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 _____	C 12/22/2020

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

(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. General Population Number of tenants without cognitive disorder: 38 Number of tenants with cognitive disorder: 0 Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 11 Total Census: 49 There were no regulatory insufficiencies cited during the onsite infection control survey completed on 12/16/20. The following regulatory insufficiencies were cited during the investigation of Complaint #91721-C.	A 000		
A 083	481-69.26(1) Service Plans 481-69.26(231C) 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.	A 083		

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

2/18/21 2/17/21

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A 083	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure service plans were based on evaluations and included all identified needs for 5 of 5 current (Tenants #1, 2, 3, 5, 6) and 1 of 1 former (Tenant C-4) tenants reviewed. Findings follow: 1. Review of Tenant #1's file on 12/16/20 revealed an assessment dated 12/14/20. According to the assessment, Tenant #1 had a gait disturbance and was diagnosed with Parkinson's disease. The Assessment noted staff should take steps to reduce risk of falling which included reminding her to use her walker, keeping her apartment clutter free and reinforcing the teaching of the physical therapist's and occupational therapist's instructions. A review of Incident Reports for Tenant #1 revealed she had falls on 8/7/20, 8/25/20, 9/13/20, 10/7/20, 11/19/20, 11/21/20, 11/22,20 and 11/23/20. Tenant #1 had a hospitalization following the final fall and then went to a transitional care unit for skilled therapy. Tenant #1's Service Plan dated 12/16/20 did not address her gait imbalance, falls or the interventions to keep her from falling. It did not address her use of an assistive device. 2. Review of Tenant #2's file on 12/16/20 revealed an assessment dated 12/2/20. The assessment identified Tenant #2 needed assistance with his nebulizer. It also noted he required reminders and help to use the bathroom through the day, and at night to use the toilet due to incontinence such as changing incontinence undergarments. Staff were also to provide comfort checks throughout the night. If Tenant #2 was awake, staff were to assist him to and from the toilet. Tenant #2 was not to be involved with anything that had to do	A 083	Tenant #1 will be corrected at the next Assessment, Facility Service Plan and Master Care Plan will be signed by Tenant or POA. #2-will be corrected at the next Assessment, Facility Service Plan and Master Care Plan will be signed by Tenant or POA.	

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A 083	Continued From page 2 with politics, war or real crime television shows according to his assessment. The assessment noted Tenant #2 was at an increased risk for falling and all pathways were to be kept clear of clutter. These needs were not identified on Tenant #2's Service Plan dated 12/15/20. 3. Review of Tenant #3's file on 12/16/20 revealed an assessment dated 11/15/20. The assessment noted Tenant #3 used a walker. She had a slow and steady gait. Staff were to occasionally supervise and stand by Tenant #3 when she walked in the halls. She needed occasional reinforcement to use her roller walker. Tenant #3 was noted to be at an increased risk for falling. Staff were to help to keep her apartment clutter free, encourage/reinforce the use of her assisted device, suggest she not use a rug in her room and encourage walking to maintain strength and balance. She was noted to tire when walking long distances. Tenant #3 needed reminders to use the bathroom through the day and night due to bowel and bladder incontinence. Tenant #3's medications were delivered to the facility by her husband who also ordered them. Staff were to let him know when the medications needed to be reordered. Tenant #3 received the medication Forteo daily subcutaneously which was administered by nursing staff. These needs were not identified on Tenant #3's Service Plan, which was dated 5/17/20. 4. Review of Tenant #4's file on 12/16/20 revealed an assessment completed on 9/24/20 after he returned to the program following a stay at a skilled nursing facility for a fall on 9/10/20. His assessment noted he ambulated with a four wheeled-walked independently but needed occasional supervision/standby help to walk. He required staff escorts to the dining room with his	A 083	Tenant # 3 No Longer at Stoney Pooint Meadow's D/C 1/7/21 Tenant #4 -No Longer at Stoney Point Meadow's D/C 12/3/20	

