a key pad on the interior stairwell door that went to an exterior door that had an electronic wandering system. The dining room exit door had a maglock door and an electronic wandering monitoring system. The community room exit door had an electronic wandering monitoring and maglock (when observed it did not have a maglock at time of observation) and a service hall with a maglock and electronic wandering monitoring system. In the memory care unit all exit doors had a maglock.	A 138	Operating alarm system is complete as of November 25th 2019. By Summit Company (see Invoice) Front Door is Magnetic locked 24/7 with key code to exit. Also has the existing Electronic Wandering System. The community room exit door has Electronic Wandering Monitoring and Magnetic Lock and card reader to exit. Completed November 25th 2019.	

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A 138	Continued From page 7 Further record review revealed the Program's policy and procedure for the Dementia Specific Unit indicated the memory care unit would be secured for the dementia specific tenants and each exit would be alarmed. When interviewed on 10-22-19 at 11:42 a.m. the Maintenance Director and Director of Housing indicated the front entrance door was unlocked from 9:05 a.m. to 4:05 p.m. There was a person at the front desk during the week until 8:00 p.m. and on the weekends from 10:00 a.m. to 6:00 p.m. The community room exit door currently had an electronic wandering monitoring system on the door; however, it was planned to have a maglock. The maglock doors were locked and a card was needed to to leave or In the event of an fire they would release. The electronic wandering monitoring system provided an alarm which was audible and also alerted on staffs' phones. The stairwells had key pads. The dining room, community room and front door had the electronic monitoring system; however, did not have another alarm feature (the front door and dining room door had a maglock). The service hall had a maglock and would alarm if left open too long. It also had an electronic wandering monitoring device system. There were no tenants in the general population that utilized an electronic wandering monitoring device. In summary, the Program did not have a primary alarm system that was connected to each exit door. The maglock provided a locking feature and did not alarm. The electronic wandering monitoring system provided a secondary alarm, as it would only alarm if a tenant was wearing a electronic wandering monitoring device. Alarms	A 138	The front door remains locked 24/7 with key code to exit, Wandering Monitoring system, and magnetic lock. All doors to exit has the electronic wandering monitoring system which is audible and also alerts staff phones. Completed; community room door and front door with magnetic lock, and wandering monitoring system that is audible and alerts staff on phones	

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A 138	Continued From page 8 were not connected to each exit door in a dedicated dementia specific program.	A 138		