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 09/28/2023

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. Number of tenants without cognitive impairment: 70 Number of tenants with cognitive impairment: 18 Total census: 88 No regulatory insufficiencies were cited during the investigations of Complaint #111413-C, #113390-C or Incident #113700-I. The following regulatory insufficiencies were cited during the investigation of Incident #113467-I.	A 000	Program Policy Motion Sensor see attached. Correction- Program will revisit with each Health Care Aide Policy re Motion Sensors in Memory Care Before Dec 1st. The training of the Memory Care Sensors will be completed by the DON or The Executive Director. Program has Motion Sensors in Memory care rooms (14). The Intent for the motion sensors is to monitor a resident's movement between 10pm and 6am. The sensor will Alert the Health Aide via phone alert to assist with Resident .	
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 regarding motion sensor alarms for 1 of 1 tenants reviewed during the investigation of Incident #113467-I (Tenant #1). Findings follow: Record review on 9/11/23 revealed the following: Review of a Resident Incident Report dated 6/3/23 at 3:07 a.m. documented staff walked into Tenant #1's apartment to check on her and found her on the floor. Staff asked her if she was okay, tried to sit her up, and noticed blood on the floor	A 150	Measures taken to ensure that this problem will not recur- Re-educate with current staff and new employees importance of responding to the sensors in a timely manner. Educate on Cassia Policy on Motion sensors. Program will run the Notify report which allows us to see time of alert and time answered.. The Nursing Department will review Notify report. This will be put in as a task for Nursing to complete. If incident report needed Nursing and Director review. The above corrections will be completed by December 1st 2023.	

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

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A 150	Continued From page 1	A 150		

that was from her head. Staff notified the nurse and then called 911.

Review of medical records on 9/28/23 revealed Tenant #1 arrived at the emergency room at 3:47 a.m. and was diagnosed with a subdural hemorrhage and a midline shift of the brain due to hematoma and required 12 staples to the laceration on her head. The on-call neurosurgeon agreed due to her advanced dementia he would not recommend surgery. The physician recommended hospice care and Tenant #1 was admitted for comfort measures.

The Motion Sensor Log revealed motion detected at 2:42 a.m. and again at 3:03 a.m.

The Resident Care policy for Motion Sensors described motion sensors were devices intended to monitor a resident's movement and alert staff that a resident may be getting out of bed or moving around in their apartment. Motion sensors were most often used at night in the memory care units to alert staff of resident movement who may need assistance with safe mobility to their destination. Memory Care units may have motion sensors in place and staff were trained in the use of these devices. Each time the motion sensors alerts, staff were to go to the resident's room and visually see that the resident was ok, up and needing assistance.

A Comprehensive Assessment completed 2/28/23 revealed Tenant #1 fell 6 times since 12/30/22 and the most recent resulted in a pelvic fracture.

The Plan of Care updated on 2/28/23 indicated she used a walker and required the assistance of one staff for ambulation and transfers as needed.

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A 150	Continued From page 2 The Plan of Care noted she would abandon her walker at times and required reminders to use it. When interviewed on 9/11/23 at 3:38 p.m. about the fall on 6/3/23 the on-call Registered Nurse stated the motion sensor activated at 2:42 a.m. Review of the Program's camera in the community area revealed Staff A continued to stay seated and used the restroom before walking to Tenant #1's room to check on her approximately 20 minutes after the sensor went off. She confirmed staff were expected to respond immediately upon activation. Staff A was not available for an interview as she was no longer employed at the Program. When interviewed on 9/12/23 the Director of Health Services reported Tenant #1 required admission to hospice care for a brain bleed and did not return to the Program. She stated all staff were educated on the motion sensors during their orientation period and they were only used in the memory care unit for tenants that were a fall risk.	A 150		

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