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A 083	Continued From page 3 walker twice daily. He sometimes became short of breath with exertion. His gait occasionally became slightly unsteady if he did not center himself after going from a standing position to a sitting position. Tenant #4 was noted to be at an increased risk of falling. Staff were given interventions on the assessment to help him reduce his risk of falling, such as encouraging him to continue to exercise for strength and use the techniques learned from physical therapy, encouraging him to change positions slowly, keep his apartment clutter free, kennel his dogs in the evening and remind him to use his walker. Tenant #5's assessment noted he used Insulin pens and staff assisted him with this administration. He used oxygen but was independent with the equipment. Tenant #4 was hard of hearing and staff needed to speak in loud voice to him. Tenant #4 was noted to be mildly confused at times and relied on his spouse for most things. His Service Plan dated 9/25/20 did not address the needs identified on the assessment. 5. Review of Tenant #5's file on 12/16/20 revealed an assessment completed on 11/3/20. According to the assessment she required reminders or help to change her incontinence products as needed. Tenant #5 also suffered disturbed sleep. She occasionally woke in the night and went into others' bedrooms and rummaged through their items. Upon redirection, Tenant #5 became sad as she was unaware what she was looking for. She was also at risk for falling. Staff were to ensure Tenant #5 was wearing appropriate non-slip footwear and help her keep a clutter free and well-lit apartment. These needs were not addressed on her Service Plan which was written on the same date. 6. Review of former Tenant's C-1 file on 12/16/20	A 083	#5- will be corrected at the next Assessment, Facility Service Plan and Master Care Plan will be signed by Tenant or POA.	

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A 083	Continued From page 4 revealed the following Resident Notes: - On 5/2/20 Tenant C-1 raised her voice, yelled at staff and shook her fist in frustration. She attempted to leave the locked memory care unit by shaking the doors. She got her hands around the neck of an aide who was able to get loose. Tenant C-1 calmed down after speaking with her son. - On 5/3/20 Tenant C-1 was shaking the door to the locked memory care unit, yelling to be let out. She then threatened to hit an aide with a broom. She pulled clothing out of her closet to take with her when she left the unit. The LPN (Licensed Practical Nurse) contacted her doctor requesting an increase in the tenant's medication, and followed up on 5/5/20 when she did not receive a reply. - Tenant C-1 became increasingly agitated after her evening meal on 5/7/20 and threatened to hurt staff if she wasn't able to get out of the program. The nurse went to assist Tenant C-1 from entering others' apartments. She grabbed another tenant's walker and did not let go. Tenant C-1 was escorted to her room by two staff members while she pushed, pinched and squeezed staff's fingers and arms. - The Director of Health Services (DHS) contacted Tenant C-1's physician again on 5/8/20 and left a message explaining the increased behaviors and requested a call back. The doctor put Tenant C-1 on an anti-psychotic medication, Zyprexa. - Tenant C-1 fell on 5/13/20. A staff person informed the LPN Tenant C-1 had been having episodes of overnight incontinence and had refused to shower that morning. Tenant C-1's son was contacted and asked to bring a pack of incontinence pads for her. - Tenant C-1 became agitated the afternoon of 5/27/20. She grabbed, yelled, screamed and	A 083		

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A 083	Continued From page 5 then bit a staff member. The DHS received a call from Tenant C-1's doctor and explained the ongoing behaviors from the last few weeks. She explained the behaviors started around 1:00 PM and continued on and off until 8:00 PM. The doctor increased Tenant #C-4's noon dose of Zyprexa. - A called was placed to Tenant C-1's doctor again on 5/28/20 about her behavior and he stated she needed to be sent to the emergency department for an evaluation. Tenant C-1 was admitted to the hospital and discharged back to the facility on 6/1/20. Shortly after returning to the program the tenant yelled at staff and threatened to break the door down and and windows out of the building if she was not let out of the locked unit. She also took another tenant's walker to try and hit the window out. Tenant #C-4 was taken to her room where she tried to bite and scratch an aide - The DHS discussed her concerns about Tenant C-1's behavior and possible over-sedation with her son on 6/2/20. - Tenant C-1 was found lying on her right side in front of her recliner on 6/3/20. A call was placed to her doctor's office and he agreed to change some of her medication from pills to be taken daily to pills that could be taken if she showed agitation. Tenant #C-4 had a fall later in the day without injury. - She rolled off the couch on 6/5/20. - Tenant C-1 was found at the memory care door yelling and banging on 6/6/20. She had a butter knife in her hand trying to get the door open. Staff A asked for the knife and the tenant raised the knife up. Staff A instructed her to put if down and the tenant put it on the table. She fell later in the day. - Tenant C-1 walked around the memory care unit on 6/7/20 and told other tenants they needed	A 083		

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A 083	Continued From page 6 to kill some people. She yelled she needed to be let out of the program. - On 6/8/20 Tenant C-1 cornered a couple of kitchen staff and tried to hit them with her walker. She was redirected, but then tried to break a window with her walker. She then knocked over a table to break a window. It took her about 40 minutes to calm down. Later that evening, she picked up a dog decoration and threw it at the window in order to get out of the building. She then approached another tenant and started pushing at her walker. Staff B intervened and redirected her away from the other tenant. The LPN received a call from the doctor who decreased Tenant C-1's medication. He also stated the tenant may need a higher level of care. - Tenant C-1 was aggressive and agitated on 6/15/20 as demonstrated by yelling and kicking at door. She yelled at other tenants and slapped one tenant on the shoulder. This behavior went on for about an hour, then eased up. Later on, Tenant C-1 was found choking another tenant and trying to push her to the floor. - On 6/21/20, several staff members were in the office at shift change when Tenant #C-4 banged on the door and yelled. She started walking towards a tenant she had hit before and staff rushed to intervene. Tenant C-1 started shaking her hand at another tenant while yelling at her. The other tenant was taken to her room and the staff went back to the office. Tenant C-1 held the door shut and did not let the staff members out of the office. The receptionist came to the unit and after 10-15 minutes, was able to get the tenant away from the door. She yelled at the receptionist and grabbed another tenant's walker. - Tenant C-1 was had falls on 6/22/20, 6/24/20 and 6/25/20. - She banged on the door and windows to the unit asking to get out on 6/26/20.	A 083		

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A 083	Continued From page 7 - Tenant C-1 was found laying on her back on the floor on 6/27/20, found on the floor next to her bed on 7/13/20 with some calf pain, and on the floor on 7/14/20. - She was found on the floor in her room on 7/19/20 and hit her head on the floor. - Tenant C-1's walker got ahead of her and she fell to her knees on 7/20/20. - On 7/27/20 the tenant grabbed and twisted the wrist of a staff while digging her nails into her arm. She also tried to bite her. - Tenant C-1 was found on the floor by her bed on 7/28/20. Blood was noted on her right temporal area with swelling and bruising noted. Blood was noted on her air conditioning unit and her walker was tipped over. She was sent to the emergency room. A call was placed to her doctor by the DHS asking to discontinue the Zyprexa due to increased falls, balance issues and drowsiness. She returned to the program. - When Tenant C-1 was checked on 7/29/20, she did not seem right. She was unable to answer questions and just stared at staff. The LPN called the tenant's son and he asked staff to monitor his mother as she had just been fully checked at the emergency room. - Tenant C-1 fell when walking in the common area on 7/30/20. - The tenant's son was notified on 7/31/20 his mother was requiring more assistance with her cares and was having more falls. He was informed he needed to look for other placement for her. Tenant #4 moved from the program on 8/20/20. On 12/15/20 at 1:30 PM, Staff C reported Tenant C-1 became more aggressive after visitation was limited due to COVID-19. She was occasionally physically aggressive, doing things such as hitting and scratching. She sometimes yelled or become	A 083		

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A 083	Continued From page 8 physical towards the other tenants. On 12/15/20 at 2:10 PM, Staff D stated Tenant C-1 had chased staff with bowls of oatmeal. She once took an end table and tried to break out a window. She had pushed a staff down and tried to bite her. Staff D recalled Tenant C-1's aggression worsened after restrictions were put in place with COVID-19 as she did not like seeing staff in face shields and face masks. The tenant was occasionally aggressive toward other tenants. She had also tried to get other tenants to help her break out of the building. On 12/15/20 at 3:25 PM Staff E reported Tenant C-1 became combative with showers. She also pounded on the door of the memory care unit trying to get out. On 12/15/20 at 4:00 PM, Staff F reported getting bruises from Tenant C-1 when she tried to intervene in a situation between Tenant C-1 and another tenant. Tenant C-1 had a Service Plan dated 8/23/19. An annual updated serviced plan was not located. The 8/23/19 service plan was not updated to address her changes of condition related to falls or behaviors. 7. The program utilized a Master Care Plan which addressed changes to tenant needs identified on the assessments. Master Care Plans could be accessed by staff to provide cares to tenants. However, the information on the Master Care Plans was not included on tenant Service Plans and was not reviewed or signed by tenants and/or responsible parties when changes were made. 8. The Director of Housing and DHS confirmed	A 083	Tenant C-1 is no longer at Stoney Point Meadows. Going Forward Stoney Point Meadows will include Master Care Plan and Service Plan to be reviewed and signed by Tenant or responsible parties within 30 days, annually or significant change. This will be monitored and trained by [redacted] DON. Plan of Correction date is 2/2/21 - DN	

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